PHD

Community Treatment Orders: what do they tell us about the exercise of power over the psychiatric patient?

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Community Treatment Orders: what do they tell us about the exercise of power over the psychiatric patient?

Are they protecting the patient, the public, or the professionals?

Volume 1 of 1

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For Harriet

Focus on the positive outcome

Abstract

Community Treatment Orders (CTOs) provide a means by which treatment for mental disorder may be imposed upon some psychiatric patients once they are discharged from detention in hospital. They are intended to prevent patients disengaging from treatment, avoiding a deterioration in their condition which may result in harm and readmission to hospital. Although initially intended for a small number of patients who posed most risk, their uptake far exceeded Government expectation, yet research has questioned their effectiveness in achieving their intended aims. This study explores the exercise of professional power over the psychiatric patient by analysing professional decision-making in the use of CTOs to better understand the reasons for their use. To do this, the theory of governmentality was used as a means of analysing professional actions. This analysis adds to the existing body of knowledge by examining the factors influencing professional decision-making. The findings highlight professional justification for CTO use and reveal the balance of care and control over the psychiatric patient.

This study employs qualitative methods to gather data from the two professional groups involved in the CTO decision-making process: responsible clinicians (RCs) and approved mental health professionals (AMHPs). Individual and joint interviews allowed the gathering of rich, contextualised data from 18 participants. The findings show that medical discourse is dominant among RC and AMHP participants. This is evident in participant accounts of mental disorder and its associated behaviours and in professional responses to mental disorder. In addition, some more socially orientated considerations form part of CTO consideration. These social factors are not, however, concerned with the patient, but with interdisciplinary dynamics and resources. These findings indicate that the balance of power rests with professionals, as opposed to patients, and that CTOs are being used to protect professionals, ahead of patients and the public.

Abbreviations

A5	Article 5, to denote the Article number of the ECHR
AC	Approved Clinician
AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
AO	Assertive Outreach
CCO	Care Co-ordinator
CMHT	Community Mental Health Team
CoP	Code of Practice (Government guidance accompanying the MHA)
CPA	Care Programme Approach
CQC	Care Quality Commission
CSIP	Care Services Improvement Partnership
CTO	Community Treatment Order
DoH	Department of Health
DSM 4	Diagnostic and Statistical Manual 4
ECHR	European Convention on Human Rights
HCPC	Health and Care Professions Council
H&SCIC	Health and Social Care Information Centre
HRA	Human Rights Act 1998
ICD 10	International Classifications of Disease 10
ICU	Intensive Care Unit
MHA	Mental Health Act 1983
NCISH	The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
NIMHE	National Institute for Mental Health in England
NR	Nearest Relative
OCD	Obsessive Compulsive Disorder
OCTET	Oxford Community Treatment Order Evaluation Trial
OT	Occupational Therapy
PICU	Psychiatric Intensive Care Unit

RC	Responsible Clinician
RMO	Responsible Medical Officer
RMP	Registered Medical Practitioner
s1	Section 1, to denote the section number of an Act
SOAD	Second Opinion Appointed Doctor
SW	Social Worker
UPIAS	Union of the Physically Impaired Against Segregation
WHO	World Health Organization
WO	Welsh Office

Introduction

This PhD study aimed to explore the exercise of professional power over the psychiatric patient through the use of community treatment orders. Community treatment orders are a statutory means of compulsorily treating psychiatric patients in the community, as opposed to in a hospital setting. CTOs were introduced into statute in 2008 following the process of legislative reform spanning 10 years. It has been suggested that their introduction was the result of two homicides committed by people with mental disorder. First, on 17 December 1992, Jonathan Zito was killed by Christopher Clunis, a patient with a diagnosis of paranoid schizophrenia and who had ceased medication treatment. Second, on 9 July 1996, Lynn and Megan Russell were murdered by Michael Stone, a convicted offender with a severe personality disorder. At that time, personality disorder was viewed as untreatable and as a result it is understood that Michael Stone was denied admission to hospital days before the murders were committed.

By 2000, the Government had published a White Paper, Reforming the Mental Health Act. Central to its proposals was the broadening of the definition of mental disorder, the removal of the ‘treatability test’ (both aimed at including those with personality disorder) and the introduction of compulsory community treatment, providing ‘flexibility for compulsory powers’ (DoH, 2000b, p. 22). Put simply, a greater number of people could be considered mentally disordered, and as a result forcibly treated. As Alan Milburn and Jack Straw put it in the Foreword to these proposals:

> *Too often, severely ill patients have been allowed to drift out of contact with mental health services. They have been able to refuse treatment. Sometimes, as the tragic toll of homicides and suicides involving such patients makes clear, lives have been put at risk. In particular existing legislation has also failed to provide adequate public protection from those whose risk to others arises from severe personality disorder. We are determined to remedy this. (DoH, 2000b, p. 1)*

This process of legislative reform resulted in changes aimed at bringing those that posed most risk within the scope of the Act, and to provide a means by which treatment could be enforced to avoid homicides and suicides by those with mental disorder. However, after only one year of their implementation, over 4,000 people were subject to community treatment orders, raising concerns about their use. Dr Rowena Daw (2009), then Vice-chair to the Mental Health Alliance, in a press release stated:

> *The new law is working in an unbalanced way. There is more coercion without adequate safeguards, to the detriment of individual patients. While there is no firm evidence as to the precise reasons for the high use of this new power, it demonstrates clearly that if the entry point to CTOs is very broad the numbers of people on them will be correspondingly large. This flies in the face of the government's stated intentions for their use. It will lead to widespread use of this coercive regime in the community.*

More than ten years after their introduction, the use of CTOs continues to grow, far exceeding Government expectation. At the same time, the detained in-patient population has grown (CQC, 2018a), representing an overall increase in the use of coercive means of managing the mentally disordered. It is this greater than anticipated use of power over patients, by means of community compulsion, that has prompted this research.

Despite Government concern for risk behaviours arising from mental disorder, and resultant legislative change, the decision to impose community compulsion rests with mental health professionals, responsible clinicians (RCs) and approved mental health professionals (AMHPs). While governed by statute and statutory guidance, RCs and AMHPs retain discretion to decline a CTO even where statutory criteria are met. Prior to the introduction of CTOs, the Mental Health Alliance, a coalition of 77 members including the Royal College of Psychiatrists and the British Association of Social Workers, opposed any form of community compulsion and warned against 'the risks of significant over-use of community treatment orders and the excessive powers the Bill gives to clinicians' (2007, p. 1). Despite this initial opposition to community compulsion and excessive professional power, RCs and AMHPs have made great use of their powers.

This research aims to examine professional justification for the exercise of power over psychiatric patients through the use of CTOs.

To achieve this, the study employed qualitative methods to gather data from those charged with CTO consideration and implementation - RCs and AMHPs. Individual and paired interviews were conducted with 18 participants, over 12 separate interviews.

The thesis consists of seven chapters, arranged over four parts. The first part is entitled 'Conceptual framework' and includes two chapters addressing the site of enquiry and the chosen theoretical framework. First, in Chapter 1, an overview of the means of community compulsion is offered, before focusing on CTOs and their operation. This is offered to provide context to later discussions about professional practices. An analysis of CTOs is then offered using administrative statistics, showing higher than anticipated uptake and research findings calling into question their usefulness in achieving their intended aims. Second, in Chapter 2, the theoretical framework underpinning this study is explained and justified. This includes Foucault's theory of governmentality, and the development of his ideas by others. This is followed by a consideration of how the development of legislative and policy frameworks govern practice. Finally, research findings in respect of professional perceptions of compulsion are explored to offer an understanding of how professionals view their role and responsibilities in respect of patients, and specifically how they justify their actions. The chapter then concludes by setting out the specific research questions addressed in this study.

The second part of this thesis, entitled 'Research design', comprises one chapter. Chapter 3 first outlines the research methods, including the ontological and epistemological underpinnings, before outlining the qualitative means by which the research question will be explored. The research process is then explained before addressing the means of data analysis and data presentation.

The third part of this thesis, entitled 'Findings', comprises three chapters. In Chapter 4, the ways in which mental disorder is understood are set out, and it is made clear which understandings offer justification for intervention. Chapter 5 builds on

Chapter 4 by outlining other influential factors relevant to professional decision-making. These findings highlight that professional decision-making is influenced by factors unrelated to patients. In Chapter 6, professional responses to mental disorder are set out along with their justification for intervention.

Part 4, entitled ‘Implications for practice, policy and legislation’, comprising one chapter concludes the thesis. Chapter 7 begins by exploring how the findings address the three research questions. Each of the research questions are restated, and a synopsis of the findings is offered to show how the questions have been met, culminating in an answer to the overall research question. Following the research questions, three key themes emerging from the data are addressed, before setting out recommendation for practice, policy and legislation. The chapter then concludes with the contribution to knowledge, limitations and suggestions for future research.

One final note, the word ‘patient’ is used throughout this research when speaking about CTOs. This is to reflect the meaning offered in s145 MHA, ‘a person suffering or appearing to be suffering from mental disorder’. However, terminology may differ at times of reporting others’ research, in which case the terminology adopted by the author is used, and in the case of references to the Mental Capacity Act 2005, the work ‘person’ is used, representing the terminology of that Act.

PART 1 CONCEPTUAL FRAMEWORK

CHAPTER 1 Community Treatment Orders

Introduction

This PhD study aimed to explore the exercise of power over psychiatric patients. To do this, professional decision-making in relation to Community Treatment Orders (CTOs) was examined. This chapter will therefore introduce CTOs, highlight the inherent tensions between professional power and patient autonomy, and explain why CTOs were chosen as the site of enquiry. The chapter will first explain that CTOs were introduced into statute in 2007, even though the courts had in effect provided for community compulsion by adopting a broad interpretation of an existing provision within the law. This explanation is offered to make clear the Government's intention to legitimise within statute the compulsory community treatment of some psychiatric patients, and in doing so reduce the detained in-patient population. The chapter will then set out who CTOs are aimed at, what they aim to achieve, the legislative process, and explain who makes the decision to impose community compulsion. These sections are informed by statute and accompanying Government guidance underpinning professional decision-making, and therefore offer the reader an understanding of the frameworks within which mental health professionals operate. This explanation of current law and policy is followed by consideration of other factors that may influence professional decision-making when deciding whether to instigate a CTO. The intention is not to provide an exhaustive list of factors that may influence decision-making, but to highlight the complexity of decision-making in the context of CTOs - specifically, the tension between the rights of patients and the public, and the challenge of balancing legal, ethical and professional considerations. Finally, by way of explanation of the chosen site of enquiry, the use of CTOs is analysed using statistical information that demonstrates that CTO use has exceeded Government expectation, and that the detained in-patient population has not decreased as a result of their use, showing an overall increase in compulsory means of managing the mentally disordered. Research evidence will then be explored to highlight the inconclusive findings about the value of CTOs, and to demonstrate that CTOs are being used beyond Government intention. This chapter will therefore offer an understanding of CTOs and a justification for this research.

Means of community compulsion prior to the introduction of CTOs

Community treatment orders were introduced into mental health statute in 2007 and became operational in 2008. Their introduction was intended to provide a means by which treatment for mental disorder could be enforced within the community as opposed to in a hospital. CTOs therefore reflect changes in the way that mental health care and treatment is delivered. Prior to their introduction, the only means of enforcing treatment beyond the confines of detention in a hospital was by the provisions governing the treatment of patients liable to be detained,[1] but subject to leave of absence from hospital under section 17 of the MHA. Section 17 (s17) leave of absence could be granted for specified occasions, specified periods or indefinite periods of time, by the patient's responsible medical officer (RMO).[2] Leave of absence was viewed as an important part of the patient's treatment plan, but it was not intended to be used as an alternative to discharge from hospital (DoH and WO, 1999a). This was made clear in the case of *R. v. Hallstrom and Another, ex parte W; R .v. Gardner and Another ex parte L* [1986] 2 AllER 306, which confirmed that the renewal of detention followed by the immediate further granting of s17 leave of absence for patients already subject to leave of absence within the community was unlawful. Nor was s17 leave of absence intended as a means of enforcing treatment upon the capacitated refusing patient while they were in the community. Where administration of treatment in the absence of patient consent was considered necessary, the RMO was to consider recall to hospital, but

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[1] Part 4 MHA sets out the provisions for providing treatment for mental disorder.

[2] Since the amendment to the 1983 Act (by way of the 2007 Act), the RMO has been replaced by the responsible clinician (RC). In the case of restricted patients, leave may only be granted with the approval of the Secretary of State for Justice.

refusal of consent to treatment was not by itself seen as sufficient grounds to recall the patient to hospital (DH and WO, 1999a). The intention of s17 leave of absence can therefore be viewed as a means of working towards eventual discharge from detention in hospital, as opposed to a means of enforced treatment beyond the confines of detention in hospital.

However, developments in case law led to the use of s17 leave of absence as a means of supervising patients liable to detention while they remained largely in the community. The case of *B. v. Barking Havering and Brentwood Community Healthcare NHS Trust* [1991] 1FLR 106, established that it was lawful to renew a patient's detention while she was largely continuing on s17 leave of absence, provided the patient's treatment as a whole included treatment as an in-patient. This development was viewed by Barber *et al.* as the beginning of s17 leave of absence being used as a lawful 'long leash' approach, enabling greater controls over patients within the community (2017, p. 460). This necessity for in-patient treatment was then diluted in the case of *R. (on the application of DR) v. Mersey Care NHS Trust* [2002] EWHC1810 (Admin) where the judge stated there was no requirement of in-patient treatment, simply treatment *at* a hospital, albeit the treatment needed to be an essential part of the overall care plan. A later challenge to the lawfulness of the use of continued s17 leave of absence while the patient remained largely within the community, in the case of *R. (on the application of CS) v. Mental Health Review Tribunal and Another* [2004] EWHC 2958 (Admin) failed and the Tribunal[3] upheld the detention of a patient, although the grasp on the patient by the RMO was described as 'gossamer thin' while encouraging progress towards discharge.

These judgments, coupled with the loose interpretation of the word 'hospital', for the purpose of treatment *at* a hospital, adopted in the case of *KL v. Somerset Partnership NHS Foundation Trust* [2011] UKUT 233 (ACC), where the care plan included fortnightly attendance at a community mental health team (CMHT) for the purpose of

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[3] The Mental Health Review Tribunal, now Mental Health Tribunal, ensures that the patient's right to a speedy and effective challenge to detention is respected. It therefore has the power to discharge patients.

medication administration and appointments with a key worker, has resulted in the ability to manage and treat detained patients in the community provided an essential element of treatment is necessary at a hospital (as broadly defined). These judgments in effect offered a community treatment order in all but name prior to the introduction of CTOs. The Courts therefore provided an increasingly elastic interpretation of s17 leave of absence, stretching it from the initial intention of a means of gradual discharge from hospital, to the facilitation of ongoing community compulsion.

Despite these developments in case law, allowing the compulsory treatment of patients liable to be detained (yet largely living within the community), CTOs were introduced as a means of discharging patients from hospital, while compelling treatment for mental disorder in the community. This signalled a clear intention on the part of Government to legislate for the compulsory community treatment of the mentally disordered, to prevent risks arising from mental disorder, rather than simply relying on the increasingly elastic interpretation by the courts of s17 leave of absence. Not only were CTOs introduced, but legislative change to s17 MHA compelled RCs to 'consider' use of a CTO where s17 leave of absence was to be granted for more than 7 consecutive days (s17(2A)), and Government guidance (DoH, 2015a) advocated that s17 leave of absence should not normally exceed one month, thus steering RCs towards use of CTOs. Thus, Governmental power operates to govern the conduct of professionals, which in turn governs the conduct of patients. These statutory changes therefore legitimised the continued compulsory treatment of some patients within the community, steered professionals towards CTO use and gave professionals the power to enforce continued compulsion beyond the confines of hospital.

Who are CTOs aimed at and what do they aim to achieve?

CTOs are available to patients of any age[4] who are detained under s3 MHA for treatment, and to mentally disordered offenders (under Part 3 MHA),[5] other than those subject to a restriction order or direction (DoH, 2008b). Eligible patients must therefore have had a period of treatment in hospital, and as a result their medical condition and treatment needs will have been established before they are discharged into the community under a CTO (Hansard, HL Vol. 687, cols. 656, 657). The Code of Practice (CoP) to the MHA states that CTOs seek to 'prevent the "revolving-door" scenario and the harm which could arise from relapse' (DoH, 2015a, p. 350). Relapse (a deterioration in the patient's mental state) has been attributed to a failure by patients to comply with treatment (DoH, 2000a). As such, CTOs are designed to:

> *allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery.* (DoH, 2008a, p. 220)

Amendments to Government guidance in 2015 restated the intention of CTOs to help patients maintain stable mental health in the community and to minimise harm. This was to be achieved by enabling the compulsory treatment of patients. Although treatment is broadly defined in the MHA as 'nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care' (s145(1) MHA), the treatment of CTO patients is most commonly by means of psychoactive drugs administered orally or by depot injection (Smith *et al.,* 2014). Medication treatment cannot, however, be forcibly administered in the community in the face of a capacitous

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[4] The MHA is not age specific (other than guardianship, which requires the patient to be aged 16 or over).

[5] Part 3 of the MHA covers patients concerned with criminal proceedings and those under sentence. It enables the courts to order the admission of patients to hospital and the Secretary of State to transfer prisoners into hospital.

refusal, but the RC is able to recall the patient to hospital if the following grounds are met:

> *the patient requires medical treatment in hospital for his mental disorder; and there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.* (s17E (1)(a) and (b) MHA)

These grounds are likely to be met if a capacitous patient refuses such treatment in the community, as the only lawful means of administering it in these circumstances is in a hospital (Part 4A, MHA).[6] The recall provision enables the detention of the patient in a hospital for up to 72 hours, during which medication can be administered forcibly provided that it is for the purpose of alleviating or preventing a worsening of the disorder, its symptoms or manifestations (s145(4) MHA). But as the purpose of a CTO is to prevent the revolving-door scenario, conditions may be set with the aim of avoiding a return to hospital. There are two types of conditions: mandatory and non-mandatory. The mandatory conditions form part of all CTOs and require patients to make themselves available to the RC for an examination with a view to extending the order,[7] and to the second opinion appointed doctor (SOAD) for the purpose of consent to treatment.[8] These conditions cannot be altered, but arguably do not have a significant impact on the patient. In contrast, the non-mandatory conditions set by the RC, with the agreement of an approved mental health professional (AMHP), have the potential for a greater interference with patient freedoms. Non-mandatory

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[6] Other grounds for recall include a deterioration in the patient's mental health to the point of needing in-patient treatment, or a failure by the patient to comply with a mandatory condition.

[7] An extension can occur at six months after the making of a CTO, following a further six-month period and then annually.

[8] The SOAD is an independent doctor who must be involved in authorising continued treatment beyond one month of a CTO in the event of patients lacking mental capacity to consent to treatment, or making a capacitated refusal of treatment. This is a safeguard for patients, ensuring independent oversight of treatment.

conditions may cover matters such as ‘where and when the patient is to receive treatment in the community, where the patient is to live, and avoidance of known risk factors or high-risk situations relevant to the patient’s mental disorder’ (DoH, 2015a, p. 333), provided they are necessary or appropriate for the purpose of:

> *(a) ensuring that the patient receives medical treatment;*
> *(b) preventing risk of harm to the patient’s health or safety;*
> *(c) protecting other persons.* (s17B, MHA)

Government guidance asserts that conditions should be kept to a minimum number, restrict the patient’s liberty as little as possible, and be expressed in a way that the patient can understand (DoH, 2015a). Conditions commonly concern adherence to medication (Doughty *et al.*, 2013), access to the patient by professionals, the requirement of residence at a specified place, and abstinence from illicit drugs and alcohol use (Smith *et al.,* 2014). These conditions are arguably restrictive of patient freedoms, and recent case law has concluded that conditions may lawfully amount to a deprivation of liberty.[9] CTOs are therefore aimed at patients who are considered as presenting a risk of harm to themselves and/or to others, and seek to prevent such harm by imposing conditions to alter or avoid concerning behaviours. CTOs as an apparatus for the identification and management of a problem population will be considered from a social theoretical perspective, drawing on Foucault’s theory of governmentality later in this chapter.

Legislative process

While CTOs provide a lawful means of restricting patient freedoms in the community in order to maintain stable mental health and to prevent harm, they are only available to patients detained under section 3 MHA or to unrestricted part 3 patients, who meet the following criteria:

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[9] MM & PJ [2017] EWCA Civ 194.

(a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

(b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

(c) subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital;

(d) it is necessary that the responsible clinician should be able to exercise the power under section 17E(1)[10] *below to recall the patient to hospital; and*

(e) appropriate medical treatment is available for him. (s17A(5)(a-e) MHA 1983 as amended) (s17A – E)

In practice, these criteria are likely to be met, as three (a, b and e above) mirror the detention criteria for the section to which the patient is already subject to make them eligible for CTO consideration. Mental disorder, above at (a), is defined in the Act as 'any disorder or disability of the mind' (s1(2), MHA), and the Code of Practice to the MHA sets out a number of 'clinically recognised conditions which could fall within the Act's definition of mental disorder' (DoH, 2015a, p. 26) This definition is broadly, yet medically construed bringing many within its scope. While the criteria at (b) should be met (as it too forms part of the detention criteria for the section to which the patient is already subject), Government guidance states that the RC should consider 'the patient's history of mental disorder, previous experience of contact with services and engagement with treatment' (DoH, 2015a, p. 329). As such, patients who have previously disengaged with services and/or treatment are likely to meet this criterion. The criterion at (e) above concerns the availability of appropriate medical treatment, and medication treatment will meet this requirement. This leaves two criteria (c and d above) that do not mirror that of the detention section to which the patient is already subject; therefore, they require consideration and justification before a CTO may be

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[10] Section 17E(1) sets out the criteria under which the responsible clinician can recall a CTO patient.

made. In relation to (c) above, the ability to provide treatment outside the confines of a hospital should not prove problematic as those being considered for a CTO will be subject to the care programme approach (CPA), which ensures the allocation of a care co-ordinator (CCO) with the remit of co-ordination of care and treatment, therefore meeting the criterion at (c) above. When establishing the necessity of the RC to recall the patient to hospital at (d) above, the Act requires the RC to consider the patient's history of mental disorder and any risk that may arise as a result of failing to receive medical treatment for mental disorder (s17(A)(6) MHA). Government guidance in relation to this criterion has changed over time, but in essence it is concerned with the potential for 'risk' arising from mental disorder (DoH, 2008a, 2015a), as such 'risk' may be offered as justification for a CTO. It may therefore be argued that the threshold for meeting the legislative criteria for a CTO are set low, providing the potential for many patients to have their freedom curtailed and to be compulsory treated within the community.

Given that the statutory criteria for a CTO are set low, CTOs may be used for the purpose of imposing a variety of treatments - for example, nursing, medication and psychological interventions - on patients with divergent mental disorders - for example, psychotic, depressive, personality or eating disorders. CTOs were however intended for severely ill patients who refused treatment and as a result lives were put at risk (DoH, 2000b). Early indications by the Care Quality Commission (CQC, 2010), following a sample of second opinions[11] for those subject to a CTO showed that 81% had a diagnosis of schizophrenia and other psychotic disorders, and 12% had a diagnosis of mood disorders. Almost all of the sample were prescribed anti-psychotic medication, with 65% being administered depot medication as part of their treatment, and 35% receiving dosages above recommended limits. These statistics indicate that CTOs were being used as a means of administering medication treatment to those with serious mental disorders. These statistics have not been replicated by the CQC, making it difficult to accurately reflect the range of patients and treatments amongst the current CTO population. However, as this study is not concerned with the efficacy of treatment

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[11] Second opinion appointed doctors (providing a second opinion of medical treatment)

or CTOs, but with the exercise of power over patients, the sample is intended to reflect the population CTOs were initially intended for.

It is however important to acknowledge that fulfilling the statutory criteria is not determinative of a CTO being made. Professionals are able to exercise discretion, choosing not to impose a CTO even where these criteria are met. The CTO decision-making process should therefore be informed by other factors - for example, human rights, and ethical, medical and social factors. These factors are discussed below under the heading 'Decision-making'. Before exploring these factors, I have made clear who the decision-makers are, as their professional expertise is also relevant to the decision-making process.

Who decides?

This section will outline who the decision-makers are and explain their distinct roles. As is evident from the information above, two professionals must be involved in CTO consideration: an RC and an AMHP. These professionals are likely to be from different professional disciplines, and they are required to have regard to different considerations. The RC will be the 'approved clinician with overall responsibility for the patient's case' (s34(1)(a) MHA), and may be from a range of professional disciplines,[12] but this role is most commonly fulfilled by registered medical practitioners (RMPs). RCs are therefore likely to bring medical expertise, and in some cases their knowledge of the patient (as a detained in-patient) to the decision-making process. This role is balanced with that of an AMHP, who can be from the same professional disciplines as the RC, other than an RMP, but in practice, they are in the majority social workers (SW). Unlike the RC who is likely to have prior knowledge of the patient, the AMHP is not required to have prior knowledge or involvement with the patient (DoH, 2015a), nor are

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[12] A registered medical practitioner, a chartered psychologist, a registered mental health or learning disability nurse, a registered occupational therapist or a registered social worker, see Mental Health Act 1983 Approved Clinician (General) Directions 2008, Schedule 1. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_086550.pdf

they required by the Act to meet the patient, albeit revisions to Government guidance suggests ‘the AMHP should meet with the patient before deciding whether to agree that a CTO should be made’ (DoH, 2015a, p. 331). The AMHP, as part of their decision-making, should consider the wider social context, including ‘support networks the patient may have, the potential impact on the rest of the patient’s family, and their need for support in providing care, and employment issues’ (DoH, 2015a, p. 331). They should also consider the ‘patient’s social and cultural background’ (DoH, 2015a, p. 331). Taken together, these distinct professional roles should ensure consideration of medical and social factors before a decision is taken to extend compulsory treatment into the community. However, concern has been raised that AMHPs have not ‘consulted any wider than reading the medical file and the responsible clinician’s statement’ (CQC, 2010, p. 103), resulting in the potential for the medical model to prevail during the decision-making process. On the other hand, a more recent study by Doughty *et al.* (2013) exploring practitioner experiences of CTOs, found that AMHPs view their role as wide, encompassing understanding the law, assessing and managing risk, taking a broad view of the patient’s situation, considering less restrictive options, avoiding discriminatory practices and, where necessary, challenging their RC colleagues. There was evidence within this study that AMHPs were concerned by too little time to fulfil their role and an expectation that they would simply rubber stamp RC decisions. That said, it appears that the expectation to rubber stamp CTOs is diminishing over time. Further consideration is given to professional knowledge and the role this plays in the exercise of professional power in Chapter 2 below.

Decision-making

Having established the need for two professionals (with distinct roles) to be satisfied that statutory criteria are met, they must also consider other factors as part of the CTO decision-making process. This section will consider these other factors, which broadly include legal, ethical, medical and social considerations, and resources. Above all, professionals as public authorities[13] for the purpose of the Human Rights Act (HRA) 1998[14] are required to uphold human rights. Use of a CTO and its associated conditions engages Article 8 of the European Convention of Human Rights (ECHR), the 'right to respect for his private and family life, his home and his correspondence' (A8(1)), and Article 5 of the ECHR, the 'right to liberty and security' may also be engaged where CTO conditions amount to a deprivation of liberty. Any interference with these rights must be justified on the basis of it being necessary, in accordance with the law[15] and proportionate to the legitimate aim. These rights may be competing, and this is recognised in Government guidance which states:

> *In some instances, competing human rights will need to be considered, which may require finely balanced judgements… Decisions restricting a person's rights will need to be justifiable as necessary and proportionate in the circumstances of the specific case. Any restriction imposed should be kept to the minimum needed to meet the purpose and aim of the restriction. (DoH, 2015a, p. 30)* [16]

These principles of necessity and proportionality are reflected in mental health-specific Government guidance which sets out the principle of 'least restrictive option and maximising independence' (DoH, 2015a, p. 9). In practice, this principle requires decision-makers to consider the range of options available. These may include

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[13] Section s6(3) HRA defines 'public authority' as '(a) a court or tribunal, and (b) any person certain of whose functions are functions of a public nature'. This will include health and social care professionals, and therefore CTO decision-makers.

[14] The HRA enshrines Articles from the European Convention of Human Rights (ECHR); these rights make it unlawful for a public authority to act in a way that is incompatible with a Convention Right.

[15] A8(2) ECHR, Potential breaches of this right may be justified on the basis of public safety, the prevention of disorder or crime, for the protection of health, or the protection of the rights and freedoms of others, and detention must be in accordance with a procedure prescribed by law, (A5(1)) and those detained must have access to a speedy legal challenge (A5(4)).

[16] *R. (Munjaz) v. Mersey Care NHS* Trust ((2005) UKHL 58) – this case states that guidance should not be departed from unless there are cogent reasons for doing so.

consideration of an alternative legal framework - for example, s17 leave of absence or guardianship under s7 MHA[17], - or removing compulsion by discharging the patient from detention. Discharge from detention may enable the patient to remain in hospital either on a voluntary basis (if they have the capacity to make that decision and are consenting), or on an informal basis (where they lack mental capacity to make treatment decisions, but are not being deprived of their liberty[18]). Alternatively, decision-makers may facilitate complete discharge from detention and hospital, allowing the patient to be free from any means of compulsion.

Concern about the level of restriction upon patient freedoms should therefore be central to CTO decision-making, but this consideration will be balanced with concern to intervene to prevent poor mental health and any resultant harm to the patient or to others. These often competing, legal concerns also involve ethical considerations, as the statutory criteria for compulsion are not concerned with the patient's capacity to make their own decision. As such, professionals are given the power to intervene in the face of a patient's capacitous refusal of treatment, so overriding their autonomy. Concern for patient autonomy was evident at the beginning of the legislative change leading to the introduction of CTOs. The Government, with CTOs in mind, appointed an expert committee in 1998 to provide recommendations for legislative change. The Richardson Report, Review of the Mental Health Act 1983, advocated the principle of autonomy, enabling patients to have 'the freedom to decide for oneself, [and] the ability to make choices which others respect' (DoH, 1999c, p. 18), including the right to 'choose whether or not to accept treatment' (DoH, 1999c, p. 18). Despite these recommendations, the Green Paper (DoH, 1999d), put concern for public protection ahead of patient choice, resulting in an inequality between those with capacity

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[17] Guardianship has the authority to require the patient to reside at a specified place, attend places at specified times for the purpose of medical treatment, occupation, education or training, and to allow access, where they are residing, to any doctor, AMHP, or other specified person. It does not, however, allow forcible treatment.

[18] Deprivation of liberty (DOL) is not defined, but case law helps with the identification of DOL. See *P. v. Cheshire West and Chester Council and another* [2014] UKSC 19.

experiencing mental as opposed to physical ill health, and placing professional decision-making ahead of patient autonomy (Peay, 2000).

Professionals are therefore able to override the capacitous decision of the mentally disordered, compelling care and treatment in the face of their objection. This is in contrast to patients with physical ill health who retain capacity, who are able to exercise choice to accept or to refuse treatment regardless of the consequences of that choice.[19] This disparity has been questioned, but calls for the fusing of mental health and mental capacity laws to ensure that the autonomy of capacitous individuals, regardless of their 'disability', has been ignored (McSherry and Weller, 2010; Szmukler et al., 2010). This distinction between mental and physical health is based on risk, a perception that those with mental ill health, unlike those with physical ill health, may pose risks to themselves or to others as a result of their behaviour, acts and omissions (DoH, 1999c, p. 19). This interference with the autonomy of capacitous mentally ill patients is therefore lawful, but may present ethical challenges for decision-makers.

The effect, therefore, of the MHA, its CoP and human rights legislation, is that a patient may be compulsorily treated, even in the face of a capacitous refusal, provided that statutory criteria for a CTO are met, that there is no other less restrictive means of providing treatment, and that treatment is necessary and represents a proportionate response to the need to protect the patient's health or safety, or that of others. These statutory provisions therefore provide a framework for decision-making, but they leave considerable scope for discretion when professionals exercise their power.

It has already been established that legal and ethical considerations are relevant to decision-making, but in the sphere of CTOs other influential factors have been cited. For example, ensuring contact with professionals, enabling early identification of relapse ensuring medication compliance over a prolonged period of time to achieve a period of stability, and signalling to the patient that they have a serious mental health problem (Coyle *et al.,* 2013). Dawson (2006) has suggested that the legal structure of the CTO regime, the availability of community mental health services, the impact of

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[19] The Kerrie Wooltorton Inquest (2009)

coercion on the professional relationship with the patient, and the expectations of third parties, influence professional decision-making.

Some of the legal, medical and social considerations listed above are concerned with outcome, and so coercive care and control is justified on that basis. The use of coercion is, however, seen in different, sometimes opposing ways. Gostin *et al.,* when considering the law governing the treatment of the mentally ill, stated, ‘It empowers the medical profession to limit liberty, bodily integrity, privacy, and capacity to act’ (2010, p. 5). The use of coercion can therefore be seen as a violation of autonomy. Conversely, coercion can be seen as promoting autonomy (Rose, 1985) - for example, compulsory community treatment as part of a CTO may prevent relapse, reduce hospital admissions, and may lead to higher functioning (Rawala and Gupta, 2014). Even in the absence of these perceived benefits, the ability to be managed in the community, as opposed to remaining a detained in-patient, can in itself be seen as enabling greater autonomy (Rawala and Gupta, 2014).

The above considerations are primarily concerned with the patient - for example, whether they meet statutory criteria and whether interference with their autonomy is justified on the basis of medical or social benefit. However, factors external to the patient may also be influential in decision-making - for example, clinical responsibility and bed occupancy (Mental Health Alliance, 2010; Doughty *et al.,* 2013). Clinical responsibility for the patient often shifts from the in-patient RC to a community RC once a patient is discharged from hospital onto a CTO. This is not the case for patients granted s17 leave of absence, who usually remain the responsibility of the in-patient RC. Use of a CTO may therefore provide a means by which clinical responsibility can be transferred (Curtis, 2014). Patients subject to s17 leave of absence also continue to be counted as in-patients for the purpose of bed occupancy. This has the undesirable effect of increasing bed occupancy levels, even though the patient is not physically in a hospital. Limited hospital bed availability may also encourage early discharge to make way for less well patients. Use of CTOs is a potential way of facilitating this early discharge, with a supportive care plan (Mental Health Alliance, 2010; Doughty *et al.,* 2013), although premature discharge may lead to redetention in a hospital, resulting in greater restrictions on the patient (CQC, 2018a).

The process of making a decision about the use of a CTO is therefore complex, requiring decision-makers to balance often competing legislative requirements and ethical considerations, including balancing the rights of the patient and the wider public, and professional and resource considerations. The weight given to these considerations may differ depending on the facts of the individual case, and professionals' view of their role in relation to the patient and to the wider public. Variation may therefore be evident in professional decision-making, and this will be reflected in CTO uptake.

Anticipated and actual use of CTOs

The Government anticipated that CTOs would be used for a few that posed most risk. They projected the use of 200 CTOs within the first year, and a gradual increase over five years, amounting to 10% of the section 3 population and 10% of the Part 3 population by 2012/13 (DoH, 2006a, p. 55). The actual figures for this timeframe reported by The National Health Service Information Centre, set out below, show a higher than anticipated uptake of CTOs, suggesting that the coercion and compulsory treatment associated with the asylum and mental hospitals has been extended to the community (Rogers and Pilgrim, 2010). The reason for this disparity between the anticipated and actual number of CTOs is unclear, but irrespective of the reason, this high uptake is surprising given the initial opposition to CTOs from the Mental Health Alliance, including the Royal College of Psychiatrists and other professional groups.

Table 1: Expected and actual percentage of CTOs for the s3 and Part 3 MHA population in England[20]

Year	*2008/09*	*2009/10*	*2010/11*	*2011/12*	*2012/13*
Detentions under s3	16,393	15,641	13,832	13,192	12,569
Detentions under Part 3	493	515	523	512	351
Total number of s3 and Part 3 detentions	16,886	16,156	14,355	13,704	12,920
Government expected CTO use	2%	4%	6%	8%	10%
Number of CTOs based on Government expectations		646	861	1,096	1,292
Actual CTO use	2,109	4,020	3,730	4,086	4,477
Actual % of s3 and Part 3 patients made subject to CTOs		25%	26%	30%	35%

This high uptake of CTOs occurred at the same time as a significant rise in the detained population, representing an overall rise in the use of compulsion. The detained inpatient population rose by 12% in the first five years after the introduction of CTOs, representing the highest number of uses ever recorded at that time (CQC, 2014). The explanation for this overall increase in use of compulsion is unclear, although a recent report by the CQC has postulated a number of hypotheses including a lack of community alternatives to detention in hospital resulting in readmission, and ‘repeated reporting of an episode of detention’ when a detained patient is moved between wards or providers (2018a, p. 20). One might anticipate that the number of hospital detentions would decrease as the number of CTOs increased. This might

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[20] The statistical data has been gathered from the Health and Social Care Information Centre, other than the Government expected CTO use, which was gathered from the DoH (2006) Mental Health Bill, Regulatory Impact Assessment.

indicate that CTOs achieved their aim of preventing the revolving-door scenario, which would add weight to the argument for their use. However, the number of detentions in hospital has not decreased, and the number of CTO patients recalled to hospital for up to 72 hours and revoked to hospital (in effect returning them to detained in-patient status) has increased. The number of recalls to hospital of CTO patients increased by 9% between 2011/12 and 2012/13, indicating a refusal of treatment or a mental health deterioration. The number of revocations following a CTO recall also rose by 3% during the same period of time, indicating the need for CTO patients to be kept in hospital beyond the 72 hours allowed by the recall provision. This suggests a severity of relapse requiring detention in hospital. This overall rise in the use of compulsion has continued, with the last reliable statistics[21] for the period 2015/16 reporting an increase in the detained and CTO populations amounting to 'the highest number since NHS Digital started publishing this series of official statistics in 2005/06' (Health and Social Care Information Centre (H&SCIC), 2016, p. 4) Taken together, these statistics bring into question the effectiveness of CTOs in achieving their intended aim of preventing the revolving-door scenario, and therefore raises questions about why and how they are being used.

What do we know about CTOs?

Prior to legislative change (but with CTOs in mind), ministers in the Department of Health appointed an expert committee (discussed above) to advise how mental health legislation 'should be shaped to reflect contemporary patterns of care and treatment and to support Government policy' (DoH, 1999c, p. 11). The response proposed that 'a real attempt should be made to understand the experience of mental health legislation in other jurisdictions so that we may learn from both the successes and the failures before we take any irrevocable steps here' (DoH, 1999c, p. 16). Following this report,

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[21] The statistics for the period 2017 have been labelled 'experimental' (H&SCIC, 2017) as a result of changes to the way these statistics are sourced and produced, resulting in data that cannot be directly compared to previous years.

extensive consultation and a legislative redrafting processes, the Government commissioned research into international experiences of using community treatment orders. One of the key findings stated:

> *there is currently no robust evidence about either the positive or negative effects of CTOs on key outcomes, including hospital readmission, length of hospital stay, improved medication compliance, or patients' quality of life.* (Churchill *et al.,* 2007, p. 7)

In spite of this finding, CTOs were introduced and, as we have seen, their use has exceeded Government expectation. The first major research into the effectiveness of CTOs within Great Britain (following their introduction in 2008) was conducted by the Oxford Community Treatment Order Evaluation Trial (OCTET). The aim of this research was to improve patient outcomes by establishing whether CTOs were effective in reducing relapse and readmission rates in patients with psychosis. It did this by comparing the outcomes for patients randomly assigned to CTOs and s17 leave of absence. The study postulated that patients discharged from hospital on CTOs would have lower readmission rates than those discharged on s17 leave of absence (Burns *et al.,* 2013). Of the sample of 333 patients (166 discharged on CTOs and 167 discharged on s17 leave of absence), 36% of both groups had been readmitted to hospital within 12 months of discharge from hospital, leading to the following conclusion:

> *In well coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychiatric patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty.* (Burns *et al.,* 2013, p. 1627)

This CTO study, the first of its kind in England, adds to the body of international research findings showing no difference in readmission rates as a result of community compulsion (Steadman *et al.,* 2001; Kisely *et al.,* 2009). Similar findings were reported by Lepping and Malik (2013) following an audit of CTO use in North Wales. Their findings established that 34% of patients subject to CTOs were recalled and their CTO revoked, and this percentage rose to 40% when including voluntary admissions to hospital. The absence of findings demonstrating clinical benefit has led to questions about the ethics of their continued use (Burns *et al.,* 2013).

However, Curtis (2014) questioned the reliability of the OCTET findings, asserting that the findings cannot be relied upon because of the methods used - specifically, the selection of patients and clinicians, the mode of implementation of CTOs, and researcher and clinicians' attitudes towards CTOs. The disparity in the length of time patients were subject to CTOs (median 6 months) and to s17 leave of absence (median 8 days) was argued to raise questions about the validity of comparing these groups on the basis that CTOs would be unnecessary where leave is only needed for a very short period of time. In relation to the clinicians, Curtis (2014) asserted that those recruited were likely to be doubtful of the value of CTOs, less likely to intervene assertively, and therefore were willing to put forward patients who might be allocated to the shorter period of s17 leave of absence. This assertion is potentially problematic, as clinicians had no way of knowing the timeframes of compulsion prior to the trial. Concern was also raised by Curtis (2014) about the change in RC from the in-patient RC (responsible for the making the CTO) and the community RC (responsible for maintenance of the CTO, but who did not instigate the CTO). He suggested that this might result in the community RC not taking full advantage of the CTO powers, on the basis that a deterioration in the patient's condition would lead to readmission, relieving the community RC of their responsibility; creating a 'perverse incentive' for the community RC to be free of responsibility for the patient (2014, p. 38). He concluded by stating:

> *It remains a strong possibility that a small subgroup of patients, characterised by repeat relapse secondary to non-compliance and with only partial insight, might derive enormous benefit from more prolonged periods of compulsory treatment*

> *in the community and might be supported in building full and productive lives outside hospital. (Curtis, 2014, p. 39)*

In contrast to the OCTET study, Rawala and Gupta (2014) established CTOs to be of benefit, offering greater justification for coercive means of managing the mentally disordered. Rawala and Gupta (2014) conducted a study with the aim of establishing whether patients with a similar profile to those discussed by Curtis (2014) above would benefit from a CTO. The sample comprised 37 patients with a primary diagnosis of 'psychotic illness and a history of significant disengagement, non-adherence to treatment and recent history of repeat hospital admissions' (Rawala and Gupta, 2014, p. 13). A comparison was made of annual average admission and bed occupancy rates for a two-year pre-CTO period and a minimum six-month CTO period. Secondary outcome measures included difference in adherence to psychotropic medication, level of illicit drug use and the effect on the patient's quality of life. The measures for quality of life included stable housing, financial stability, social support and engagement in vocational activities. The findings presented strong evidence in support of CTOs, finding that admission rates fell by 90% and bed occupancy rates fell by 92% from the pre-CTO period to the CTO period. The reduction in the duration of hospital admission was less marked at 10% and treatment adherence improved by only 10.8%. Illicit drug use is also reported to have reduced (although the findings are confusing in that more patients appear to have ceased illicit drug use than had initially been identified as illicit drug users pre-CTO), and patients' quality of life improved by 78.4%. These findings are, however, based on clinical record keeping, and so are only as robust as the record keeping. The measure of treatment adherence is also questionable as collection of prescription was used as a positive indicator for 12 of the 37 patients. Collection of prescriptions is not, however, evidence of taking medication. In contrast to these promising findings, a 48-month follow-up study to OCTET concerned with social outcomes reported that 'a longer duration of CTO does not correspond with measurable improvements in patients' long-term social situation, despite the curtailment of their personal freedoms' (Vergunst *et al.,* 2017, p. 1382).

The issue of adherence to medication treatment is central to CTO use, and so the means by which it is administered is also of importance. In a study of 193 patients subject to a CTO, the CQC (2010) found that 98% of them were prescribed antipsychotic medication; of that group, 33% were prescribed oral medication, 53% depot medication, and 12% prescribed both oral and depot medication (giving a total of 65% subject to depot medication). The predominance of depot medication was thought to be a result of a preference for professional management of medication. Put crudely, the professional, as opposed to the patient, has the power to determine and administer treatment. This mode of treatment was predominant, even though most patients expressed a preference not to be treated in this way (CQC, 2010). The CQC also identified that 30% of a sample of 208 patients subject to a CTO had no history of non-compliance or disengagement with services, suggesting that the power is being used as a preventative measure, departing from parliament's intention (DoH, 2007).

In relation to the use of CTO conditions, Smith *et al.* (2014) found that conditions were rarely monitored, and that a failure to comply with conditions infrequently resulted in recall to hospital. Of 179 conditions set, 95 breaches were identified, but only 8 resulted in recall to hospital. If this approach is widespread, it raises questions about the ethics of imposing restrictions upon a patient's liberty, where monitoring and intervention are inadequate to justify the infringement of patient rights. More worrying was the finding that patients complied with conditions as they were under a misapprehension that they would be recalled if they failed to comply (Smith *et al.,* 2014). The coercive nature of a CTO is potentially worsened by either ignorance or even dishonesty, as a failure to comply with non-mandatory conditions does not give rise to the ability of the RC to automatically recall the patient.

The inconclusive nature of CTO research findings in relation to their value caused Light (2014) to question what we are trying to do by using CTOs. She identified the numerous measures that have been used to establish their effectiveness, including avoidance of hospital admission, stabilising people's health to enable illness insight, treatment engagement, prioritising community-based treatment and improving quality of life, but she suggested the need to better understand the reasons for their use before effective outcome measures are identified.

So what is the problem?

As outlined above, the introduction of CTOs in 2008 was largely fuelled by a public protection agenda. This happened in spite of the increasingly elastic interpretation of s17 leave of absence taken by the Courts, allowing for compulsory community treatment. The introduction of CTOs therefore signalled a clear intention on the part of Government to legislate for the compulsory community treatment of a few who posed most risk, with the intention of eradicating or minimising harm. However, the bar was set low, with statutory criteria arguably allowing, in effect, for the compulsory treatment and curtailment of freedoms of the many. The decision to make a CTO was devolved to professionals with distinct roles, thus bringing different considerations to the decision-making process. Aside from fulfilling statutory criteria, consideration of human rights and ethics, and medical and social factors should play a part in decision-making. This results in the complex exercise of balancing often competing concepts, including care and control, and choice and autonomy. In addition to considerations concerned with the patient and the public, research evidence shows that other factors play a part in decision-making - for example, clinical responsibility and resources, only adding to the complexity of decisions, which arguably should be legally justified. Since their introduction, CTO uptake has far exceeded Government expectation, despite professional opposition prior to their implementation. This greater than anticipated uptake has happened in spite of an evidence base indicating the ineffectiveness of CTOs in achieving their intended aim - that of preventing relapse - and resultant recall and readmission to a hospital. Despite the high uptake of CTOs, the detained in-patient population has not decreased - quite the opposite, detention numbers stand at the highest number ever recorded. This increase in coercive means of controlling the mentally disordered warrants some enquiry into professional decision-making, specifically to understand their justification for the exercise of power in the context of CTO decision-making.

CHAPTER 2 Governmentality

Introduction

This chapter sets out the theoretical framework underpinning this research project. Having identified, explained and justified CTOs as the site of enquiry to explore the exercise of professional power over the psychiatric patient, I will now critique Foucault's theory of governmentality. Governmentality theory provides a means by which actions can be analysed; as such, it is the chosen framework in which the discussion of CTOs is located. Foucault, having written extensively about madness (2011 [1954]), (2006 [1961]), (2001 [1967]); medicine (2002 [1994]); power (1980 [1972]) and discipline (1968), (1991 [1977]), (1978), provides a framework in which professional actions in the mental health sphere may be analysed.

The chapter first synthesises Foucault's view of governmentality and how it shifted over time. This is followed by consideration of how his ideas have been developed by others to show how governmentality provides a theoretical framework through which the exercise of professional power over patients may be analysed. Second, as the government of populations is dependent upon understandings of a problem, it is necessary to explore the discourses that allow for the categorisation and alteration of problem populations. For this reason, the chapter examines the knowledges employed within the mental health sphere that inform professional conduct and actions. This knowledge is presented under the heading 'Legislative and policy frameworks, and professional practices', reflecting political apparatus and less formal discourses. A historical overview of the legislative frameworks governing the care and treatment of the mentally disordered is then offered to show how concepts of mental disorder have changed over time and, importantly, to highlight the shifting roles of professional power over patients. Consideration is then given to more recent policy initiatives, some resulting in legislative change, as these more recent developments make clear how professional actions are shaped and how mentally disordered patients are managed. Throughout, consideration is given to professional practices and, finally, to ‘Professional perceptions of compulsion’, before concluding with the key research questions that emerge from this analysis.

Governmentality

The term ‘governmentality’ is argued by O’Malley (2008) to fuse together government and mentality, referring to a certain mentality of government, which asserts the aim of harnessing the capacity for self-governance. The theory or ideas of governmentality were first developed by Foucault (1991 [1977]) and offer a perspective on how mechanisms of control might operate. Foucault charts the shifting of power in Western societies between the middle of the sixteenth century to the end of the eighteenth century, from that of sovereign rule enforced by public displays of punishment to a more complex form of government where power is increasingly developed and deployed by professionals. Put simply, governmentality offers a new understanding of how populations are categorised and directed. Foucault’s theory of governmentality encourages us to think about the expansion of forms of social control. The hierarchical, supreme authority of state rule is expanded to government through the individual and institution employing differing knowledge, discourse and techniques to guide and alter the behaviour of populations and of self. This is not, however, to suggest that sovereignty was replaced by professional governance; rather, Foucault saw the construction of sovereign power as essential to discipline and government (Foucault, 1978). Foucault at one point referred to this analytic as a ‘triangle, sovereignty - discipline - government, which has as its primary target the population and as its essential mechanism the apparatuses of security’ (1978, p. 102). Power therefore no longer emanates from one source, the sovereignty, but from a multitude of agencies, employing diverse means of governing, to bring about differing ends (O’Malley, 2008).

One example of the relationship between sovereign power, discipline and government is clearly illustrated in the disciplinary regime of prisons. Foucault (1991 [1977]) used the example of a new type of prison, referred to as the Panopticon, designed in the eighteenth century by Jeremy Bentham, as an example of a carceral organisation operating disciplinary coercion to confine populations and to regulate actions. These rituals of exclusion and of discipline[22] are argued by Foucault to operate to a binary division and branding - for example, the dangerous/harmless, - and 'coercive assignment, of differential distribution (who he is; where he must be; how he is to be characterized; how he is to be recognized; how a constant surveillance is to be exercised over him in an individual way' (1991 [1977] p. 199). Bentham's Panopticon is offered by Foucault as the architectural figure of these mechanisms of power with its circular building comprising a central observation tower surrounded by an open space overlooking cells for occupants, allowing for surveillance by a supervisor to monitor its inmates. Bentham asserted that power should be visible (this was achieved by occupants' constant view of the tower) and unverifiable (occupants, due to bright lighting, would be unable to tell whether they were being observed at any given time, but would be in the knowledge that they might be observed at any time) as such passive power was sustained independent of the person who exercised it (Foucault (1991 [1977]). The Ponopticon and its function of discipline therefore served as an anonymous apparatus of power, engendering occupants' responsibility for the constraints of power, thus bringing about self-regulation.

The Panopticon provides a theoretical example of how government may be founded on sovereign command (in this case, of obedience), bringing the offender into the disciplinary gaze (O'Malley, 2008) for the purpose of governing the conduct of a problem population. However understood, sovereignty and discipline are recognised in the context of problematics of governmentality concerning the best ways to exercise power, to alter behaviours, to train and correct, to classify and to allow for experiments, not just of its inhabitants, but also providing an 'apparatus for supervising its own mechanisms' (Foucault, 1991[1977], p. 204) - for example, warders. While the Panopticon provides an example of the operation of power, Foucault asserted that 'instruments and modes of intervention of power' could be implemented in other environments, - for example, in hospitals, workshops and schools (1991 [1977], p. 205).

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[22] Foucault argued that rituals of exclusion arose from the management of lepers and discipline from the plague ((1991)[1977]).

The problems to be governed are not, however, viewed as unproblematically 'real'; rather, they are regarded as invented, reflecting 'governmental *understandings* of the way things are' (O'Malley, 2008, p. 54). Understandings of problems are established on the basis of rationalities or knowledge(s) (how things are and how they should be) - an established set of norms. These problems are described (referred to by Foucault as 'discourse'), allowing subjects to be categorised, and behaviours to be deliberately altered, as such human conduct is seen as malleable. These government rationalities (problems, categories, solutions and aims) are then linked to 'technologies' or tactics - for example, risk-based schemes to deal with the problem (O'Malley, 2008). Discourses are, however, numerous and subject to change, resulting in a multitude of fragmented power relations from diverse origins, effecting objectives and operations (Foucault, 1968).

These discourses or knowledges used to shape behaviours may be formally rationalised, - for example, by laws and policy (political apparatus), - or may be less formally articulated, - for example, professional practices. Studies of governance have shown the intrinsic link between governance and thought; put another way, successful governance is dependent on specific knowledges and values resulting in strategies, techniques and practices to govern the conduct of conduct (Rose, 1999). Power is therefore diffuse, emanating from different sources, capable of implementation in diverse settings, for differing populations and for differing purposes.

Foucault's ideas of governmentality have been developed by a shifting in governance from an individualised approach, to a focus on abstract factors external to the subject (Castel, 1991) and by placing even greater emphasis on the relocation of power from that of the state to individuals (Rose, 1999). Castel argues that the strategies used to control problem populations relocate from the individual subject to the administrative management of problem populations considered a risk. Castel asserts that the statistical collation of data about a range of factors liable to produce risk led to new modes of surveillance. These risks are viewed as objective among a population, as opposed to internal to the subject, resulting in the execution of preventive policy on the basis of the likelihood of risk behaviours as opposed to expert knowledge of the subject based on face-to-face interaction (Castel, 1991). In the mental health sphere, this means that interventions are not based on individual assessment of mental disorder but on an analysis of the risk factors relevant to the psychiatric population. Intervention is not therefore aimed at the treatment of the individual but at the prevention of risks posed to broader society. If we are to consider this mode of governance in relation to CTOs, it can be argued that the introduction (by Government) and instigation (by professionals) of CTOs is less concerned with the individual and the transformation of that individual, but instead is intended to provide a mechanism of control of a deviant population to protect the public by seeking to reduce risk behaviours associated with the mentally disordered.

Rose (1999) too questions conventional ways of thinking about power and proposes alternative ways of thinking about contemporary regimes of government, where state power is relocated to individuals. He argues that people were freed from political authority (subject to the limits of laws), but this ‘freeing’ was ‘accompanied by the invention of a whole series of attempts to shape and manage conduct’ (1999, p. 69). This was achieved by public ‘codes of civility’ and by equipping citizens with ‘languages and techniques of self-understanding and self-mastery’, (1999, p. 69). Rose (1999) is therefore less concerned with the source of authority and more concerned by the tools and technologies used to tackle contemporary thought and politics.

Rose (1999), when considering governmentality as a means of allowing critical thought of problems of the present turns his attention to questions of freedom. Freedom may be understood as the limiting or absence of coercion (where consent is not forthcoming), or as justified short-term coercion, to enable autonomy. In the mental health sphere, those arguing from a libertarian stance advocate greater entitlement to resources, increased legalism to limit professional power and constraint of non-consensual use of treatment (Gostin, 1977). In contrast, those adopting a welfarist ideology would argue that it is sometimes necessary to intervene to protect the person or others. Rose refers to the ‘genealogy of freedom’ (1999, p. 10); by this he is referring to the shifting justification for coercive controls. For example, Rose argues that limited constraint may be justified to allow for the freedom of others; as he puts it, ‘the constraint of a few is a condition for the freedom of the many, that limited coercion is necessary to shape or reform pathological individuals so that they are willing and able to accept the rights and responsibilities of freedom’ (1999, p. 10). Here, governance and freedom are not seen as adopting opposing positions, but instead governance is articulated as essential to enabling freedom. Rose (1999) offers the introduction of the Poor Law as an example of constraint allowing for freedom. He explained that the Poor Law forced individuals to rise from impoverished circumstances in fear of having freedom removed where the need for relief was acknowledged. In this example, the problem of conduct (not being financially self-reliant) is articulated as moral character. This concern for the maintenance of moral order and the politics of freedom are argued by Rose to continue (1999). Put simply, practices of governance are justified by freedom, and freedom has come to define our ethical politics and practices. Tactics are therefore employed to govern those considered a threat to the moral order of society (Rose, 1999). Individuals are not only governed through ‘public codes’ but by ‘private embarrassments … *government through the calculated administration of shame’ (*Rose, 1999, p. 73). Morality is established much as Foucault asserted, through binary division and branding, - for example, ‘the normal and the pathological’ (Rose, 1999, p. 73). This potential for shame therefore leads to an effective means of governance as a result of individuals playing a part in civility (Rose, 1999). Rose (1991) therefore argues that events, however grand, occur at the minor level, and these small shifts may be independent of one another, but nevertheless effect change.

This emphasis on freedom as justification for coercion and concern for the maintenance of moral order is evident in the mental health sphere. The closure of psychiatric institutions and the introduction of community means of compulsion (largely as a result of financial pressures) were articulated as offering greater freedom, while imposing limits to that freedom based upon constructed moral framing of acceptable conduct. The introduction and instigation of CTOs may therefore be viewed as a strategic deployment of coercion allowing greater freedom for the patient and the public. For example, the imposition of a CTO and associated conditions is justified by enabling freedom from confinement. This limited constraint may be justified on the basis of altering behaviours to enable greater freedom. Similarly, these constraints may be justified to allow freedom for the public from deviant behaviours considered immoral. Yet maintaining moral order by this means is dependent upon an awareness or acceptance of difference and the need for correction to maintain civility. This individualised approach may prove problematic in the sphere of mental health where a level of capacity to understand these concepts may be lacking. Thus, difficulty in understanding such concepts may result in the inability of patients to govern themselves, leaving governance to accredited experts.

These developing ideas of governmentality provide a framework in which an analysis of power over the psychiatric patient is possible. In common with these ideas is the role of sovereign rule. While the role of sovereignty is argued to have diminished, it remains, if only by means of statute setting out laws and associated Government guidance. The desire to discipline also remains evident and is based on an understanding of a problem. The problem may be individualised or concerned with a problem population; either way, it is established by binary division and branding. This desire to discipline and to correct results in governmental management. Governmental management is argued by Rose (1999) to be justified by freedom, and is intrinsically linked to morality. These elements; sovereign, discipline and governmental management, were evident in Foucault’s notion of a ‘triangle’, and despite these developments in ideas of governmentality it remains relevant. This analytic is, however, dependent on present problems and shifting thinking and understanding that influence action.

To understand the ways in which governance operates, we must therefore turn our attention to knowledge, the constructed nature of problems and the conditions under which certain things come to be considered true, as these influence techniques that shape the way others act to certain objectives. Having given an overview of governmentality, I will now turn my attention to the knowledge and discourse employed within the mental health sphere, as it is this knowledge and discourse that shape professional conduct of both themselves and of others to achieve certain ends.

The knowledges and discourses of mental health are various, including political apparatus and professional practices.

Legislative and policy frameworks and professional practice

Having critically reviewed governmentality and considered how these ideas assist an understanding of professional power in the context of CTO consideration and instigation, this part of the chapter will consider the knowledge and discourse that inform professional conduct, and professional perceptions of, and justifications for, compulsory means of treatment. This knowledge and discourse includes political apparatus - for example, legislation and Government policy - and less formal knowledge and discourse, including concepts of mental disorder and professional practices. The political apparatus governing the care and treatment of those considered mentally disordered has changed over time. These changes illustrate how mental disorder has been understood and managed, and show how sovereign power has been devolved to professional groups. The balance between legalism and professionalism, and concern for patient and public protection has shifted over time, resulting in differing approaches to the care and control of the mentally disordered. Understanding how power is devolved, to whom and to what aim, is essential to understand how mental disorder is understood and responded to, and how actions are legitimised.

This part of the chapter will therefore chart the history of mental disorder in chronological order, placing emphasis on the knowledge, discourse, power relations and interventions governing the care and control of those considered mentally disordered. A brief overview of the historical means of managing the mentally disordered is given, before greater emphasis is placed on developments since the nineteenth century, by which time the medical profession had secured support for the proposition that mental disorder is a disease (Scull, 1979). Consideration is given to the differing discourses of mental disorder from within and outside the medical profession, before outlining changes to Government policy and legislation, resulting in the introduction of CTOs. Having outlined these changes and identified how they may be understood from a governmentality perspective, consideration will be given to professional perspectives of, and justification for, use of compulsory treatment, before outlining the research questions.

Certificated confinement

The confinement of those considered mad dates back to the fifth century. This illustrates that binary division and branding has its roots in history, and that categorisation led to measures to confine problem populations. Confinement between the fifth century and the mid 1700s fell to family, monarchy and justices (via the means of common law) before the introduction of statute law in 1744. The Vagrancy Act of 1744,[23] along with common law,[24] allowed for the confinement of lunatics considered dangerous in a jail, a house of correction or a private madhouse (Fennell, 2010). This Act is an example of sovereign command, discipline and governmental management. By 1774, with the introduction of the Madhouses Act, a more complex form of governance where power was increasingly deployed by professionals was evident. This Act is argued by Hervey (1985) to be aimed at preventing the illegal confinement of the sane, a response to 'claims of cruelty and illegal confinement' (Butler and Drakeford, 2005, p. 8). Medical practitioners were given authority to confine on the basis of unsoundness of mind and, later in 1845,[25] the introduction of The Lunatics Act extended medical authority to providing treatment without consent. This Act was aimed at providing adequate asylum accommodation to pauper lunatics and is argued to be a result of professional advantage, humanitarian concern and economic and political interests (Busfield, 1996). Medical authority was, however, diluted with the introduction of the Lunacy Act 1890, which required judicial authority for admission and detention in an asylum. Judicial authority continued and was arguably extended with the introduction of the Mental Deficiency Act 1913, which broadened the scope of who could be confined and introduced a means of community compulsion by way of guardianship.

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[23] Confinement on the basis of two justices and a complaint.

[24] *Rex v .Coate* (Keeper of a madhouse) 1772.

[25] A reception order was on the basis of a relative or other person supported by two medical recommendations.

Thus, the broadening scope of mental disorder was met with new modes of control. Up until this point, judicial authority allowed for the compulsory confinement of problem populations, and while medical practitioners had a role in this, their role was largely limited to containment.

Medical discretion and the beginnings of consensual care

Judicial authority was lost to medical discretion with the introduction of The Mental Treatment Act 1930. This Act was the first to allow for 'voluntary boarders' and out-patients, thus moving away from purely coercive means of confinement based on certification. While this Act (along with The Mental Health Acts of 1959 and 1983) set legal limits to professional discretion, the identification and treatment of mental disorder lay with the medical profession. The claim of mental disorder as a disease led to the adoption of a range of treatments, including the custodial function of removing problem populations from society (Scull, 1979). However, the status afforded to the medical profession was marginal as a result of the lack of application of the medical or disease models that rely upon the identification of symptoms to categorise illness. These categories allow the prediction of the occurrence of symptoms, leading to diagnosis and control of the disease by treatment (Horwitz, 1982; Moncrieff, 2009). However, identification of diagnosis has been argued to prove problematic as mental disorder is often not accompanied by physical pathology (Tyrer and Steinberg, 1998). In addition, treatment of mental disorder did not produce good effects; as such, it was argued that the custodial function of the medical profession could have been fulfilled by lay people (Scull, 1979). This combination of voluntary boarders, out-patients and ineffective treatment meant that the medical profession did not hold all power; nevertheless they retained a role in the diagnosis and treatment of mental disorder. Thus the categorisation and control of the mentally disordered continued.

By the 1950s, a downturn in the mental hospital population had begun. In Britain, this was attributed to the introduction of psychoactive medication treatment. However, the correlation between new forms of treatment and reduced institutionalisation has been questioned as the same correlation was not evident in other jurisdictions (Scull, 2015). Instead, Scull cites changes in social policy as a more important determinant of deinstitutionalisation. In 1961 Enoch Powell then Conservative Minister for Health, announced plans to run down institutions. Although financially driven (Scull, 1977), the closure of institutions was portrayed as a beneficial reform. This reform was accompanied by critiques of institutions and psychiatry, predominantly by psychiatrists from the United States with a psychoanalytical perspective who saw diagnosis as unhelpful and viewed all humans as experiencing some degree of pathological flaw. Laing and Szasz, both psychiatrists, saw psychiatry as a coercive instrument of oppression. Neither denied the existence of behaviours that deviate from the norm, but they were opposed to the coercive nature of the controls over such behaviours (Szasz, 1971, 1998; Laing, 1985). However, there were differences to their approaches. Laing, rather than advocating the abolition of psychiatry, saw it as useful in segregating those who could not or would not take care of themselves. He was concerned with finding ways to understand such behaviours, to find 'alternatives to the depersonalizing and bureaucratic protocols of hospitalization for people in acute mental and emotional turmoil' (Burston, 1996, p. 237) and advocated the facilitation of madness free from the coercive sanctions that psychiatry imposes (Burston, 1996).

Szasz, in contrast to Laing, believed madness to be a myth, and saw no role for medical involvement in madness, especially involuntary involvement. He viewed madness as a moral issue or problems with being, as opposed to a pathological disease or illness. He therefore rejected medical explanation and intervention, instead favouring legal controls, and advocated autonomous psychotherapy concerned with the mind (1985). Both Szasz and Laing therefore recognised the existence of behaviours that deviate from the norm, and the potential need for intervention. But the need for medical intervention is debated, and any such intervention is only seen as acceptable if it is given on a consensual basis as opposed to on an institutional basis. Power should therefore rest with the individual, respecting autonomy, as opposed to the inequality of the state defining and controlling individuals. This approach differs from ideas of governmental management by means of binary division and branding to discipline and to correct. As such, any approach concerned with autonomy and equality are incompatible with Foucault's ideas of governmentality.

This difference in opinion between concepts of the pathological and the normal was, however, short-lived. Disagreement between psychiatrists about the value of diagnosis, a lack of consistency between psychiatrists when diagnosing, the experiment by David Rosenhan[26] raising questions about psychiatrists' ability to distinguish between the normal and the abnormal (1973), and the need for homogeneous groups to participate in medical research, led to efforts to standardise diagnosis (Scull, 2015). The introduction of diagnostic manuals with the aim of maximising inter-rater reliability is described by Scull as 'a decisive weapon in the battle to re-orientate the profession' (2015, p. 388). The classificatory system led to links between diagnosis and drug treatment, resulting in professionals and the public conceptualising mental illness as a disease to be treated by drugs (Scull, 2015). As such, a biological discourse of mental disorder dominated and the psychiatric profession was legitimised (supported by the marketing muscle of the pharmaceutical industry (Scull, 2015)). With each edition of diagnostic manuals, the number of disorders grew, and with that so did the number of people considered mentally ill. This adoption of the medical model enabled the elevation of the psychiatrist to a position of power - power to categorise and to control.

The introduction of a statutory social work role: a counterbalance to medical dominance?

Within England and Wales medical authority was retained throughout the 1959 and 1983 legislative changes under the Conservative Governments. However, the introduction of mental welfare officer, under the 1959 Act, and the approved social worker, under the 1983 Act, gave social workers, rather than doctors, the power of applying for detention in hospital and guardianship. The creation of these roles, along with other changes to the 1983 Act - for example, the introduction of rules governing

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[26] Eight sane people gained admission to twelve different hospitals. All complained of hearing voices, yet behaving normally, all were diagnosed as schizophrenic.

the medical treatment of patients, and in some cases the requirement of independent medical oversight of such treatment - may be argued to dilute medical power by increasing legalism, thus offering a counterbalance to the dominant medical paradigm (Gostin, 1983).

The introduction of the approved social worker (ASW) in the 1983 Act was supported by an increasingly high standard of training (Hargreaves, 2000) aimed at bringing consistency and improved competence to the assessment and detention process (Brown, 1983), and recognition of the need for a social assessment to counterbalance the dominant medical paradigm. The 1983 Act therefore marks a significant shift away from medical dominance, which was argued by Gostin (1977) to have placed too much power in the hands of the medical profession. The ASW had a determinative role in compulsory treatment and was required by the Act to have 'regard to any wishes expressed by relatives of the patient or any other relevant circumstances' (s13(1) MHA). This focus on the wider social context during Mental Health Act assessments drew upon the social model of disability. The social model of disability arose in the mid-1970s following the publication of the Fundamental Principles of Disability document (Union of the Physically Impaired Against Segregation (UPIAS), 1976). This document argued that individuals are not disabled by their impairment, but by the disabling barriers in society. The social model of disability therefore sought to dismantle the traditional medical model of disability that looked to physiological and psychological cause for an inability to fully participate in society, and to treatment and cure to address the problem. The social model, in contrast, argued that society disabled impaired people by isolating and excluding them from full participation in society.

It is argued by Forrester and Hutchinson that the 'social model is at the heart of social work' (2012, p. 225), and Bogg, when discussing the ASW and AMHP roles, states: 'the principles of the social model of disability are pervasive within both policy and practice' (2010, p. 5), both emphasising the importance of the social model of disability within the social work and AMHP professions. Those adopting a social model of disability therefore distinguish between the physiological or psychological impairment and the disability, which is the disadvantage or restriction imposed by society. The individual is as a result oppressed, and societal change is necessary to eliminate disability (UPIAS, 1976). A similar approach is adopted in the sphere of mental health, in that societal factors can be seen as disabling, but equally social work authors have argued that social experience ‘may have originally contributed to someone’s mental distress’ (Tew, 2011, p. 104). Engagement with the individual therefore looks beyond diagnosis to include family, social networks, employers and others within their social community, and sees mental distress as grounded in people’s experiences, rather than diagnostic categories (Tew, 2011). The shift away from care and treatment as the central focus is argued to enable the person to take control and responsibility, and prevent the notion of others sorting out the patients’ mental distress for them (Tew, 2011). This approach is argued by Tew to recognise the expertise of the service user; therefore, those engaging with the person are not elevated to that of expert, but rather work alongside people as they reclaim a life that is meaningful to them (2011), representing a sharing of power. In the psychiatric sphere, this represents a challenge to the power of the psychiatrist and the social worker, and to the legitimacy of coercive treatment. This approach is not consistent with Foucauldian ideas of governmentality as notions of normal and pathological, and the need to exert power to bring about correction of an abnormal state are lost. In practice, adoption of such an approach would be incompatible with the statutory control functions of the medical and social work professions, and as such the utility of this discourse is compromised. Thus, statute, although introducing a counterbalance to medical dominance, serves to govern professional conduct, which in turn governs the conduct of others.

It is clear that the medical profession had up until this time had a monopoly over the classification, treatment and confinement of patients, and this medical authority has been attributed to professional knowledge (Fennell, 2010). However, the introduction of a statutory social work role, along with treatment rules and independent medical oversight, was intended to lessen the power of the medical profession. These developments in the legislative frameworks governing the care and treatment of those considered mentally disordered show shifting concepts of mental disorder, and a shifting of power between medical paternalism and legalism (Gould and Martin, 2012). While changes to the 1983 Act may on the one hand be argued to pose a threat to the dominant medical discourse, conversely, the statutory social work functions may be argued to move away from the empowering and liberatory intent of the social model (Beresford, 2005). This departure from a social model may also be worsened by the integration of social care within the bigger organisation of health care operating the disease model (Beresford, 2005). Indeed, research by Peay (2003) suggests that ASWs do not counterbalance the dominant medial desire to treat, suggesting an acceptance or buy-in of the dominant medical paradigm. If this were the case, medical discourse has come to be considered true, and for a Foucauldian perspective, the discourse as opposed to the profession drives professional actions.

The re-emergence of medical dominance and societal control?

While the introduction of the ASW (along with other statutory changes in 1983) can be argued to represent concern for patient rights, later amendments to the 1983 Act (in 1995 and 2007) extended professional power beyond the confines of the hospital to the community[27] for patients considered a risk. Alaszewski (1999) argues that reform of the British health care system has adopted a particular focus on risk assessment, risk management and preventative interventions with public protection in mind, a stance similar to that of Castel (1991). Mental health is no exception to this. The introduction of the Care Programme Approach (CPA) in 1990 (DoH), providing a framework for the co-ordination of effective mental health care for adults with severe mental health problems within secondary services, is an example of a preventative strategy, advocating partnership working to avoid risk. CPA was later revised, first in 1999, introducing a focus on risk assessment and management (DoH, 1999b), and the need to ensure continued contact between patients and services, and second, in 2008 with a focus on those with ‘complex characteristics’ (DoH, 2008c, p. 11) considered ‘at higher

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[27] Supervised discharge (s25A) introduced by the Mental Health (Patients in the Community) Act 1995, and Community Treatment Orders (s17A) introduced by the Mental Health Act 2007.

risk' (DoH, 2008c, p. 12), including those made subject to a CTO (DoH, 2008a). Despite the introduction of CPA, incidents[28] involving those with mental disorder in the early 1990s gave rise to concern about inadequate community care.

The instigation of community care within the mental health sphere resulted in the closure of psychiatric institutions.[29] Within the 50 years spanning 1955 to 2005, 120,000 psychiatric beds were lost (Rogers and Pilgrim, 1996; Winterton, 2007). During this time homicides by patients with mental disorder living within the community contributed to the Government's conclusion that community care had failed (Dobson, 1998). These events attracted media attention and justified a 'safety first' approach from Government (Pilgrim and Ramon, 2009). This resulted in policy initiatives and legislative change aimed at public protection. The conditions in which events lead to policy change are described by Butler and Drakeford (2005) as a process of scandal, committee of inquiry and policy development. In the case of Christopher Clunis (discussed above) it is argued that scandal emerged as a result of his ejection from hospital, (as opposed to by his own initiative), and the provision of disjointed and unconnected community care offering no safety, thus allowing blame to be apportioned. Indeed blame was apportioned by the committee of inquiry for inappropriate early discharge, a failure to admit at times of crisis and a failure to provide adequate community care to someone who posed risk to others, providing 'raw material for … claims-makers' (Butler and Drakeford, 2005, p. 154). Following this scandal the supervision register was introduced in 1994 by the Conservative Government (DoH, 1994), to identify people with severe mental illness considered a significant risk to themselves or to others, to ensure they received care and treatment in the community. However, the register was not universally applied, with some areas making no entries as a result of the administrative burden (Vaughan, 1996), rendering it ineffective. The supervision register was followed by the introduction of supervised discharge for patients discharged from detention in hospital, and is argued by Fennell to

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[28] Benjamin Silcock jumping into the lion's den at London Zoo in 1993, the killing of Jonathan Zito by Christopher Clunis in 1995, and the killing of Lyn and Megan Russell by Michael Stone in 1996.

[29] The closure of institutions was prompted by Enoch Powell's Water Tower Speech in 1961.

mark ‘the turning of the tide away from a rights-based focus towards an approach based on risk management, public protection, and ensuring compliance with medication’ (2010, p. 54), a move aimed at managing a problem population. However, uptake of supervised discharge was scarce, in part because it lacked statutory power to enforce medication compliance, leaving professionals unable to compel compulsory treatment. Non-compliance with treatment was seen as unacceptable (DoH, 2000a), and as a result supervised discharge was replaced in 2007 with the CTO, which was intended to help prevent relapse and harm by the imposition of compulsory community treatment (DoH, 2008a). Power to compel treatment to achieve these aims was therefore devolved to professionals.

The process of legislative change devolving power to professionals was not, however, universally embraced. The Labour Government’s intention to revise mental health legislation and in doing so introduce CTOs, led to what is referred to by Cairney as a ‘ten-year stand-off between UK ministers and the vast majority of interest groups’ (2009, p. 672). These groups, opposing the proposed legislative reform, joined forces under the umbrella of the Mental Health Alliance. This alliance which represented the views of over 70 organisations, raised concern about the proposed increase in professional powers, and the resultant loss of patient dignity and autonomy, a stance arguably incompatible with governmental means of management. In addition to this opposition, other commentators continued to challenge the applicability of the medical model in the mental health sphere, and questioned the efficacy of such modes of control.

Moncrieff, a psychiatrist and founder of the Critical Psychiatry Network, challenged medical dominance by questioning the assumption that drug treatments alter problems, which have come to be understood as mental disorders. She argues that ‘psychiatric drug treatment is currently administered on the basis of a huge collective myth; the myth that psychiatric drugs act by correcting the biological basis of psychiatric symptoms of disease’ (2009, p. 237). She proposes that drugs induce abnormal states, including sedations, that can account for therapeutic effects, and therefore the institution of psychiatry, pharmaceutical industry and state have constructed a false knowledge about the nature of psychiatric drugs. Moncrieff argues that the ‘way that vested interests have embedded themselves into the fabric of our knowledge about psychiatric drugs demonstrates the symbiosis between power and knowledge highlighted by Foucault’ (2009, p. 237). This unparalleled power results in a false knowledge, which in this case, she argues has become our real knowledge. She argues that this knowledge is responsible not only for the acceptance of the need for treatment, but also for the potentially harmful effects. These points taken together raise questions about the use of power in psychiatry, specifically the validity of the disease model and the widespread use of medication treatments prescribed for mental disorder.

Despite concerns about increased professional power, and treating illness and preventing violence ‘as a pretext for a political endeavour to enforce conformity of lifestyle and behaviour’ (Moncrieff & Smyth, 1999) the Government with CTOs in mind commissioned an analysis of the effectiveness of similar provisions within differing jurisdictions. Churchill *et al.* concluded: ‘there is currently no robust evidence about either the positive or negative effects of CTOs on key outcomes, including hospital readmission, length of hospital stay, improved medication compliance, or patients’ quality of life’ (2007, p. 7). Despite this finding and large-scale opposition about increased coercion and societal control, CTOs were introduced suggesting that their introduction was based upon concern for public safety as opposed to patient protections (Webber and Nathan, 2012). In addition to the introduction of CTOs, the 2007 amendments broadened the definition of mental disorder, removed all but one exclusion to use of the Act, and lowered the threshold for treatment success from that of treatment being ‘likely’ to benefit the patient, to it simply being administered for the ‘purpose’ of benefiting the patient. Put simply, as long as medical treatment is intended to benefit the patient, it does not matter if this effect is unlikely, suggesting greater emphasis on public safety than on patient protections.

Taken together, these legislative changes result in the potential for many more patients to be considered mentally disordered and, as a result, to be compulsorily detained and treated in a hospital, and compulsorily treated in the community. This

2007 amendment Act therefore provided professionals with a means of categorising patients, justifying coercive controls and legitimising their professional power and decision-making. Legislation setting such broad parameters and leaving scope for professional decision-making both shapes professional decision-making and has the potential for influencing decision-making. Decisions may therefore be influenced by fear of blame being apportioned where decisions are taken not to intervene, and as a result risk behaviours resulting in harm emerge. If this is the case, a clear departure from early legislation drafted with patient rights in mind is evident, and notions of a counterbalance to the dominant medical discourse are potentially lost. Overall, this represents a return to greater societal control (Carpenter, 2009).

While the amendments in 2007 did not remove the independent oversight of a professional other than a psychiatrist for the purpose of detention under the Act, changes were made to the professional roles concerned with CTO consideration and instigation. Legislation departed from the approved social worker role (previously fulfilled by social workers only), replacing it with an approved mental health professional, and replaced the responsible medical officer (previously registered medical practitioners) with a responsible clinician. These roles may still be performed by social workers and medical practitioners (respectively); however, both roles are open to other professional groups (see Chapter 1). This broadening of professional roles may result in different knowledge and discourse informing decision-making; however, in practice the role of the RC continues in the majority to be fulfilled by registered medical practitioners and the AMHP role is predominantly fulfilled by social workers. Regulations and guidance governing these roles highlight the legal and medical aspects of the RC role (DoH, 2008a, 2008d, 2015b), and the distinct role of the AMHP in offering an important counterbalance to clinical models of mental disorder (DoH, 2008a; Lamb, 2014).The College of Social Work further asserts the importance of the AMHP role in ‘recognising the social antecedents and determinants of mental distress’ (Allen, 2014, p. 11). The participants involved in this study were entirely drawn from these two professional groups. As such, one would anticipate representation of medical and social paradigms within the decision-making process. The approach of aligning different models to different professions is, however, potentially problematic, as it is erroneous to assume that RCs pay no heed to other aetiological factors, or to assume that those fulfilling the AMHP role are not influenced by biological concepts. In reality, the complex interaction between a range of factors is likely to inform professional actions.

Arguably, these more recent legislative changes continue to reflect the dominant medical discourse, but at the same time AMHP training is informed by a social perspective (Beresford, 2005). The AMHP might therefore be less inclined to support a mode of intervention that is primarily concerned with the treatment of symptoms, as opposed to an exploration of, and support for, external factors. Beresford (2005) has, however, argued that there is the potential for the erosion of the social model within mental health services, which may result in the predominance of the disease model. If this were the case, treatment would be likely to be accepted as a legitimate form of intervention, regardless of its coercive nature, and failure to intervene be seen as negligent. Such an approach would be consistent with ideas of governmentality and Foucault's notions of the triangle analytic, in which Government through legislation governs the conduct of conduct. By this I refer to knowledge and discourse (considered to be true) forming the basis on which professional actions to categorise and to control are shaped and legitimised.

Broader mental health policy: recovery

At the same time as these latter policy and legislative changes aimed at risk management the concept of recovery became central to the mental health policy agenda. This section will explore the definitions of recovery, how competing concepts of recovery have been incorporated in to mental health policy, and how concepts of recovery contrast with narratives around risk.

The concept of recovery was first introduced by Abraham Low, a neuropsychiatrist, in the 1930s as a means of providing peer-led aftercare following discharge from hospital (Pilgrim and McCranie, 2013). Recovery is therefore rooted in patient-led consensual care. Over the last 30 years this concept has been developed, however it remains a contested concept (Bonney and Stickley, 2008, Leamy et al., 2011). Pilgrim and McCranie (2013) identify four discursive trends including recovery as a personal journey, a critique of services, therapeutic optimism and a social model of disability. Recovery as a personal journey dominates literature, however uncertainty remains about what people are recovering from, whether recovery is biologically, psychologically or socially rooted, or whether it is concerned with an approach towards those recovering (Pilgrim and McCranie, 2013). Whilst notions of recovery tend to be optimistic in nature (Dixon, 2015), some patients view recovery as a source of oppression due to an intolerance towards those who do not change (Rogers and Pilgrim, 2014). Recovery is therefore regarded as a process and an outcome. Outcome, like process, is uncertain – for example, outcome may be regarded as recovering a life, aligned with social understandings of mental disorder, or recovery from illness, most commonly associated with biomedical understandings of mental disorder (Pilgrim and McCranie, 2013). These differences in meaning and purpose have however been argued to bring benefit – for example, to researchers, service providers, policy makers and politicians – enabling ‘groups to assume, or pretend, that they are all talking about the same thing, even if important differences remain’ (Pilgrim and McCranie, 2013, p. 40). Indeed these differences are evident in Government policy, leading to further ambiguity about the meaning of recovery.

Having identified that the concept of recovery is ambiguous, consideration is now given to how this concept has been incorporated in to mental health policy, highlighting the differing discourses of consensual and coercive care. Recovery became a central tenet of Government policy with the setting of standards for modern mental health models within the National Service Framework for Mental Health (DoH, 1999e). Sustained recovery was advocated by means of psychological interventions as opposed to the short-term benefits brought about by medication treatment. Social antecedents to mental health were recognised and emphasis was placed on consensual care, choice and recovery as social inclusion, as opposed to compulsion. This ethos was supported by the NHS Plan (DoH, 2000c) which pledged to boost the mental health workforce and bring about reform by introducing services aimed at recovery. However, soon after publication of the NHS Plan, Government policy moved from a position of recovery being synonymous with consensual care, to that of recovery being associated with compulsion.

Whilst advocating consensual care wherever possible, the Government's vision for mental health care stated 'when this is not possible, a modern mental health service must be supported by legislation that reflects new patterns of care and treatment, respects civil liberties, and promotes effective recovery' (DoH, 2001a, p. 7). Whilst the optimism of consensual care aimed at recovery remained, proposed legislative reform at this time focused on coercive means of providing care and treatment (DoH, 2000b). During the 10 years of legislative reform leading to the introduction of CTOs the concept of recovery was maintained within Government policy concerned with service provision for specific groups – for example, older people (DoH, 2001b), those with personality disorder (NIMHE, 2003), and women in mental health (DoH, 2006b), and more broadly in standards aimed at achieving best practice for education and training of all staff in mental health services (DoH, 2004a). The rhetoric of recovery continued to oscillate between consensual and coercive care. Support, time and recovery workers were introduced in 2004 by the National Service Framework for Mental Health – Five Years on, aimed at strengthening the 'focus on service users, through drop-in groups' (DoH, 2004b, p. 47). Engagement, promoting social inclusion and listening to service users views on how services should change were all central to this Government policy, all indicative of consensual care. However, with the advent of legislative reform introducing compulsory community treatment by means of CTOs in 2007 use of the term recovery appeared both the occupy discourses of consensual and coercive care. For example, policy focused on New Ways of Working stated 'most teams will have a focus on recovery … emphasis will be on rehabilitation and living as valued a life as possible' (CSIP/NIMHE, 2007, pp. 27/28), suggesting a focus on patient perspectives, while government guidance in respect of CTOs made clear that 'patients do not have to give formal consent' (2015a, p. 330), albeit CTOs are intended to 'help patients to maintain stable mental health outside hospital and to promote recovery' (2008a, p. 220, 2015a, p. 328), thus conflating coercive means of care and recovery. This conflation of coercion and recovery is a departure from early understandings of recovery which were rooted in patient-led consensual care, and gives rise to philosophical tensions between patient-led consensual care and coercive means of care, driven by concern for risk behaviours arising from mental disorder.

Having considered concepts of recovery and how these have been integrated in to mental health policy I will now explore the potential contradictions between the optimism of patient-led recovery and coercive care aimed at the management of risk behaviours associated with mental disorder. These opposing positions are illustrated by Pilgrim and McCranie who state:

> *When the expressed needs of those who are mad and their defined needs in the view of others (such as relatives and mental health professionals) do not coincide, then the discourse shifts from reasonable or unreasonable expectations of recovery from distress, via consensually agreed forms of therapy, much more to one about a power struggle* (2013, p. 22).

This contrast between consensual and coercive care is argued by Pilgrim and McCranie (2013) to be most clear in mental health legislation that provides a form of coercive social control. In the specific context of community treatment orders (previously referred to as supervised community treatment (SCT)), Banks *et al.* recognised this paradox and questioned how 'person-centred support, emphasising choice and autonomy, can be reconciled to a context in which individuals with capacity to refuse treatment are subjected to SCT' (2016, p. 182). Having explored CTO practice within the context of personalisation Banks *et al.* established that service users experienced 'little or no choice, control or involvement in decisions surrounding the making of the CTO and setting of conditions' (2016, p. 184). Compliance with CTOs and associated conditions was often as a result of a perceived threat of readmission to hospital and misunderstandings about the powers to enforce treatment and recall patients to hospital. A lack of awareness about entitlements to advocacy and legal challenge was also evident, and a lack of investment in explaining these rights was apparent in that accurate information had the potential to undermine respect for the authority of a CTO. These findings clearly conflict with concepts of patient-led recovery, however, it may be argued that use of continued compulsion in the community provides a less restrictive means of aiding recovery (Rawala and Gupta, 2014), indeed Banks *et al.* (2016) found that patients retrospectively saw benefit in CTO conditions aiding recovery.

This departure from self-led recovery in the context of mental health law and more specifically CTOs is primarily as a result of risk management policy equally advocated by Government. Dixon (2015) argues that patients are encouraged to manage their own welfare, but limits are placed on this where patients pose a risk to themselves or others. Such risks are likely to result in concepts of recovery being disposed of, or being reframed to mean short-term coercion is justified to aid long-term recovery. It is therefore likely that the concept of recovery means coercive care for the intended CTO population (and therefore the subjects of this study), but by contrast, recovery may mean consensual care for those presenting no, or low risks, who equally may be eligible for a CTO. Indeed, Banks *et al.,* (2016) recommend a focus on greater stakeholder involvement in CTO decision making, especially consideration of service user wishes, adequate time for CTO consideration, and better provision of information. This consensual approach may be particularly relevant to professionals who provide care beyond the decision-making process, for example, care co-ordinators, relatives and care providers (Doughty *et al.,* 2013, and Stroud *et al.,* 2015, 2017). In contrast, 'the impact of choice on positive outcomes has not been demonstrated for those with serious mental health problems' (Banks *et al.,* 2016, p. 187), as such coercive means of aiding recovery are likely to dominate. This however is not incompatible with a governmentality perspective of power being used to bring about positive change and self-regulation.

Professional perceptions of compulsion

Having considered ideas of governmentality, and legislative and policy frameworks informing professional practice, consideration is now given to professional perceptions of compulsion, as this will help an understanding of professional justification for intervention. This is done by reviewing research in relation to compulsion more generally, and then research concerned with community compulsion by way of CTOs. As CTOs are relatively new to England and Wales, there is limited research concerned with professional perceptions. For this reason, consideration is given to professional views within England and Wales, pre-and post their introduction, and to some international research. Some of the studies reviewed consider professional perceptions and actions from a Foucauldian perspective. Where this is not the case, an analysis of the findings from this perspective will be offered to help an understanding of how professional perceptions and actions demonstrate or otherwise Foucauldian ideas of governmental management and disciplinary power. While this study is not concerned with patient or other stakeholder perceptions of power, some consideration is given to research including their views, as these will become relevant to later discussion and conclusions (outlined in Chapter 7 below).

Professional perceptions of compulsion in different clinical settings

A study by Roberts *et al.* (2002) examined mental health professionals' attitudes towards legal compulsion by measuring professional endorsement of compulsory treatment in different clinical situations. This study did not specifically address compulsion by way of a CTO,[30] but instead focused on responses to diagnosis, physical environments (prison) preventive detention (for those with a personality disorder), capacity and the right to resources. Thus, the study gives an indication of the broad range of factors that may offer justification for professional intervention. While the study obtained the views of a number of professional groups, including general practitioners and Mental Health Act Commissioners, the findings that are most relevant to this study are those concerned with the views of psychiatrists and approved social workers. These two groups showed similarity in their views of the need for compulsion, particularly for those with mental disorder in a prison environment, and patients with a disturbed mental state as a result of physical illness or injury, and were unanimous in

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[30] By this time CTOs were outlined in the White Paper, Reforming the Mental Health Act.

their view that compulsory treatment was not justified for those with drug addiction or sexual deviancy. This might indicate a shared concept of mental disorder across these two professional groups and agreement about which labels offer justification for intervention. However, agreement was not evident across these two professional groups when considering the endorsement of treatment for those with a personality disorder. Approved social workers were significantly more inclined to endorse treatment for those with a personality disorder, including preventive detention for this group. Medical reluctance to endorse compulsion for this group might be the result of a prevailing medical view that personality disorder is untreatable (Sulzer, 2015), and therefore does not offer justification for compulsory treatment and preventive detention. This does not, however, explain the greater willingness on the part of ASWs to endorse compulsory treatment for this group, unless professional accountability provides sufficient justification for decision-making.

Aside from clinical determinants to compulsion, other factors, such as reciprocity and capacity, were relevant to decision-making. ASWs in contrast to their medical colleagues were significantly more concerned that compulsion should be met with an entitlement to resources. Such a principle, designed to benefit the patient, may therefore offer justification for ASWs' use of compulsory intervention. Of interest, however, is the majority view among psychiatrists and ASWs that the compulsory treatment of those retaining capacity to make their own decisions is not justified. This stance is compatible with arguments in favour of patient autonomy, but is incompatible with Foucauldian ideas of governmental control allowing for constraint to alter behaviours irrespective of capacity. However, the report indicates that psychiatrists might be willing to override the capacitous refusal of a patient if the 'consequences are sufficiently dire' (Roberts *et al.*, 2002, p. 80), suggesting that concern for risk behaviours may dominate concern for the autonomy of capacitous patients.

Prior to the introduction of CTOs, Peay (2003) explored professional decision-making within the context of the MHA in England. To examine duo-disciplinary decision-making, doctors and approved social workers (ASWs) were presented with identical information about three hypothetical cases, covering a range of practice scenarios. The study examined whether individual and paired professionals would reach similar decisions about the application or non-application of the MHA when faced with the same case information. More importantly, from the perspective of this study, Peay (2003) also examined how participant decisions were justified. The three scenarios concerned the decision to admit a patient to hospital under compulsion, the decision to discharge a detained patient from hospital, and the decision to compulsorily treat a detained in-patient. The findings showed little consistency of decision-making, both between and within professional groups. Overall, the law had marginal impact on decision-making in respect of the three decisions. This was attributed to a lack of legal knowledge and a preference among participants for professional and ethical decision-making.

In the scenario concerned with discharge from hospital, participants were prepared to 'bend their clinical assessments' (Peay, 2003, p. 80) to bring the patient within the scope of the law to enable use of compulsion.[31] This bending of the law was driven by outcome, and indeed outcome influenced, and offered justification for, decision-making. Concepts of best interests (a concept that is not integral to mental health statute), concern for risk and fear of failure dominated decision-making.[32] Thus, outcome was more important than legality and patient safeguards, and the autonomy of capacitous patients. Risk was reported to be assessed according to conceivable risk as opposed to foreseeable risk, and intervention was justified on grounds of being beneficent rather than non-maleficent. Thresholds for intervention were therefore set low and were justified on the basis of best interests. Participant concern for outcome and the consequences of their decisions was not, however, purely driven by the best interests of the patient or the public, but was also driven by their own professional positions (Peay, 2003, p. 111). This was evident during consideration of complex cases - for example, doctors (responsible for treatment) articulated a desire for someone to 'hold their hand' or to 'share the responsibility' when discussing compulsory treatment (Peay, 2003, p. 115). These findings illustrate governmental means of management.

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[31] Section 25A MHA 'supervised discharge'. This was replaced with CTOs.

[32] 36 of 40 psychiatrists and 25 of 40 social workers self-identifying as best interests decision-makers, in preference to legal or ethical decision-makers.

Concern for best interests, risk and fear of failure are all offered as justification for intervention into the lives of those considered mentally disordered. Professional expertise and dominance is evident, rendering notions of legal limits, and patient safeguards and autonomy inferior. This study also highlights that broad legal parameters and professional accountability may have the undesirable effect of extending governmental management as a means of protecting professionals as well as patients and the public.

A later study concerned specifically with AMHP decision-making showed concepts of mental disorder and the appropriateness of medical treatment to be the most significant determinants to the use of compulsory powers under the MHA (Buckland, 2014). These concepts were also influential to how AMHPs viewed and interpreted the Act, and understood their role in relation to it. The transition from social worker to AMHP was seen to bring a slight elevation of status. It was also associated with a greater alignment to psychiatry - for example, an acceptance of the need for treatment and concern for a medical evidence base. That said, some participants were unhappy with increased medicalisation, as dominance of this approach elevated the status of medical discourse, and in doing so minimised other discourses. However, despite these concerns and evident discomfort with the legal definition of mental disorder, AMHPs were found to have adopted a medical discourse, making links between illness and the need for treatment when speaking about Mental Health Act assessments. Risk was associated with illness in the view of AMHPs and was offered as justification for intervention. This encroachment of disciplinary power was argued by the author to have been made worse by a perceived or actual lack of alternative discourses and responses to mental disorder.

When examining how AMHPs view their role in compulsion Morriss (2015), like Buckland (2014), identified that AMHPs believed it brought about an elevation of status. This view was also held among non-AMHP social work colleagues and medical colleagues, and was attributed to AMHPs’ legal knowledge, social control function and ability to manage complex situations. AMHP perceptions of their role in making an application for compulsory detention was seen as prestigious as opposed to ‘dirty work'. Less favourable elements to their role included the gravity of their social control function and the potential for harm to the patient as a result of detention in a hospital. The lack of availability of psychiatric beds and the potential for risk situations to arise as a result of failing to admit a patient to a hospital, either because of a lack of bed availability or as a matter of choice, was viewed as more troublesome than the social control function of the AMHP. This suggests that the potential for adverse incidents was seen as more troublesome to AMHPs than their social control function, as such AMHPs may be more inclined towards governmental management than respecting patient autonomy.

This social control function and concern for adverse incidents was further highlighted in a later study by Morriss (2017). Building on her earlier study about AMHP identity, Morriss, when writing about the implications of being a social worker seconded to a Mental Health Trust, identified the invisibility and difficulty in defining the role, yet the role was understood to mean the mopping up of work that others did not want to do. This view was directly related to 'criticism and high-profile cases' (2017, p. 1348). While it was accepted that service users may become unwell despite intervention, this was not seen as a negative reflection on any work the social worker had done; rather, it was seen as the nature of that work. However, 'suicide or serious […] harm' involving a service user would result in scrutiny by others (2017, p. 1349). Here, concepts of mental disorder as illness, the resultant need for intervention and the possibility of risk behaviours all support governmental ideas of the categorisation and control of problem populations. This concern for risk (stemming from high-profile cases) is in line with Castel's (1991) view of shifting mechanisms of control focused on risk populations as opposed to the individual subject. Indeed, the acceptance of patients becoming unwell suggests a lack of concern with the transformation of the individual or self-regulation from a Foucauldian perspective. This greater concern for risk and consequences (including potential blame), than the societal control function of the social worker may lead to defensive practice, resulting in greater use of professional power at the expense of patient autonomy, a finding compatible with Peay (2003).

These studies, pre-dating and since the 2007 legislative changes in England and Wales, have similarities in that they all highlight the influence of medical models of mental disorder on diagnosis, treatment and risk management. This paradigm justifies the protection imperative (protecting patients, the public and professionals), and ranks patient autonomy as less important. These studies are, however, concerned with compulsion more generally, as opposed to community compulsion. As such, patients are likely to be considered unwell and, as a result, risky. Professionals may therefore be more inclined towards a welfarist approach as opposed to adopting a libertarian stance for this group. This may differ when intervening in the lives of those considered well enough to live in the community. To establish professional perceptions of, and justifications for, community compulsion research in relation CTOs is now considered.

Professional perceptions of community compulsion

In anticipation of CTOs in England and Wales, Crawford *et al.* (2000) sent out a postal survey to psychiatrists designed to establish their attitudes towards plans to extend compulsory powers into the community. Some 46% of respondents were in favour of community compulsion, with the remainder either being unsure or disagreeing, and one in six being prepared to refuse implementation of the plans. Some respondents viewed community compulsion as long overdue, while others raised concerns about anti-therapeutic practices, and increased compulsion and stigma. The conclusion was a lack of consensus on the need to extend compulsion into the community and, in line with Szmukler and Holloway's (2000) suggestion, a greater emphasis on patients' capacity was advocated. These findings did not therefore indicate a desire on the part of psychiatrists to increase their powers to include coercive modes of community treatment. Even where risk behaviours were evident, concern for capacity and consideration of whether risk is linked to illness were seen as relevant, as participants acknowledged that those with capacity were entitled to make unwise decisions. This study highlighted that factors other than mental disorder and associated risks were relevant to decision-making, and suggested limits to governmental management.

In the ten-year period since the introduction of CTOs in England and Wales, research has predominantly focused on their efficacy. However, international studies and more recent research in England has examined professional perceptions of community compulsion by way of a CTO. This section reviews recent research concerned with CTOs since their implementation (as opposed to pre-empting their introduction). First, Lawn *et al.* (2015 and 2016) offered an insight into patient and worker perspectives of CTOs in South Australia. CTOs were experienced as positive, negative and justifiable. With patient participants using moral framing (moralistic language indicating deserving or underserving of treatment) to try to understand why they were made subject to a CTO, to make sense of their experiences of being on a CTO and to convey lessons learnt (Lawn *et al.,* 2015). By contrast, workers were more inclined to use moral framings (performing a moral act) to justify use of compulsion. Patients saw themselves as different and in need of correction. This included a belief that they had done something wrong and as a result were being punished. Patients expressed a need to change 'unacceptable behaviour' and/or get 'better' in order to get off their CTO (Lawn *et al.,* 2015, pp. 10, 11), suggesting an internalisation of biomedical concepts of mental disorder as difference and in need of correction. Patients, rather than experiencing benevolence, talked of being seen as untrustworthy (related to not taking medication), as being bad, punished and coerced into correction (Lawn *et al.,* 2015).

Workers used moral framings to separate right from wrong and to justify their 'right to detain over the patients' right to choose' (Lawn *et al.,* 2015, p. 9). This exercise of power was, however, framed as virtuous; as intervention intended to make the patient feel better, by providing a 'safety net' (Lawn *et al.,* 2015, p. 9). Placing patients on a CTO was also seen as the only way of enforcing 'deserve[d]' treatment, as a result of 'finite' resources (Lawn *et al.,* 2015, p. 10). The concept of receiving deserved treatment was common to accounts concerned with best interests as justification for intervention. However, the study identified that patient participation in best interest decisions was not evident. Workers therefore articulated benevolence as a balance to the coercive nature of compulsory treatment, albeit the study identified that this seemed more concerned with ‘wanting people to appear to be better, to be more socially acceptable, rather than the person actually feeling better’ (Lawn *et al.,* 2015, p. 13). This would suggest that actual outcome is less important than appearing to do the right thing, the right thing being to control those with mental disorder.

A further study by Lawn *et al.* (2016) examined the use of metaphors to understand how the meaning of CTOs is constructed, with the aim of better understanding how the tensions between recovery and agency, and coercive controls might be managed. Their study revealed that worker and patient experiences were multi-dimensional, including negative and positive constructs. Power, control, punishment and CTOs as a tranquilliser were dominant themes, and in the majority had negative connotations from a patient perspective. Patients likened CTOs to being ‘incarcerated or jailed’, ‘chained and shackled’, and described the effect of a CTO as ‘invisible chains’. One patient explained CTO use as a response to worker views of her being ‘psychotic’ and ‘suicidal’. Such a focus on treatment compliance (as response to mental disorder) was argued to encourage coercion, erode trust and ignored patients’ ‘real’ concerns. For example, one patient explained that her calm demeanour had indicated to workers that the CTO was a success, but this calm exterior, as she put it, ‘a drugged up zombie’ served to mask her inner emotions, those of feeling ‘depressed, apathetic [and] emotionless’ (Lawn *et al.,* 2016, p. 9). That said, one patient, by use of the term ‘wake up’ was articulating his decision to alter behaviour to avoid repeat hospital admissions, indicating that he had ‘succumbed to workers’ control’ (Lawn *et al.,* 2016, p. 12). However, worker accounts revealed that patients would be unwilling to comply with treatment in the absence of a CTO, such that any reluctant acquiescence might be lost with the ending of a CTO, indicating that coercive controls were ineffective in engendering self-regulation.

These constructs are far removed from notions of patient autonomy or care, and instead are more closely aligned to coercive controls. Constructs of mental disorder, the need for treatment and control are evident, although the likelihood of interventions justified by these means producing benefit is questioned. Indeed, CTOs were viewed by patients as a means of workers asserting authority, as opposed to being beneficial to patients.

By contrast, this authority was portrayed by workers as beneficial to patients. CTOs were justified as enabling decisions to be made for those lacking capacity (until they gained 'insight'), avoiding the negative mental and physical consequences of mental disorder, including the avoidance of dangerous behaviour, and supporting patients' right to treatment. Despite worker claims of benefit, some contradictory views were evident within the data. CTOs were articulated by some workers as disempowering, a 'big stick', and as something they would 'hate' to be on. But despite these views, CTOs were justified as being beneficial to patients, and these benefits were to be achieved through the compulsory administration of medication treatment, thus providing a 'safety net' (Lawn *et al.,* 2016, p. 8). These constructs were challenged by the authors of the study for a number of reasons, most notably on the basis that benevolent paternalism runs the risk of hindering engagement, which may serve as an 'alternative to practice predominantly focused on risk' (Lawn *et al.,* 2016, p. 12), and use of the term 'safety net' was argued to dismiss patients' more negative constructs and portray intervention as the provision of support as opposed to coercion. The findings in this study were acknowledged by the authors to exemplify Foucault's ideas of power and knowledge, and were recognised as disciplinary mechanisms used to define and correct. However, articulated, CTOs provide for coercive treatment for a problem population, to control and correct, albeit the notion of engendering self-regulation by this means appears unlikely.

Following the introduction of CTOs in England and Wales in 2008, studies have been carried out to explore stakeholder views of their use. These indicate that discourse differs pre-and post CTO implementation. Manning *et al.* (2011), soon after the introduction of CTOs, explored psychiatrists' views and experiences of CTOs. By this time a majority of psychiatrists (60%) stated a desire to work in a system that included CTOs, representing an increase from the 46% in favour of CTOs identified in the study by Crawford *et al.* (2000) prior to their implementation. Psychiatrists thought use of a CTO would help therapeutic relations, and when rating factors influential to decision-making identified the following as very important: promoting adherence to medication, protecting patients from the consequences of relapse in their illness, ensuring contact between patients and health professionals, and providing an authority to treat. In contrast, providing security for patients' family or caregivers, reduced substance misuse and reciprocity were rated as less important. These findings concerned with factors influential in the making of a CTO show that biological constructs of mental disorder have greater influence than social constructs. This finding was mirrored in the reasons given for CTO discharge, leading to the conclusion that 'clinical reasons were rated as being more important in decision-making than ethical or bureaucratic concerns' (Manning *et al.,* 2011, p. 332). Variation in psychiatrists' views was evident, but concern for the patient's civil liberties, the degree of coercion and the potential for social factors to undermine the effectiveness of CTOs were less dominant concerns than clinical factors. This greater concern for clinical factors, coercion and control led the authors to conclude that such an approach was consistent with Foucauldian ideas of governmental management in that medical knowledge was accepted as truth, providing justification for intervention.

Studies by Doughty *et al.* (2013) and Stroud *et al.* (2015, 2017), explored the views of numerous stakeholders, offering an insight into the consistent and divergent views of those fulfilling different roles in the CTO process. Like the above study, findings by Doughty *et al.* identified that the response to mental disorder was predominantly medical. Social support was absent from participant accounts other than 'medically focused conditions […] seen to provide a platform onto which social rehabilitation could be built' (2013, p. 44). This highlights the adoption of a medical discourse in favour of a social understanding that would speak to the possibility of improved mental health as a result of changes to social circumstances. This narrow, medically orientated construct shuts down the possibility of differing approaches that favour a sharing of power and patient autonomy, and as such accords with Foucauldian concepts of professional power and governmental management.

This means of management was not, however, viewed as negative by all stakeholders. Nearest relatives saw some benefit in the 'safety net' function of a CTO and the ability to recall patients to hospital. Responsible clinicians similarly saw CTOs as beneficial in encouraging compliance with medical treatment, and facilitating early and speedy recall to hospital. However, not all RC participants shared this view. Some questioned the efficacy of CTOs in achieving reduced hospital admissions or improved engagement. Care co-ordinator views were reported as mixed and this was reflective of the types of cases they had. For example, being responsible for service users who were willing to accept the authority of a CTO and who appreciated the value of medication made for easier relations than for those who viewed their CTO as punitive, and as a result were difficult to engage. Concern for damage to therapeutic relations was evident, but equally the beneficial effects of medication treatment and ability to recall the patient quickly to hospital were seen as beneficial. Service providers were reported to be overwhelmingly positive in their views of CTOs and saw them as engendering better relationships between service providers and statutory services. This was seen as particularly helpful at times of deteriorating mental health to enable speedy intervention. This ability to recall to a hospital and enforce medication was also perceived as improving safety. AMHPs too, although more critical of CTOs than other participants, saw some benefit for service users. Stable mental health as a result of continued medication treatment and improved understanding of their mental health issues were seen as beneficial. Criticisms centred around lack of service user input into decision-making; the greater emphasis on medical rather than social aspects of care; use of coercion where compliance was forthcoming; poor dissemination of information to services users to help them understand the CTO and to exercise their rights; conditions viewed as restrictive of freedoms or punitive; and administrative and procedural frustrations. Many of these criticisms by AMHPs adopt a social approach, advocating partnership working and autonomy. However the beneficial aspects were firmly rooted in a medical discourse, which assumed difference and a need for treatment. This illustrates that a medical discourse dominated and that it offered justification for intervention. This dominance served to undermine the social considerations, leaving little room for alternative responses based on a sharing of power or advocating patient autonomy.

The above study was further developed by Stroud *et al.* (2015). This publication was primarily concerned with CTOs as a means of providing legal recognition of the need for care and as a structure for containment for the right user. CTOs as a ‘safety-net’ or as a means of setting ‘boundaries’ were key themes (Stroud, 2015, p. 90). While participants articulated notions of safety-net and boundaries in different ways, from a Foucauldian perspective they were concerned with modes of control, justified by mental disorder. For example, an RC participant made clear links between a failure to attend appointments and the resultant return to hospital for the purpose of administering depot medication. An AMHP and service provider articulated a swift response to patients becoming unwell, and a patient articulated CTOs as a means of keeping them on track and preventing them from straying off the path. These responses were not necessarily viewed as negative; indeed, professionals, relatives and patients saw some benefit in the legislative framework of CTOs in providing enhanced care, placing an onus on services to provide such care and improved communication. Respect for the legal authority of the CTO was seen as crucial to its success. This was articulated by service users as an understanding that failure to comply with medication treatment would result in recall to hospital. This provided motivation to some participants to comply with the CTO, although acceptance of CTO conditions was described as grudging. Conversely, where patients were unwilling to ‘buy into’ the CTO, or did not want to ‘accept that anyone has a right to tell them what to do’, the CTO was seen as unhelpful (Stroud *et al.,* 2015, p. 90). Community treatment orders were therefore seen as useful for those willing to accept the authority of a CTO, but potentially counter-productive for those opposed to the power. In summary, the study indicated that biomedical understandings of mental disorder were adopted by most participants, with CTOs being used by professionals to structure interventions. However, the effectiveness of CTOs was questioned for those unwilling to co-operate with community treatment (the very group they were intended for), thus potentially eroding the societal control aspect of CTOs.

The control aspect of CTOs was further highlighted by Stroud *et al.* (2017) when exploring the factors relevant to CTO discharge. Taking medication was rated an extremely or very significant factor, but so too were social factors - for example, appropriate accommodation and meaningful occupation. However, it was unclear whether improved social circumstances alone would result in discharge from a CTO. Similarly, not always accepting treatment was extremely significant in determining the need for renewal of a CTO, but so too was concern for chaotic lifestyles, recreational drug use and social isolation, whereas concerns raised by carers, family and friends, and risk behaviours were extremely significant to the decision to recall a patient to a hospital. Compliance with treatment and social factors were therefore rated as extremely significant to decisions to discharge and renew CTOs. However, it was unclear whether CTOs were seen as improving social factors, whether improved social factors alone would result in a decision to move away from compulsion, or whether citing social factors was just another means of justifying coercive controls.

A distinction between short-term and long-term justification for community compulsion was evident in a study by Jobling (2015). This study was concerned with the practice of supervised community treatment[33] in England, from a practitioner perspective and identified that ethical considerations were predominantly weighed against best interests, including risk to patients and the public. While ethical discomfort was evident among practitioners, all practitioners saw some value in CTOs in the short-term as a means of protection and risk management, and in the long-term to bring about stability and recovery. Discourses were often intertwined, but discourse concerned with control dominated. For example, the study identified that ‘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’ (Jobling, 2015, p. 147) by ensuring a cost-effective means of treatment adherence in the community. CTOs were viewed as a means of preventing relapse (even where medication was accepted) by allowing ease of a planned, less distressing recall to hospital, thus argued to allow for a more proactive, rather than reactive recall to hospital. CTOs were viewed by some as a ‘quick fix’ (2015, p. 150), with the potential for poor engagement and therefore poor practice proving detrimental to patients and

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[33] Up until 2015 CTOs were also referred to as supervised community treatment.

practitioners. In contrast, some saw CTOs as enhancing contact between patients and practitioners, and affording patients a better right to services. Practitioners were, however, aware of these dual dominant discourses of ‘recovery/choice and risk/control’ and expressed concern about the “mixed messages’ they could engender’ (2015, p. 151). The dominance of control over patients’ lives may be explained by the view that situations of risk presented practitioners with little choice. However, some practitioners debated whether CTOs were useful in managing risk behaviours, rather managing perceptions of risk as opposed to risk itself. Prevention of risk was not, however, limited to risk to patients and the public, but also risk to professionals should adverse incidents arise. For example, one practitioner described feeling ‘terrified’ (about the management of a patient), but having ‘ticked all the boxes’ (2015, p. 159). This suggests that dual dialogues are not simply concerned with the balance of ethics, and best interests of the patient and the public, but include consideration of the best interests of practitioners too. The divesting of sovereign power to professionals therefore creates professional accountability, and in turn has the potential for defensive decision-making to avoid blame. Power may therefore be exercised to bring about ‘socially acceptable behaviour’ (2015, p. 157) as a means of protection, while dialogues of maintenance, insight, recovery, acceptance of the need for treatment, and resultant increased responsibility and autonomy (all concepts rooted in paternalistic care) are offered as counterbalance to control. However, some practitioners did not view recovery as autonomy, but as maintained by compulsion. This suggests that the longer term goals of stability and recovery are not attainable in the absence of compulsion, and as such Foucault’s concept of governmental management to engender self-regulation cannot be achieved. Of interest, service user participants within this study viewed recovery as interdependence as opposed to independence, so did not anticipate ultimate freedom from compulsion or attainment of autonomy. It was unclear from the study why this might be: as a matter of free choice or, from a Foucauldian perspective, as a result of becoming subject.

As with practitioner perspectives, the study revealed conflicting service users’ views about the use of CTOs. Positive perceptions included CTOs as service provision, risk management, recovery and maintenance. Service provision was viewed as a means of access to support and certainty about how difficulties would be dealt with (including admission to hospital). Risk, related to participants' views that CTOs imposed controls to help protect themselves and/or others, as these risks were perceived as unmanageable alone. Recovery involved making a comparison between the past (being ill) and the present, and looking to the future (recovery), and maintenance concerned stability, being out of hospital and in the community, positive change and improved mental health. Improvement was attributed to medication, as one participant explained 'I suppose being on a CTO and the right medication I'll conquer it, hopefully I'll get over things, but we'll see' (Jobling, 2015, p. 138). Less favourable perceptions included service users being opposed to the biomedical approach to mental disorder, being 'labelled' as mentally disordered and set apart from normality, and being subject to surveillance. Compliance with medication treatment was viewed by all participants as the primary aim of practitioners when using the CTO, 'not only as a means to an end for practitioners, but as an end in itself' (2015, p. 143). This may be a result of the reported dearth of other treatment options, and CTOs being viewed as a cost-cutting exercise. Rather than serving the interests of service users, some saw the CTO as serving professional interests, allowing for 'defensive decision-making' to manage risk to their reputation (2015, p. 144). Overall risk management and protection were factors common to practitioners and service users, and were focused on immediate control. Participant views about the long term diverged with practitioners being concerned with patient responsibility and autonomy, and service users being concerned with a sharing of responsibility. But common to both groups was an expectation that those subject to a CTO should be in receipt of services, services that they might not benefit from in the absence of community compulsion.

The latter part of this chapter has been concerned with legislative and policy frameworks, professional practices and professional perceptions of compulsion, and has highlighted modes of control that can be explained by Foucault's triangle analytic: sovereign power, discipline and governmental management. Medical power to categorise and control gained momentum, shifting from that of jailer to medical expert.

This expertise has, however, been questioned on the basis of the legitimacy of coercive controls and a lack of evidence base supporting biomedical understandings of mental disorder. Further challenges were made to medical dominance by the introduction of a social perspective when considering compulsory powers. This role, along with increased legalism affording patients greater rights, has been argued to erode medical dominance. However, the introduction of surveillance and community compulsion in the 1990s and CTOs in 2008, driven by a public protection agenda, arguably act to increase coercive controls.

Despite initial opposition to CTOs, research evidence indicates that discourses concerned with control outweigh discourses concerned with patient autonomy. Discourses concerned with control are by no means entirely negative, and indeed are often portrayed as beneficent to patients. In some cases, patients themselves see some benefit to coercive controls, although the majority view them as punitive. Common to all accounts (including those of patients and other stakeholders) is the dominance of medical discourse. Although questioned by some, this adoption of medical discourse offers justification for classification and control - control on the basis of risk associated with mental disorder. Risk management is not, however, limited to patients and the public, but also includes professional protection. Use of coercive controls is therefore driven by factors outside the scope of legal criteria. This is also evident in accounts concerned with service provision, while other considerations - for example, patient capacity - are less influential in decision-making. Despite the predominant concern for risk (to patients, the public and professionals), there is an acceptance that patients become unwell and that enforced treatment may not result in improved mental health, further supporting arguments that appearing to make an improvement or to tick the boxes, offers justification for professional intervention. This study therefore seeks to understand what influences come to bear on those deciding whether to agree to a CTO, and to understand how professionals account for CTO use and what they seek to achieve. The arguments offered for CTO use in the above studies are counter to assertions of advocating patient autonomy, therapeutic engagement and avoidance of stigma, but they may be explained by concern for public perceptions, accountability and blame. The social perspective that is evident within professional accounts therefore appears to have been lost in favour of medical discourse as justification for coercive control. This study therefore seeks to understand how professional accounts reveal the balance of care and control over the patient, and reflect notions of personal autonomy and professional power.

Research questions

In summary, the following main and subsidiary research questions will be addressed by this study:

Community treatment orders: what do they tell us about the exercise of power over the psychiatric patient? Are they protecting the patient, the public or the professionals?

1) What influences (conceptual, theoretical and professional) come to bear on those deciding whether to agree to a CTO?
2) How do professionals account for the use of CTOs, and what are they seeking to achieve by their use?
3) How do these accounts reveal the balance of care and control over the psychiatric patient, and reflect notions of personal autonomy and professional power?

PART 2 RESEARCH DESIGN

The second part of this thesis comprises one chapter which sets out the research design and the qualitative methods employed to explore the operation of power over the psychiatric patient. It provides an explanation and justification for the methods employed for this study. The chapter first addresses the research methods employed, setting out the ontological and epistemological underpinnings and a justification for the choice of semi-structured interviews as the most appropriate means of generating data to answer the research questions. Finally, the chapter focuses on the research process, including reflexivity, sampling strategy and sample selection, before moving on to ethical considerations and presentation of the data.

CHAPTER 3 Research methods and process

Introduction

Having introduced CTOs as the site of enquiry to explore the exercise of professional power over the psychiatric patient and set out the theoretical framework underpinning the discussion of CTOs, this chapter provides an account of the research methods and process. The research adopts a social constructivist ontological position and employs qualitative methods. The chapter outlines and justifies the methodological choices before discussing use of semi-structured interviews as the means of gathering research data to answer the research questions. It will then provide a critically reflective account of the research process. This will be achieved by making clear the approach to sampling and method of analysis. Ethical considerations are also included before concluding with a consideration of data presentation.

Research methods

Ontological and epistemological underpinnings

Bryman (2008) highlights the debate about the differing approaches to social research and draws particular attention to critiques of applying scientific models to the study of the social world. As there is no single acceptable way of conducting research, researchers choose a method based upon their ontological and epistemological positions. Ormston *et al.* defines ontology as ‘beliefs about the nature of the social world’, and epistemology as ‘the nature of knowledge and how it can be acquired’ (2014, p. 2). The differing ontological positions within social science research are primarily concerned with the distinction between quantitative and qualitative research strategies. This distinction concerns not only the numerical and non-numerical nature of data, but carries with it differing approaches and methods (Punch, 2014). Quantitative research generally relates to an objective ontology and is most likely to be associated with the epistemological position of positivism. Positivism is an approach that dominates the theoretical underpinnings of the natural sciences and is concerned with the objective and unbiased study of society and human behaviour. This objective study reveals ‘laws’ of human nature allowing explanation of why something is happening (Burr, 2015). This approach most commonly employs statistical analysis and the measurement of variables for generating and testing theories (Field, 2009).

In contrast to positivism, research with an interpretivist or constructivist epistemology (most commonly associated with qualitative methods) is concerned with how, as opposed to why, something happens. Emphasis is therefore placed on human interpretation of the social world. Ritchie *et al.* highlight the importance of participants’ and investigators’ interpretations of the phenomenon being studied in understanding the connections between ‘social, cultural and historical aspects of people’s lives and to see the context in which particular actions take place’ (2014, p. 12). Constructivism, like interpretivism, focuses on the perspective of those with lived experience and the context of such experience, but emphasises the constructed nature of knowledge. Constructivism rejects the idea of an objective, true account of phenomena, and instead argues that knowledge is constructed through the active roles of individuals, and as such there are multiple, co-existing perspectives of the world as opposed to one truth.

As the aim of this research was to explore the operation of professional power over the psychiatric patient, a research method compatible with identifying professional interpretations of social structures and their behaviours in relation to these structures was essential to its success. Schwandt, when explaining social constructivism, states: ‘human beings do not find or discover knowledge so much as we construct or make it … we do not construct our interpretations in isolation but against a backdrop of shared understandings, practices, languages, and so forth’ (2000, p. 197). This paradigm is compatible with Foucault’s ideas of governmentality in which he asserts the plurality of co-existing forms of government, employing differing tactics, based on differing knowledges and discourses to bring about differing ends (1978). While Foucault’s observations did not arise from analysis of text derived from interviews, his analysis of discourse and its relationship to power can be applied to this study. Foucault’s analysis of how the social world is shaped through use of language is an approach close to social constructivism; as such, this combination of social constructivism and governmentality will inform this research.

Different research methods have been employed in previous CTO studies. Most UK research concerning CTOs is quantitative in nature and has explored the effectiveness of CTOs in achieving reduced recall and readmission rates to hospital (Burns *et al.* (2013); Lepping and Malik (2013); Rawala and Gupta (2014)). Research less concerned with the effectiveness of CTOs in achieving their aim has also employed statistical means of analysis. For example, Smith *et al.* (2014) used retrospective descriptive surveys to gather data to examine the relationship between breaches of CTO conditions and recall to hospital, and quantitative methods have also been extended by Manning *et al.* (2011) and Coyle *et al.* (2013) to the gathering of mental health professionals' views and experiences of CTOs. Doughty *et al.* (2013) and Stroud *et al.* (2015, 2017), however, relied upon mixed and qualitative methods when exploring service users' and practitioners' experiences of CTOs. Research within the UK concerned with CTOs has therefore predominantly relied upon quantitative methods for exploring the effectiveness of CTOs and stakeholder views of their use. As a result, it remains largely unclear why CTOs have proved unsuccessful in achieving their intended aim and, importantly, why CTOs continue to be used in the face of evidence highlighting their ineffectiveness.

This research will add to the existing body of knowledge and will bring differing theoretical perspectives and methods to the exploration of CTOs. This research will add to the existing body of CTO research by specifically examining the exercise of power over patients by way of CTO use. In order to explore the exercise of professional power over the psychiatric patient, factors relevant to professional decision-making will be examined. This will include conceptual, theoretical and professional influences, an examination of what professionals seek to achieve by their use of CTOs, and how notions of care and control, and autonomy and professional power are balanced. Use of qualitative methods will highlight professional knowledge and allow an exploration of how professionals draw upon this knowledge to inform CTO decision-making. The discourse used will highlight how competing interests are balanced and show which discourses dominate in decision-making. Qualitative methods have been used to good effect to explore patients' and mental health workers' experiences of CTOs in South Australia (Lawn *et al.,* 2015), to examine how decisions are taken by AMHPs in respect of compulsory powers under the MHA (Buckland, 2014), to ascertain the view of AMHPs in relation to their role in compulsory detention (Morriss, 2015) and to explore mentally disordered offenders' perspectives on social control (Dixon, 2015). Qualitative methods are therefore appropriate to address the main research question, 'Community Treatment Orders: What do they tell us about the exercise of power over the psychiatric patient?'

There are, however, numerous qualitative methods from which to choose. Initial consideration was given to attending hospital discharge meetings with mental health professionals with the intention of capturing interdisciplinary conversations about CTOs' use. This, however, was ruled out for a number of reasons. First, initial conversations with professionals led me to believe that CTO consideration is often unplanned, rushed and happens outside formal planning processes, a view evidenced in findings by Doughty *et al.* (2013). Second, conversations in the presence of the patient might be limited - for example, full discussion about the reasons for considering a CTO, including risk behaviours, may not be forthcoming (Coffey *et al.,* 2016), and finally, for pragmatic reasons, conversations involving the patient were not necessary for the purpose of a study concerned with professional decision-making and would have involved the additional complexity of NHS ethical approval. Consideration was also given to the use of case studies as a means of eliciting data to answer the research question. Flyvbjerg defines the case study as a 'detailed examination of a single example' (2011, p. 301). While some limits were set to reflect the predominant CTO population within sample selection, I was keen to capture a range of factors relevant to CTO consideration, and was less concerned by consistency of decision-making among participants when faced with the same facts. For these reasons, I was enthusiastic to hear views about numerous patients as opposed to limiting the scope of discussions to the facts of one case. I was also keen to understand whether local variation was evident, and failing to discuss patients familiar to participants might have lost this detail. These difficulties could have been overcome by use of multiple case studies with differing compositions (Ritchie *et al.,* 2014), but access to patient data would have involved the complexity of NHS ethical approval. In the absence of NHS ethical approval, hypothetical case studies (vignettes) could have been devised, with careful consideration given to the content. However, deciding on criteria for inclusion in case studies would be complex and might fail to capture the range of factors relevant to participant decision-making, which might result in the over- or under-representation of factors relevant to decision-making. Discussing cases unfamiliar to participants might also have lost the dynamic of interdisciplinary relations relevant to decision-making. For these reasons, immersing myself in professional meetings and the use of case studies were not considered the most appropriate means of gathering data to answer the research questions. In the event, semi-structured interviews were chosen as the most appropriate means of eliciting information to answer the research questions. The reasons for this are set out below.

Semi-structured interviews

Semi-structured interviews were used as the method of generating data from those involved in the CTO decision-making process, RCs and AMHPs. Whittaker explains that semi-structured interviews enable ‘sufficient structure to facilitate data analysis while giving … sufficient flexibility to explore participants’ responses in depth (2009, p. 34). A semi-structured interview schedule (Appendix 1) was devised with a range of possible questions to facilitate the conversations with RCs and AMHPs. The semi-structured interview schedule provided prompts to the key topics to be covered, but allowed sufficient flexibility for participants to pursue topics of interest to them. The aim of the interview schedule was to facilitate a conversation following a logical process, addressing the key topics, while not being so rigid as to inhibit participant accounts. Interview schedule guides tend to advocate an order: first, introductions and context setting allowing participants to be introduced to the subject matter and to allow for the development of conversation; second, more detailed questions may be asked to elicit participants' views of the subject matter to provide data aimed at answering research questions; and finally, winding down, including an opportunity for participants to share any views not already expressed (Ritchie *et al.,* 2014). The interview schedule devised for this research followed this format, first addressing the recorded nature of interviews, consent and a general introduction to the subject matter. As part of the general introduction, open questions were asked about the processes for considering CTOs, whether participants enjoyed this element of their work, whether they felt equipped to undertake CTO consideration and what their views were about the introduction of CTOs. These general questions were followed by more specific questions about a patient for whom participants had considered a CTO. For example, participants were asked how they came to consider the CTO they had chosen to speak about, to describe the patient's characteristics and the issues involved in their CTO consideration, whether it was a typical case and whether in hindsight they would have done anything differently. Finally, participants were given an opportunity to share any other views and ask questions.

This format was followed for both individual and joint interviews. While keen to ensure that I asked sufficient questions to elicit data to answer my questions, I was mindful of Bryman's (2008) advice that the interviewer should be attentive and avoid being too intrusive, as listening is key to being responsive to what the interviewee is saying and to facilitating their ability to share their views. However, when interviewing pairs (an RC and an AMHP together), it was important to consider the dynamics between participants. While Lewis and McNaughton Nicholls (2014) caution against group discussions between participants involving issues of power and status which may inhibit their contribution, joint interviews between RCs and AMHPs allowed their shared and differing perspectives to be illuminated. Joint interviews also facilitated their responsiveness to one another, and on occasion this resulted in the interviewee becoming the interviewer, allowing a fluidity of conversation and sharing of views independent of my input. Had any participant dominated during a joint interview to the point of inhibiting their colleague, I would have intervened to ensure that both parties were able to share their views; however, this did not occur within the sample. Another concern was the potential for participants to provide formalistic or normative answers to questions as a result of wanting to appear to follow procedures governing decision-making - for example, statute or Government guidance. However, in the event participants did not appear concerned by the need to give what might be considered 'right' answers. Use of initial indirect questioning may have contributed to participants' ease of answering (Rubin and Rubin, 1995), and participants' enthusiasm to participate (no interviews were cancelled or postponed) may indicate a willingness to share unadulterated views. To ensure that the interview schedule provided appropriate prompts to generate data to answer the research questions, an initial pilot interview was conducted, recorded and transcribed. Having established that one interview generated a wealth of information relevant to my chosen site of enquiry, I proceeded with data collection.

Research process

Reflexivity

Another epistemological consideration is the relationship between the researcher and the researched. One model argues for the objectivity of the researcher; in contrast, some argue, as a result of the relationship between the researcher and the researched that the researcher cannot be neutral and value free. As such, the position of 'empathic neutrality' advocating transparency of assumptions, bias and values in the conduct of research was adopted (Ormston *et al.,* 2014). It is therefore important critically to reflect on the 'brought self' and the identities we bring when engaging in the research process (Lincoln *et al.,* 2017). This reflection should be evident throughout the research process, from research design to writing up (Delamont, 2002). Reflexivity is therefore addressed within numerous sections of this chapter. This section will consider my professional roles and knowledge, and how these have impacted on my choice of research question, and the fieldwork element of this research. Reflexivity in relation to data collection, analysis and writing up is addressed in later sections of this chapter, entitled 'Ethical considerations', 'Analysis and Nvivo 10' and 'Presentation of the data'.

From practitioner and trainer to researcher

As a registered social worker, I have worked in independent and statutory mental health care settings as a manager and a social work practitioner. My work within statutory mental health services included the role of the ASW, which later became the AMHP. These roles require consideration and, where appropriate, instigation of the statutory means of compulsion for those considered mentally disordered. Prior to the change from ASW to AMHP I became involved in the training of ASWs and RMPs (also involved in the consideration and instigation of the statutory means of compulsion). I continued in this training role during the legislative changes of 2007, which saw the introduction of CTOs. CTOs extended the means by which professionals could exert power over patients, yet, despite initial reservations from within the mental health professions (Pinfold and Bindman, 2001), the uptake of CTOs far exceeded Government expectation. This greater than anticipated uptake of CTOs (in the face of initial reservations), resulting in increased curtailment of patient freedoms, prompted my interest in professional justification for CTO use.

My professional experiences therefore prompted my enthusiasm to engage in research activity; however, I have done this in the context of continuing in my training role, both of AMHPs and RMPs. My prior experience as a practitioner, and current role as trainer, therefore afford me insider status (Pelias, 2013). Insider status is recognised as bringing both positives and negatives to the research exercise. The positives include my understanding of the statutory and conceptual frameworks in which professionals operate, and the terminology reflective of these frameworks. I also have an understanding of mental disorder and the challenges of this faced by patients and those seeking to support them, and of organisational and political pressures. This knowledge may, however, serve as a means of bias, challenging scholarly detachment. However, as discussed above, having adopted qualitative methods, I am not concerned with achieving an objective detachment, but instead recognise the importance of my interpretations of the area of study and the context in which these interpretations sit.

Acknowledging my preconceived ideas as a result of my professional role and knowledge is therefore an important aspect of reflexivity. As a trainer in the field of mental health and capacity law, I have a keen interest in the law governing the care and treatment of those considered mentally disordered. I am naturally orientated towards considering the application of law and concepts of necessity and proportionality. By this I mean that I am concerned that any intervention in the lives of those considered mentally disordered should only occur when lawful, considered absolutely necessary, and, when it is considered necessary, is kept to the minimum. These values influence my teaching, and for this reason I assume that these concepts dominate participant decision-making. This is not, of course, necessarily the case, and as the research is not concerned with the application of the law (other than it presenting as one of many factors potentially influencing professional decision-making), I have had to caution myself continually against being drawn into irrelevant avenues, conclusions and writings. Being aware of my bias (and participants' knowledge of my training role), I had to make clear at the start of interviews that my aim was not to examine practice through a legal lens, as any assumption on their part of my intentions may have skewed their responses during the interview process.

A critically reflexive approach has therefore been adopted throughout this research to minimise the impact of my experience and my relationship with participants on the research process. To achieve this, I have been explicit about my choice of conceptual frameworks and underpinning theory; I have made clear my interest in, and knowledge of, the chosen site of enquiry, and my professional relationship with participants. Further on in this thesis the findings will be grounded in the data, reflecting the views of participants. The presentation of the findings will include excerpts from transcripts, and these excerpts will be set in context to ensure transparency.

Sampling

A purposive sampling strategy was employed for this research. Purposive sampling aims to ensure 'those sampled are relevant to the research questions that are being proposed' (Bryman, 2008, p. 415). This approach was adopted to allow selection of a sample with characteristics relevant to understanding the social phenomenon being explored, the exercise of professional power over psychiatric patients. As the site of enquiry focuses on CTOs, the sample was purposively chosen for the following reasons.

First, participants needed to be from the two professional groups involved in CTO decision-making, AMHPs and RCs. It is acknowledged that this limited inclusion criteria omits consideration of patient perspectives of the exercise of professional power by way of a CTO, and the perspective of others involved in the maintenance of CTOs – for example, care co-ordinators, service providers and relatives - however, as this study aimed to understand the greater than anticipated uptake of CTOs participation was sought from the two professional groups with the legal power to decide whether or not to make a CTO. Participation by AMHPs and RCs was on the basis of being willing to discuss CTOs in general, and more specifically to share their consideration of a CTO for a specific patient. The outcome of their CTO consideration did not act as an exclusion criterion; by this I mean that I was keen to include participants who had both instigated and declined CTOs. This approach was intended to ensure illumination of the range of factors relevant to CTO consideration irrespective of decision outcome. To further illustrate the range of factors relevant to CTO consideration, the sample included pairings of an AMHP with an RC colleague (having worked together to consider a CTO), and individuals. These joint and individual interviews aimed to illustrate any similarities and differences between professionals, and highlight any professional and practice dynamics affecting decision-making. For example, within the CTO decision-making process the roles of the RC and the AMHP are distinct and require consideration of different factors. RCs are primarily concerned with statutory criteria being met, including the presence of mental disorder, risk and the need for medical treatment (s17A(5), MHA), and AMHPs, in addition to being satisfied that the above statutory criteria are met, must establish the necessity and proportionality of any CTO conditions, and the appropriateness of a CTO, bearing in mind the 'wider social context' (DoH, 2015, p. 331). The intention of joint and individual interviews was the establish whether these distinct roles, their different professional training and possible divergent theoretical perspectives, influenced decision-making. As the sample was to include RCs and AMHPs, it was necessary to recruit from both health and local authority services. I therefore approached a large mental health Trust, with a geographical spread encompassing numerous local authorities. The aim of this spread was to establish whether working practices in differing areas impacted professional decision-making.

The second determinant for the sample concerned the characteristics of the patients considered for CTOs. CTOs are most commonly used for male patients subject to section 3 MHA, with a diagnosis of schizophrenia (Doughty, 2013; CQC, 2014). Selection of AMHP and RC participants was therefore based on their ability to discuss consideration of a CTO for a patient with these characteristics. This inclusion criteria were intended to bring sufficient homogeneity of experience. Restricting the sample to include consideration of CTOs for patients with these characteristics was important for two reasons. First, this population of patients broadly represents the concerning characteristics leading the Government to introduce CTOs for the purpose of managing the risk of harm associated with this group. Exploring decision-making in relation to this group should therefore reveal whether CTOs have provided a means by which professionals control such patients. Second, this limited inclusion criteria will allow for rich insights into professional use of power for this group, offering an understanding of how and to what ends their power is exercised.

As the research is concerned with professional power, any inclusion of the views of others - for example, patients and others professionally or personally concerned with patients - are seen through the eyes of participants, and therefore cannot be viewed as reflecting or representative of others' views. Inclusion of these views is, however, important as participant perceptions of others' views are sometimes used as justification for professional decision-making.

Sample size

The initial aim was to discuss consideration of 15 CTOs with a range of RC and AMHP participants across a number of geographical areas, as it was anticipated that data from 15 interviews would be sufficient to address the research questions and would be manageable within the fieldwork timeframe. The sample was reflective of RCs from one mental health Trust, working across three different local authority areas, and AMHP participants were drawn from these three local authority areas. One of these local authority areas worked to a boundary divide of North and South, and participants were drawn from both of these distinct geographical areas. As such, RC and AMHP participants were drawn from four distinct areas, with differing working practices.

Depending on the willingness of participants to engage in joint interviews, the intention was to include data from between 15 and 30 participants. In the event, 12 interviews were conducted. Eight of these were joint interviews between AMHPs and their RC colleagues, and the remaining four were with individual AMHPs. Unfortunately, no RC participants offered to participate in individual interviews. In total, the interviews comprised 18 different participants as two participants were interviewed on two separate occasions, as one AMHP offered to participate in a joint interview in addition to her individual interview, and one RC offered to participate in two separate joint interviews. Of the 18 participants, 7 were consultant psychiatrist RCs (4 of which were hospital based and 3 were community based), and 11 were AMHPs (4 of which held lead posts, and 7 did not) (see appendix 4). The interviews involved discussions of 11 different patients, as one participant who was interviewed twice (alone and with a colleague) chose to speak about the same patient on both occasions. That said, aside from the specific patients discussed, general discussion about CTOs' use inevitably elicited information about other patients. While detailed discussions about 15 different patients was not achieved, in hindsight this was not necessary to achieve collation of detailed data. Given the homogeny of the group and limited inclusion criteria, it is argued that a smaller sample size will include the necessary internal diversity (Ritchie, 2014). Having begun the process of transcribing, coding and data analysis following the first interview, early identification of recurrent themes enabled me to identity the point of saturation. Having conducted 12 interviews, I was satisfied that I had enough data to conclude analysis.

Ethical considerations

Ethical approval

Prior to conducting this research, ethical approval was sought. Ethical procedures for the University of Bath and the Mental Health Trust for the geographical areas from which my medical participants were selected, were followed (Appendix 5 and 6 respectively). The University of Bath's ethical approval process required submission of a standardised ethical approval form for consideration by a committee. The Mental Health Trust's ethical procedures were more involved, including assurance of the University of Bath's ethical approval, submission of 'essential documents' including a research CV, a participant information sheet and a consent form, the support of a clinical representative from within the Trust, and attendance at the National Health Service (NHS), National Institute for Health Research, Good Clinical Practice training. I attended this training on 8 February 2014, and while it was weighted towards quantitative medical research, it set clear expectations for the maintenance of a research portfolio to ensure an ethical approach throughout the research process. This was to be achieved by consideration of consent, the potential for harm and privacy. How these considerations were managed is discussed in more detail below under the headings 'Informed consent', 'Avoiding adverse consequences' and 'Confidentiality, anonymity and the limits of these'. The research also involved social work participants employed by three local authorities. As employees of local authorities (as opposed to vulnerable people within their care), the three differing local authorities allowed me to conduct interviews on the basis of the University of Bath's ethical approval.

It is acknowledged that ethical considerations arise as a result of participants being asked to discuss consideration of CTOs, which included the sharing of patient information. At the time of embarking upon this study the ethical procedures for the

Trust, local authorities and University of Bath were followed, ensuring the data was fully anonymised preventing identification of patients. The ethical procedures followed did not require consultation with patients (or carers) about the research design. However, were I to embark upon this study now, or in the future carry out research concerned with patients (or carers), I would involve other interested parties in any grant application, research design, undertaking the research, data analysis and dissemination of findings, to ensure robust consideration of other stakeholder perspectives (National Institute for Health Research, 2014).

Informed consent

A core principle of social research is the informed consent of participants. Participation on this basis requires the sharing of sufficient information about the research project for participants to offer their voluntary involvement. This information should include the purpose of the research, what participation will involve, information about those conducing the study, the voluntary nature of involvement, confidentiality and, where necessary, funding arrangements (Webster *et al.,* 2014).

To meet these requirements, I distributed a participant information sheet (Appendix 2) at the point of recruitment to the study. The information sheet included an explanation of the study and what participants were being asked to do. Contact information for myself and my supervisors was included to enable participants to ask further questions, and the voluntary nature of involvement along with information about confidentiality were included. As all participants were selected from professional groups, as opposed to vulnerable groups, there were no concerns about the capacity of participants fully to understand the nature of the study.

Participants were asked to contact me if they had an interest in the study, ensuring no persuasion was used. This was especially important given my professional relationship with participants. Once contacted by potential participants, I made arrangements to meet at a mutually convenient time, leaving enough time for an interview to take place if agreement was forthcoming. Placing the onus on potential participants to contact me was an attempt to mitigate any power imbalance between me as researcher and trainer, and participants. It was during this meeting that consent was further discussed and recorded by use of a consent form (Appendix 3). The consent form restated the voluntary nature of participation and, as guided by the Social Research Association, participants were made aware of their 'entitlement to refuse at any stage for whatever reason and to withdraw data just supplied' (2003, p. 27), thus ensuring that any ongoing involvement was voluntary. The consent form also included principles of confidentiality and anonymity, as such participant consent was based on a clear understanding of the nature of the study, and how confidentiality and anonymity would be maintained. Confidentiality, anonymity and the limits to these are discussed below.

Avoiding adverse consequences

The Social Research Association stress the importance of researchers' 'moral obligation to attempt to minimise the risk of physical and/or mental harm to themselves and to their colleagues from the conduct of research' (2003, p. 24). This requires consideration of any potential harms, and protection from or minimisation of, such harms. The form of social enquiry chosen for this research presents little risk of harm, but it is acknowledged that distress may be caused as a result of participation in the research. Distress may be caused by participants' reflections on their working practices, or by a perceived inability to avoid answering questions. Ritchie *et al.* (2014) highlight this latter difficulty by drawing a comparison between surveys allowing for 'not applicable' or 'don't know' answers, and qualitative research in which a relationship is established between the researcher and the researched, potentially giving rise to the researched feeling unable to bypass questions. Recognising the potential for this, participants were advised that they could decline to answer questions and that interviews could be terminated at their request. Acknowledging my training role and the consequent power imbalance, participants were also assured that no judgement was being made about practice; rather, my concern was to gain an understanding of their perspective on CTOs.

In relation to distress as a result of discussing practice, the participant information sheet provided my contact information, and advised communication with professional supervisors where practice issues arose. In the event, all participants were fully engaged during the interview process and no distress was evident. Bryman (2008) recognises the potential for harm beyond the gathering of data, by failure to maintain confidentiality, particularly of persons and places. This potential for harm can be managed by use of pseudonyms and by avoidance of identifying place names. These aspects of harm avoidance are discussed in more detail below.

Confidentiality, anonymity and the limits of these

The participant information sheet made clear how participant information would be stored and used. This included a clear statement that interviews would be audio recorded and transcribed. At the point of transcription, all personal details were removed and data was stored securely. These steps were taken to ensure the maintenance of participant confidentiality and are consistent with the requirement of ethical approval. Limits to confidentiality are, however, accepted within social work research (Shaw and Holland, 2014). These limits commonly concern risk of harm to a vulnerable person or the committing of a crime. As a registered social worker, I am bound by the Health and Care Professions Council requirement to share information where it is considered necessary to 'safeguard service users and carers and others' (HCPC, 2012, p. 2). This may include identification of incidents of dishonesty, danger to the service user or illegality. As such, information about the limits to confidentiality was included on the participant information sheet, with a clear reference to the professional code of conduct by which I am bound. Limits to confidentiality were also reinforced on the consent form by asking participants to sign a statement, 'I confirm that I have read and understood the participant information sheet for the above study and have had an opportunity to ask questions'. Participant initials were required against each statement on the consent form in addition to their signature. While appearing cumbersome, this was a requirement of the Trust's ethical approval procedure and focused participant attention on each aspect of consent, including the important aspect of confidentiality and its limits.

In relation to the presentation of the data, participants were assured that pseudonyms would be used to maintain participant anonymity, and that participant places of work and their geographical locations would be kept confidential. Participants were also assured that any patient names disclosed during interview would not be reproduced within the data. Had any of the data (aside from names and locations) made it easy to identify people or places - for example, serious reported incidents involving patients - these details would have been omitted to protect confidentiality and anonymity.

Analysis and Nvivo 10

Punch (2014) highlights the numerous ways in which data may be analysed, leaving open the right approach to qualitative data analysis. Coffey and Atkinson explain that the central concern linking these numerous approaches is the 'transforming and interpreting qualitative data – in a rigorous and scholarly way – in order to capture the complexities of the social worlds we seek to understand' (1996, p. 3). The systematic methods of analysis must therefore be described to offer confidence in the findings.

Interviews with participants were recorded, and these recordings were transcribed in full, offering a highly reliable record to return to as hypotheses were developed (Silverman, 2005). Thematic analysis was then employed as a means of organising and analysing the data. Spencer *et al.* describe thematic analysis as an approach 'which involves discovering, interpreting and reporting patterns and clusters of meaning within the data' (2014, p. 271). An iterative approach to the assigning of codes to group emerging themes was adopted. Initially an inductive approach to generating themes was adopted, by this I mean that initial codes were data driven, rather than theoretically driven. This process is recognised by Boyatzis (1998) as requiring the researcher to be open and flexible, whilst bringing a degree of pertinent knowledge to the area to aid the recognition and conceptualisation of data relevant to the research questions. The term 'code' is one of numerous terms to describe the process of identifying and grouping data with something in common. Ritchie *et al.* (2014) use the terms 'theme' and 'category' to distinguish two stages of data analysis. The first stage involves indexing data according to themes, which serves to organise the data. The second stage, referred to as 'developing categories', allows the essential meaning of the data to be captured, and thus the process of analysis develops. Coffey and Atkinson (1996) argue that codes are not of themselves a method of analysis, but provide a means by which meaningful data can be identified to allow for interpretation and conclusions. For the purpose of describing the manual elements to data analysis I will refer to 'codes', meaning the initial identification of themes, and 'categories', meaning the process by which discourse was analysed to identify similarities, differences and the meaning of the data.

The process of listening to, transcribing and coding interviews to identify themes took place alongside interviews. Manual coding of transcripts was initially used to identify themes and to identify the point at which no new insights were being generated by the data. For example, initial codes including 'mental disorder', 'illness', 'unwell', 'relapse', 'insight', 'treatment' and 'substance use' were initially assigned to group themes, before further analysis of categories was carried out. In order to test emerging themes and ensure reliability, my supervisors offered independent oversight of the consistency of assigning codes and categories, this was important given the inclusion of brief data extracts within the thesis (Silverman, 2005). Once saturation point was reached, all transcripts were imported into NVivo 10, a software program designed for the storage, organisation and analysis of qualitative data. This allowed for ease of organising and retrieving data. In addition I utilised the word 'frequency' function of NVivo 10, which allowed me to establish whether the themes I had identified were prevalent within the data. However, there are limits to this approach, most notably frequency is not an indicator of significance. After some consideration, I was persuaded not to include the numerical occurrence of specific themes. Ritchie *et al.* (2014) highlight the potential for reporting frequencies to detract from the value of qualitative research in its ability to offer meaningful descriptions of phenomena, processes and explanations. Indeed, it soon became clear that frequency was not an indicator of significance, as the absence or infrequency of themes may be an equally significant finding. As Potter puts it, 'deviant cases can be some of the most analytically revealing' (2004, p. 616). Indeed the inclusion of contradictory cases alongside dominant themes is an important aspect of validity (Silverman, 2005).

Having simplified the data by assigning initial codes to themes, the process of establishing categories began. The process of categorising data allows for an interrogation of the commonalities, differences and meaning within the data. During this stage of analysis, the decision to focus specifically on Foucault's theory of governmentality, as opposed to his work on the history of madness, was confirmed. Clear evidence of power relations and concern for risk made this the best theoretical fit by which the data could be examined. Having reached this conclusion the data was re-examined in light of the theoretical framework to further explore how and why professional power was being put to work. To examine the data, the analytic approach of discourse analysis was employed to understand participant versions of reality through use of their language. Potter asserts that discourse analysis 'emphasizes the way versions of the world, of society, events and inner psychological worlds are produced in discourse' (1997, p. 146). There are, however, numerous forms of discourse analysis. For the purpose of this study, I am adopting a version of analysis which is discourse as a form of social action. Potter describes this as a 'form of discourse analysis the aim is used to make visible the ways in which discourse is central to action, the ways it is to constitute events, settings and identities' (2004, p. 609).

To examine participants' use of language, large sections of categorised data were cut and pasted into word-processing software. This allowed for an ongoing examination of the nature of participants' reality. Foucault (1968) asserted the plurality of discourses, used by different individuals and groups, which are subject to transformations and are used to differing ends. Analysis therefore had to move beyond reporting what was said to examining what the discourses were doing, how discourses are constructed to achieve an aim, and examine what resources were being employed to achieve that aim (Potter, 2004). This process was cyclical and often took me back to the original recordings and transcripts. Themes that initially appeared distinctive later merged, making separating out the data for reporting problematic. For this reason, there are some overlaps within the findings chapters, although attempts have been made to keep this to a minimum.

Presentation of the data

Coffey and Atkinson highlight the relationship between data analysis, writing and representation of social phenomena. As they put it, ‘we do not simply “collect” data; we fashion them out of our transactions with other men and women. Likewise, we do not merely report what we find; we create accounts of social life, and in doing so we construct versions of the social worlds and the actors that we observe’ (1996, p. 108). Reporting the findings is therefore a means of communicating accounts of social life as experienced by participants (Rubin and Rubin, 1995). It is at the point of writing that the passing event (the interview) becomes fixed (Shaw and Holland, 2014), and the interaction between the researcher and researched becomes an interaction between the researcher and the reader (Flick, 2002). Findings must therefore be presented in a way that accurately represent participant accounts (Rubin and Rubin, 1995) and are ‘persuasive and convincing’ (Bryman, 2008, p. 661).

In this thesis, the findings are presented across three chapters. The chapters do not lend themselves to neatly address separate research objectives, and so there are some overlaps within the findings chapters. Each chapter begins with a clear statement about its content and makes clear which research objectives are addressed. As they do not address separate research objectives, the chapters have been presented in a way that is consistent with the CTO decision-making process. The first two findings chapters address factors influential to CTO decision-making - for example, concepts of mental disorder (Chapter 4), and interdisciplinary dynamics and resources (Chapter 5). The final findings chapter presents participants’ responses to mental disorder (Chapter 6). To convey participant accounts, direct quotations have been included following discussions of the findings. This use of discussions and quotations is usual in the reporting of qualitative research (Gabriel, 2015), as it helps the reader understand what is being said by participants and illustrates how the conclusions have been drawn, thus providing a convincing argument (Rubin and Rubin, 1995). Use of verbatim quotations is argued by Kirk and Miller (1986) to offer the most accurate portrayal of participant perspectives, thus avoiding researchers' personal perspectives influencing reporting.

Use of discussions and quotations that illustrate both common and divergent themes are included to provide detail and realism. Dominant theses are presented first, supported by a number of quotations chosen as a result of their direct reference to the subject matter. This avoids the reader having to make an inference (Rubin and Rubin, 1995). Less dominant themes are summarised or supported with fewer quotations. An attempt has been made to avoid lengthy quotations, but instead to include a range of quotations across the data to represent variation within the data. While participant names have not been used (instead pseudonyms have been used), their profession is given as this provides the context - for example, their professional responsibility and the experience they bring to the decision-making process. Whether interviews were individual or joint is also made clear as this indicates where participants talked freely or where interdisciplinary dynamics were in play. A participant list setting out pseudonyms, professional training, whether the participant was interviewed alone or with a colleague and the duration of the interview is set out in Appendix 4. While the findings chapters draw upon literature informing the thesis, commentary on literature and the implications of the findings is contained within the concluding chapter entitled 'Discussion and conclusions' (Chapter 7).

PART 3 FINDINGS

The third part of this thesis presents the findings across three chapters. Chapters 4 and 6 show the dominance of medical discourse among RC and AMHP participants. This dominance can be broadly categorised into two areas: first, by the ways in which mental disorder is understood by participants (Chapter 4), and second, by participants' responses to mental disorder (Chapter 6). Chapter 5 is concerned with other factors that influence professional decision-making - for example, inter-professional relationships and resources. The findings are presented in this order as it broadly mirrors the decision-making process; how mental disorder is understood, consideration of other factors relevant to CTO decision-making, and the response to these.

The findings across Chapters 4 and 6 are important as they illustrate professional knowledge and discourse, and show how this knowledge and discourse is used to exercise power over patients in the context of CTO decision-making. Chapter 5 which is concerned with interdisciplinary dynamics and resources, illustrates the role of other factors relevant to the CTO decision-making process.

The data presented is contextualised to support the findings, and excerpts from conversations with participants are included to illustrate the analysis. Wherever participants are introduced, their profession is identified, and it is made clear whether the excerpts are from joint conversations between RCs and AMHPs, and whether they are from individual interviews with either an RC or an AMHP. The findings are considered in light of the research questions, and the analytical framework that were set out in Chapter 2.

CHAPTER 4 The dominance of medical discourse 1: How mental disorder is understood

They called me mad, and I called them mad,
and damn them, they outvoted me.
(Nathaniel Lee, in Porter, 1991, p. 1)

Introduction

This chapter presents an analysis of the data that shows the dominance of medical discourse among those making decisions about the use of compulsory powers, specifically community treatment orders, under the MHA 1983. This dominant discourse is evident in the ways in which participants understand mental disorder. These understandings can be divided into two categories: first by participants' identification of difference, and second, by participants' explanations of patients' experiences of mental disorder. Participants' identification of difference is evident in a number of ways. Most dominant is the dialogue of diagnostic classifications, although use of the terms 'psychotic illness', 'insight', 'relapse and readmission' and 'madness' are also used as a means of identifying difference, most of which offer justification for intervention. Participants' explanations of patients' experiences of mental disorder are often viewed as 'risk' behaviours resulting from mental disorder. Consideration of risk to others, and self, is evident within the data, although not all risks offer justification for intervention. The terms 'illness' and 'unwell' were used interchangeably by participants when explaining difference and risk, albeit these terms were most evident when discussing risk. These terms distinguish between normal and pathological, and offer justification for intervention.

Having identified that the most dominant discourse is that of diagnostic classifications it is worth considering their origin and how they are put to work. Revisions to DSM-III in 1980 were viewed as a means of redefining psychiatric expertise from that of a psychodynamic model to a biomedical model, aimed at achieving scientificity for psychiatry through diagnostic reliability. This increased diagnostic reliability through standardisation was also intended to improve treatment regimens (Whooley, 2010). This biomedical approach has however been criticised for its potential to inhibit other understandings of mental health problems, for over-medicalising deviant behaviours (Horwitz, 2002), and for facilitating the proliferation of pharmaceutical treatments (Rose, 2003). Indeed, establishing a biological cause for mental disorders and a corresponding treatment can prove problematic - for example, personality disorders do not include organic malfunctioning and are established on the basis of behaviours - thus undermining claims of biological scientificity that DSM-III sought to establish (Manning, 2000). This reliance on behaviours (symptoms) alone in the absence of causes when establishing diagnosis is argued by Mayes and Horwitz (2005) to result in a theory-neutral approach that could be adopted by clinicians from all theoretical persuasions, thus potentially undermining the biomedical model. Similarly, use of diagnostic classifications by psychiatrists may serve different purposes - for example, facilitating a common language, enabling insurance claims and avoiding the most stigmatising diagnosis, (sometimes in co-operation with patients) - thus subverting the biomedical model (Whooley, 2010). Acknowledging these debates about the origins and use of diagnostic classifications, it is clear from the data that diagnostic classifications are closely aligned to the need for medication treatment, indeed participants commonly used diagnostic classifications as justification for medication treatment. This along with very limited consideration of social causation or treatment in its broader sense, by participants, justifies the assertion that a biomedical model is most commonly adopted by participants when describing mental disorder and treatment for mental disorder.

Given the emergence of two key themes, the analysis of data within this chapter is presented under the following main headings: ‘Participant explanations of mental disorder’, and ‘Risk behaviours resulting from mental disorder’. Subheadings will, however, be used to explore the numerous dialogues used to define difference, and to differentiate between risk to others and self. The employment of different and numerous discourses to justify the adoption of techniques to guide and alter behaviours is consistent with Foucault's ideas of governmentality. The thesis does not however adopt a reductionist view of governmentality as a calculated means of exercising oppressive power, but instead draws upon the broader conceptual and theoretical understandings of governmentality (discussed in chapter 2 above). To borrow from Rose, governmental tactics have been employed in the name of 'public good and private well-being' (1999, p. 6) to bring about freedom, as opposed to purely oppressive means of control. When writing about the governance of humans Rose states 'to govern humans is not to crush their capacity to act, but to acknowledge it and utilize it for one's own objectives' (1999, p. 4). Presupposing the freedom and capabilities of the governed in addition to those that seek to govern is therefore important to our understanding of the exercise of professional powers (Dean, 2010, Rose, 1999).

The data within this chapter helps address all three subsidiary research questions. First, it is clear that biological concepts of mental disorder influence decision-making; second, mental disorder offers justification for use of CTOs, specifically to reduce risk behaviours arising from mental disorder; and finally, accounts reveal that care is offered as justification for control and professional power takes precedence over patient autonomy, as opposed to power being used to allow for patient autonomy. It is however important to restate that these findings are relevant to the sample – RC and AMHP participant discussions of CTO consideration for male patients subject to s3 of the MHA, most commonly diagnosed with psychotic illnesses. These findings therefore cannot be generalised beyond this group (Miles *et al.,* 2014). This is especially important given the low statutory threshold for CTO instigation allowing divergent groups to be made subject to CTOs for the purpose of treatment (in its broadest sense).

Participant explanations of mental disorder

In the context of explaining mental disorder, the terms 'Illness' and 'unwell' were predominantly described by means of diagnostic classifications, and signs and symptoms of mental disorders, although the emphasis placed on diagnostic classifications, and signs and symptoms of mental disorders varied within participant accounts. In some instances, diagnostic classifications were offered as explanation of mental disorder in the absence of any further defining characteristics. However, there were examples of diagnostic classifications being offered and further explained by detailing symptoms of mental disorder, and symptoms of mental disorders were offered in the absence of a diagnostic classification. Other terms - for example, ‘psychotic’, ‘insight’, ‘relapse’ and ‘readmission’ - were also used as a means of setting patients apart from a normal state. Less frequently used were the terms ‘mental disorder’ (akin to the legal definition) and ‘mad’.

It might be anticipated that AMHPs would be more inclined to use legal language as an explanation of mental disorder than their RC colleagues. This assertion is based on the differing training received by these two professional groups to enable them to undertake CTO consideration, and professional guidance designed to shape professional conduct. AMHPs receive approximately six months of full-time training with significant emphasis and assessment on the law informing practice; this is in contrast to the two-day approved clinician (AC) training, which enables professionals to become RCs. Despite this difference in training and the requirement that AMHPs bring a social perspective to CTO decision-making (DoH, 2008a), no clear distinction can be seen among RC and AMHP participant accounts. I begin by outlining how diagnostic classifications were used by participants, before exploring other, less dominant means of explaining mental disorder.

Diagnostic classifications

Diagnostic classifications derive from two diagnostic manuals: the *International Statistical Classification of Diseases and Related Health Problems 10th Revision* (ICD 10) (World Health Organization, 1992) and the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM 5) (American Psychiatric Association, 2013). These manuals aim to promote inter-rater reliability, ensuring consistency between those making a diagnosis, by establishing criteria to classify disease (although consistency between clinicians has been questioned by Kirk and Kutchins (1994)). While written to allow for statistical analysis, the general descriptions and guidelines within these manuals are used by health professionals - in practice, most commonly psychiatrists - to assign diagnosis to patients. However, the following accounts show that use of diagnostic classifications are common to the two professional participant groups: RCs, all of whom are registered medical practitioners, and AMHPs, all of whom are social workers.

The following excerpts illustrate the dominant use of diagnostic classifications among RCs and AMHPs. Siri and Ben, both RCs in interview with AMHPs, offered diagnostic classifications. However, the use of diagnostic classifications was not the preserve of RC participants during joint interviews. Desmond, an AMHP in interview with his RC colleague, offered diagnostic classifications, and Hope, an AMHP, offered diagnostic classifications when interviewed alone. This was illustrative of diagnostic classifications being used among RC and AMHP participants. This use of diagnostic classifications (in the absence of other explanations of mental disorder) by both participant groups demonstrates the dominance of the biomedical approach to mental disorder. This discourse serves to set patients apart from a normal state and offers justification for intervention.

The use of diagnostic classifications had two functions: first, to describe individuals with whom professionals had worked. Here diagnosis was offered as a defining characteristic of patients. Second, diagnosis was offered as a means of grouping those suitable for CTO consideration. Siri and Ben, both RCs, and Desmond and Hope, both AMHPs, offered diagnostic classifications when discussing a patient with whom they had worked. These diagnostic classifications were offered in different contexts and therefore illustrate general use of diagnostic classifications when speaking about patients.

Siri made reference to the diagnosis of ‘schizophrenia’ when speaking about a patient’s appeal against his CTO. Ben’s comments came in the context of discussing the success of a CTO in preventing the redetention of a patient who had previously spent many years living in a hospital environment. Desmond’s reference to a diagnostic classification formed part of his response to my asking why a CTO had been considered for the patient he had chosen to speak about, and Hope cited diagnostic classifications when asked about the characteristics of the patient whom she discussed.

> ***Siri:*** *He doesn't accept he has schizophrenia or a mental illness.*

> ***Ben:*** *He's got chronic schizophrenia, and he lives in a therapeutic community, he's not subject to the Mental Health Act and hasn't been for about ten years since he was a long-stay patient.*

> ***Desmond:*** *So, he is about 37 now this young man, but he is diagnosed with paranoid schizophrenia, Asperger's and substance misuse.*

> ***Hope:*** *Paranoid schizophrenia with some elements of a grandiose personality disorder.*

The above quotations are illustrative of a dominant finding that RCs and AMHPs, when talking about patients with whom they had worked, included diagnostic classifications as a defining characteristic of patients, almost always to the exclusion of any other defining characteristics. While a medical diagnosis is not a necessary criterion for implementation of a CTO, it is likely that a diagnosis will have been assigned to the patient during their preceding in-patient admission, if not prior to that. Use of this dominant medical dialogue facilitates a common professional language in which labels categorise patients and determine a response to disease, thus justifying professional intervention. This commonality among participants of assigning diagnostic classifications might be a result of the integration of health and social care professionals, allowing the dominant discourse to prevail (Tew, 2011). This accepted use of diagnostic classifications almost to the exclusion of other explanations of mental disorder suggests the dominance of medical discourse, and has the potential for excluding a critical appraisal of the social context of mental disorder and influencing professional decision-making when considering the imposition of CTOs. This was evident in participant responses to mental disorder and is discussed in Chapter 6 below.

Hugo, an RC, during a joint interview, and Hope and James, both AMHPs, interviewed alone, referred to diagnostic classifications as explanation of mental disorder when more generally discussing the suitability of patients for a CTO. This dominant discourse is based upon knowledge held by professionals, as opposed to patients, and serves to elevate the status of professionals, and in doing so affords less consideration of patient knowledge and autonomy.

> ***Hugo:*** *I just strip it down to patients with schizophrenia who are revolving door.*

> ***Hope:*** *When somebody doesn't have the capacity to agree to that, or they don't believe that they have a paranoid schizophrenic illness, they don't believe that they have a bipolar disorder, but we know that they have this history of quite long periods of in-patient treatment, and they have been stabilised on medication.*

> ***James:*** *Someone who has a significant history of, usually schizophrenia or bipolar disorder, who by examining the history you can see they agree to be seen by their care co-ordinator and they typically are initially concordant but there is historic ... no I think I have had enough now and I think I want to stop [medication treatment].*

These accounts go further than using diagnostic classifications, by indicating that this knowledge is that of professionals as opposed to patients. Hugo, by use of the term ‘revolving door’ (DoH, 2007, p. 3), indicated a need for professional intervention to prevent the cycle of readmission to hospital. Hope, by her use of the phrase ‘but we know’, implied that the patient did not hold the same knowledge as professionals, and James’s use of the professional term ‘initially concordant’, to mean compliant, signalled a disbelief in the patient’s willingness to continue treatment. Each of these statements indicated a superior professional knowledge, and a desire on the part of professionals for patient compliance. This knowledge and status offers justification for professional intervention by means of statutory power. This expert knowledge, justifying coercive controls to alter behaviour, can be understood from a Foucauldian, governmentality perspective.

The diagnostic classification of schizophrenia is common to the above excerpts concerned with specific patients and more generally CTO consideration; as such, this diagnostic classification offered justification for intervention. However, an exceptional case was seen in the following account by James, an AMHP, interviewed alone, who suggested diagnostic classifications that might be excluded from CTO consideration. While diagnostic classifications were maintained as a means of setting patients apart from a normal state, not all diagnostic classifications offered justification for professional intervention and oversight by way of a CTO.

> ***James:*** *So, it is actually looking at the experience of the patient and basically saying where are the moments where you could see a CTO would be helpful to keep this person and prevent them relapsing. This is why I am very sceptical about the use of CTOs in personality disorder and eating disorder. … you won't find a single instance of CTO in people with personality disorder or eating disorder in this neck of the woods. It is not to say that there is a blanket ban on them, but the key issue is particularly is someone in danger of becoming unwell and losing capacity and losing the ability to actually manage things, and then it is too late.*

The above excerpt, while maintaining use of diagnostic classifications to define patients, introduced the idea that some diagnostic classifications warrant professional intervention by means of a CTO - for example, schizophrenia and bipolar disorder - and some do not - for example, personality and eating disorders. This might be explained by the behaviours (referred to by participants as ‘risks’), associated with differing diagnosis, and the perceived treatability of differing diagnosis. For example, those with a diagnosis of schizophrenia might be viewed as presenting greater risk towards others than those with personality or eating disorders. The treatability and means of treatment administration for differing diagnosis might also be relevant to CTO consideration - for example, medication treatment was viewed by participants to be successful for those with a diagnosis of schizophrenia. However, this means of treatment is likely to be less successful for those with personality or eating disorders. Risk behaviours, or the likely success of treatment in managing risks associated with different diagnosis, may therefore be relevant to professional decision-making. This accords with Castel's (1991) view that strategies of control relocated from the individual to problem populations considered a risk, (in this case, those with a label of schizophrenia) thus justifying the adoption of modes of surveillance aimed at prevention. However, a departure from Castel's (1991) view is evident in that some problem populations - for example, those with eating and personality disorders - are not considered to pose sufficient risk to justify intervention by means of a CTO. Risk behaviours associated with mental disorder are explored further in the latter part of this chapter.

These accounts show that participants used diagnostic classifications as a means of defining a patient or groups of patients. This use of diagnostic classifications offers an authoritative framework in which decision-makers can label patients with an umbrella term without further exploring their characteristics; patients are therefore seen as nothing more than a diagnostic classification or, as the following excerpts reveal, a sum of their symptoms. These labels, determined on the basis of expert knowledge, set patients apart from a 'normal' state. This abnormal state assumes the need for treatment, and in some cases legitimises the use of authority to impose treatment. This bureaucratic authority sets limits on patient freedoms and seeks to gain compliance with a regime in order to bring about a normal state. This process is evident in many of the following accounts in which symptoms of mental disorder are evident in addition to diagnostic classifications.

Diagnostic classifications and symptoms of mental disorder

Diagnostic classifications were sometimes further explained by describing criteria leading to diagnosis - for example, paranoid schizophrenia is described in ICD 10 as ‘dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances’ (WHO, 2010, p. 80). In practice, these criteria are referred to as symptoms of mental disorder. Tony an RC in interview with an AMHP, and Alice, an AMHP, interviewed alone, both alluded or referred to symptoms that indicate schizophrenia, after offering a diagnosis when asked about the characteristics of the patient for whom a CTO had been considered.

> ***Tony:*** *He has a long history and is diagnosed with paranoid schizophrenia. I will start from about 2000 when I think he was on oral medication and fairly compliant at that point, stable as far as I know. He is a religious man and part of his religious ideas was the Bible telling him that the medication he was on was a good medication for him, so he complied for that period. Then for some reason the Bible told him otherwise, so he stopped. He lived in a warden-controlled block of flats and he gradually became more ill, became more paranoid about other people in the vicinity, there was some disinhibition on his part towards other elderly female residents as well. That culminated in pushing one of the other residents in the back in the garden thinking that they were stealing stuff from his room.*

> ***Alice:*** *It was a 55-year-old gentleman with a diagnosis of schizoaffective disorder and he has a long history of mental health difficulties which he struggles to accept, and he finds it very hard. When he becomes unwell, this is usually in the context of excessive use of alcohol and illicit drugs, then he doesn't take his medication and then things start to drift and he becomes unwell. When he becomes unwell, he becomes very aggressive and hostile, self-neglects, neglects*

> *his home and he becomes very paranoid and has delusions, or just spirals very badly out of control.*

In both accounts, symptoms of certain types of mental disorder - for example, paranoia - were described as risk behaviours resulting from mental disorder - for example, disinhibition, aggression and hostility. These behaviours, viewed by participants as consequent to mental disorder, offered justification for intervention by means of a CTO and correction on the basis of preventing potentially harmful behaviours to self or others. Reference to symptoms of mental disorder as illness and associated behaviours without other explanations further highlights an adoption of the biomedical approach to mental disorder and serves to maintain this dominant discourse. The survival of such psychiatric diagnosis, rooted in a biomedical approach to mental disorder, has been questioned by Pilgrim (2007), particularly in the light of attacks from within the psychiatric profession. However, as Georgaca and Avdi, explain, ‘there is a close mutual relationship between discourses and practices; dominant discourses, which become taken for granted, support and enable social and institutional practices, which in turn maintain them’ (2012, p. 156). Use of diagnostic classifications and associated symptoms of mental disorder, as Chapter 6 goes on to explore, are closely linked to participant responses to mental disorder. It is therefore argued that use of this discourse represents a form of social action, legitimising professional positions, and actions.

This approach was also evident in the following account by Ben, an RC, during a joint interview, when discussing a patient for whom a CTO had been agreed. However, this account was exceptional in that reference to bullying and poor academic attainment indicated consideration of social factors that might be causative of mental disorder. That said, a biomedical response to mental disorder was still evident.

> **Ben:** *He’s a 52-year-old guy, he has at least, god how long, how many years, decades of mental illness, he has got a diagnosis of treatment resistant schizophrenia, he became unwell, he has got a 27-year-old history, became*

> *unwell as a teenager, he was bullied, he kind of didn't do terribly well with his O-levels, did a bit of work, and became ill, erm, characterised by thought disorder, paranoid delusions, long history of admissions to hospital.*

While possible social, causative factors of mental disorder are evident within this account, use of a diagnostic classification, the term ‘unwell’ and reference to symptoms, such as ‘thought disorder’ and ‘paranoid decisions’, and compulsory medical treatment by means of a CTO being posited as the best solution all indicate the dominance of the biomedical approach. While references to bullying and poor academic attainment were made, there was not suggestion within the data that these had an impact on the patients thought disorder, or professional decisions about intervention. As a result, social factors are secondary and are lost when determining a response to mental disorder.

Psychotic illness

The less specific term ‘psychotic’ was used by participants to denote mental disorder and associated behaviours causing concern. The term ‘psychotic illness’ is used to describe mental disorders characterised by hallucinations and/or delusions (symptoms of mental disorder). This would include the diagnostic classifications of schizophrenia, but would also extend to other disorders such as schizoaffective disorder, delusional disorder, substance-induced psychotic disorder, and mood and personality disorders, to name a few. The term ‘psychotic illness’ is therefore less specific than a diagnostic classification, but nevertheless indicates that criteria are met for a clinical diagnosis and as such, in the absence of any other explanations of mental disorder, a biomedical approach is given priority. However, of note, the term ‘psychotic’ was used in the context of participants describing risk behaviours resulting from mental disorder that cause concern about the potential for harm to the patient or to others. It is of interest that the labels ‘schizophrenia’ and ‘psychotic’ dominated accounts, as opposed to other diagnosis - for example depression and anxiety disorders. This may however be anticipated as the predominant group for whom CTOs are used are male patients with a diagnosis of schizophrenia or schizoaffective disorders (CQC, 2010, Doughty *et al.,* 2010). As the inclusion criteria for this study included male patients subject to section 3 MHA, it is perhaps unsurprising that the labels of ‘schizophrenia’ and ‘psychotic’ are used by participants.

The term ‘psychotic’ was evident when participants spoke about specific patients for whom they had considered a CTO, and more generally when considering CTO use. This is demonstrated in the following accounts. First, in the accounts by Desmond, an AMHP, and Reg, an RC, interviewed together, and Tony, an RC, interviewed with an AMHP colleague, and James, an AMHP, interviewed alone, the term ‘psychotic’ was evident when speaking about specific patients. In each of these excerpts, the term ‘psychotic’ is associated with unacceptable behaviours. Desmond and Reg’s comments came in the context of explaining the ‘combination’ of behaviours contributing to their decision to use a CTO, Tony’s comments came in the context of describing the patient’s characteristics, and James’s comments were made in response to my asking what depot medication treatment sought to achieve for his patient.

> ***Desmond:*** *He was seen brandishing a kitchen knife and he was driving erratically; he was rimming the car, driving it without wheels and sparking it, and feeling the electricity coming up through his foot, so quite psychotic.*
>
> ***Reg:*** *There are people who have accumulated forensic history who become very, very psychotic.*
>
> ***Tony:*** *When he came back to his flat things again started to go down, he became more and more paranoid, there were incidents reported not just in the block of flats. I think there was an incident at one of the local supermarkets. We ended up going out to do an assessment and at this point he was obviously quite psychotic, but also had an almost manic edge to his presentation.*

> ***James:*** *I think obviously from the history he has got [a] deeply ingrained psychotic illness with a pronounced tendency to relapse, sometimes even when he has been concordant [with treatment].*

These accounts by RCs and AMHPs show that the term ‘psychotic’ was associated with behaviours viewed as unacceptable and in need of correction, and as such justified professional intervention. While the decision outcome of these separate CTO considerations differed in that Desmond, Reg and Tony instigated CTOs as a means of imposing medication treatment to minimise unacceptable behaviours, James, in contrast, refused a CTO in preference for s17 leave of absence, which was viewed as a more powerful means of control. While differing legal provisions were used, the term ‘psychotic’ was offered as justification for use of a bureaucratic authority as a means of correcting unacceptable behaviours (associated with mental disorder) and engendering compliance.

Use of the term ‘psychotic’ to justify intervention was not limited to participant discussions about individual patient’s, but was also used more generally to denote a severity of illness warranting intervention. This was evident in the following separate accounts by Ben, an RC, and Charlie, an AMHP, who more broadly discussed CTO consideration in different joint interviews.

> ***Ben:*** *I guess from my perspective, so the majority of my work is with people with severe mental illness, of course, a recovery service, and the majority of those by definition are people with psychotic illnesses.*

> ***Charlie:*** *I kind of narrow my views about CTOs over time, but usually it is someone with a psychotic illness who has had many admissions to hospital, who is on a depot and who accepts that depot within a CTO framework and without it says that they won't accept it.*

The account by Ben made clear that psychotic illness is a 'severe' mental disorder, and by implication warrants intervention, and Charlie, associated psychosis with repeat admissions to hospital and the need for depot medication. This, too, suggested a severity of illness and the need for control by professionals, as professionals have control over admission to hospital and depot medication administration. This label, in the absence of other explanations, therefore prioritises a biomedical understanding of mental disorder, denotes unacceptable and unpredictable behaviours in need of control by professionals, and as such legitimises professional intervention to bring about compliance and a normal state. Other general terms (aside from 'psychosis') commonly occurring within the data included 'insight' and 'relapse', and these are discussed below. These terms were also used to describe symptoms of mental disorder and were frequently linked to one another. These terms in the majority were used to justify intervention.

Insight

The term 'insight' was frequently used among participants. Use of this term was most common among RC participants, but was understood by both participant groups to mean an understanding into one's situation and compliance with treatment. More frequent use of this term by RCs might be the result of the definitions being medically orientated. Johnson and Orrell (1995) refer to definitions consisting of several components. First, the patient may recognise themselves to be unwell, but may not be able to distinguish symptoms - for example, hallucinations - from normal perceptions. They may also deny ill heath, but identify hallucinations as abnormal perceptions, attributing them to other causes. Second, insight is best understood as dimensional rather than categorical, as partial awareness may be evident. These definitions are argued by Johnson and Orrell (1995) to be more sophisticated than the earlier understandings purporting that insight is to be determined on the basis of whether or not the patient believes the doctor. However, they note that these definitions may miss social and cultural components to insight, and importantly patient perceptions. These deficits are likely to result in the dominance of professional power, doing little to engage patients and encourage self-determinism.

From the following separate accounts by Tony and Siri, both RCs interviewed with AMHPs, it is clear that participants considered their patients lacking in understanding of their mental disorder (from a professional perspective). This lack of understanding was considered a symptom of mental disorder and as a result justified professional intervention.

> ***Tony:*** *He was lacking in insight, he was refusing to accept that he had a mental illness at this point or there was anything wrong with him, or has ever been wrong with him. We felt that if we did not keep him under CTO he would rapidly stop medication.*

> ***Siri:*** *Because there is one person you know [initials] to this date we have been in so many Tribunals and Hearings[34] and he doesn't accept he has schizophrenia or a mental illness, but for some reason he will take the depot as long as he's on the CTO.*

In these accounts professionals possess a knowledge of mental disorder that is not understood or shared by patients. This is evident in Tony and Siri's assertions that patients 'refuse' or '[do not] accept' their label of mental disorder. This knowledge of mental disorder, possessed by professionals, is intrinsically linked to the need for treatment, and in both cases, treatment was enforced by means of a CTO. As such, professional knowledge of mental disorder and the associated need for treatment offers justification for use of professional power, and this knowledge takes precedent over patient understandings.

Lack of insight, in some cases, was held responsible for poor decision-making on the part of patients. This too offered justification for professional intervention to ensure

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[34] Mental Health Tribunals and Hospital Managers' Hearings, both means of appeal by patients against compulsion under the MHA.

the ‘right’ decision was made. This was evident in the following accounts by Joe and Hope, both AMHPs, and Ben, an RC. Joe’s reference to insight came in the context of justifying use of the MHA during an interview with his medical colleague. Hope’s comments came during an individual interview in the context of explaining the distinction between detention and a CTO to a patient, and Ben (during a joint interview) was explaining the continued use of a CTO as a result of a patient not understanding the need for treatment.

> ***Joe:*** *He had no insight into the medication and how it was helping him and again he was coming up with the same thing – ‘I think it is making me put on weight’. It was actually a different medication they put him back on but he just couldn't make any of the links at all.*

> ***Hope:*** *He would often go back to the argument that there was nothing wrong with him and he didn't need medication and that conversation is really difficult because it is difficult not to come across as patronising, saying ‘Well, if you had a blood disorder you would have to; you would be willing to consent to that treatment because it kept you well and because your disorder is in your mind’. The mind is such a complex piece of equipment that that part of your mind might not work properly, but this part of your mind is believing that that doesn't matter. I said, ‘But what it has done is led you to be hospitalised for long periods of time’.*

> ***Ben:*** *If you are taking medicine for anything, whether it's a headache or a psychosis, you are making that balanced decision of, you know, desirable effects versus side effects. Now if you don’t have any insight, if you don’t think it’s necessary, all you are going to see are the [laugh] undesirable effects, which is why it’s so important, especially in people who don't, who aren’t accepting treatment, but we have got the authority to give it to them.*

In these accounts a right choice is implicit, and where patients failed to make the right choice, lack of insight (a symptom of mental disorder) was used as justification for professional intervention. The right choice was assumed by professionals to be the acceptance of treatment. In Joe's account, the patient's concern about weight gain as a result of medication treatment was seen as less important than the need to administer treatment. As such, use of a CTO was justified to ensure the patient's compliance in the face of their reluctance; as a result, the social concerns of the patient were lost. Hope's use of the word 'patronising' implied that the patient may have some understanding but suggests inferior patient knowledge in comparison to professional knowledge which is assumed to be 'truth'. In addition, her assumption that the patient would accept treatment for a physical disorder suggested that the patient's mental disorder, and resultant lack of insight, impeded his ability to make the right decision. Ben, too, implied a right and wrong decision by playing down the undesirable effects of medication and stating the need for authority to overrule the wrong choice. All of these accounts showed a lack of insight or inferior understanding as a result of mental disorder, justifying professional intervention and elevating the administration of medication treatment above other concerns. This need to administer medication treatment as a result of lack of insight or inferior understanding highlighted the dominance of a biomedical discourse legitimising professional power.

Insight is therefore an important concept in ensuring patient compliance. On the basis of participant perceptions, those with insight would presumably understand the need for treatment and therefore accept it, and those lacking in insight as a result of mental disorder become subject to compulsion, the end result being compliance and correction. In all the above accounts, CTOs were instigated for the purpose of enforcing medication treatment. This reliance on mediation treatment is based on a biomedical approach to mental disorder that lacks consideration of social factors. It also fails to acknowledge patients' views of their illness, which could be argued to undermine therapeutic relations, and any notion of patient choice and autonomy.

There was one exception, however, within the data. Joe, an AMHP, during a joint interview, questioned whether one patient's lack of understanding of mental disorder was a result of his cultural beliefs. Joe’s consideration of culture came in the context of discussing a patient with whom he had worked for some time, which might account for Joe’s broader consideration of the patient’s circumstances.

> ***Joe:*** *There were also some cultural issues to take into account because […] being in mental health services wasn't a good thing for him. He was from a different culture and he didn't believe that he needs to be in mental health services. He was separated from his family, so he wanted to stop the medication as soon as possible.*

Despite consideration of ‘cultural issues’ being the root cause of lack of insight, a CTO was instigated for the purpose of medication administration; as such, the patient’s cultural beliefs were secondary to biomedical understandings. This supports Johnson and Orrell’s (1995) assertion that definitions of insight miss cultural components, the impact being a lack of patient engagement and autonomy.

The meaning of insight was, however, subverted to mean compliance by some participants, and as such insight became an irrelevance provided patients were willing to comply with the proposed treatment plan. Tony, an RC, during a joint interview, when discussing CTOs generally, showed greater concern for patient compliance with treatment than for their understanding of mental disorder. This was also true of Hope, an AMHP, interviewed alone, when discussing the patient she had chosen to speak about.

> ***Tony:*** *Even if they do not have insight, as long as they get to a stage where they understand that the medication is necessary, and it is required under the CTO.*

> ***Hope:*** *He did meet the criteria; he was aware of his responsibilities in having to, not necessarily accept that he has a disorder, but that he does need an injection every two to three weeks. Thinking about it now, you cannot make somebody*

> *believe that they have got a disorder if they don't want to, but you can, have to, give somebody a chance to comply with their treatment.*

These accounts suggest that the patient’s understanding of mental disorder and the need for treatment becomes irrelevant provided they agree to treatment. As such, there is no requirement for patients to buy into professional perceptions of mental disorder, provided they are willing to do as they are told. Thus, professional power is maintained; a CTO is utilised to convey the necessity of treatment, irrespective of patient insight. From a Foucauldian perspective, this suggests an absence of professional concern to engender self-regulation. Patients are therefore unlikely to arrive at this position, and as a result run the risk of remaining subject to control by others. Therefore, coercive controls are not being used to bring about autonomy, but instead serve to remove autonomy.

However, in the following accounts by Reg, an RC, and Desmond, an AMHP, interviewed together, the irrelevance of insight is extended to CTOs. Provided patients are willing to comply with professionals, neither are required. Their comments came in the context of my asking, ‘How do you come to consider CTOs?’ as such the accounts are not concerned with specific patients, but represent a broader view of the relevance of insight and compliance to CTO consideration. Reg was of the view that insight is likely to engender compliance, in which case a CTO might not be necessary. In contrast, Desmond was less concerned by insight, but was satisfied that a CTO might not be necessary where a patient is willing to comply with treatment, irrespective of their insight.

> ***Reg:*** *We tend to have a clearer picture around whether the person has got good understanding, good insight, because I think the two protective factors are insight and engagement, so if there is good insight from the person then there is a chance that they will engage better.*
>
> ***Desmond:*** *Lack of insight is not a key factor, only if the lack of insight serves as a barrier to engagement it would be a factor for me. If the person doesn't have*

> *insight but is willing to engage and it is not a barrier to the person taking the medication, then for me there is a clear distinction there.*
> ***Reg:*** *We are looking at preventing acute relapses and that kind of, and that automatically reduces risk for them and for others, then if that purpose is achieved by the person taking medication, engaging, then why is there any need of CTO, because if they are taking medication and engaging, then it is less likely they will become unwell, less likely the risk will become unmanageable.*

This discussion between Reg and Desmond shows that compulsion may not be considered necessary for those willing to accept treatment irrespective of insight. While participants have adopted different views on the importance of insight and compliance, the biomedical approach to mental disorder dominates and the end game is always administration of medication treatment.

Relapse and readmission to hospital

Across the interviews, relapse and the consequent need for readmission to hospital was seen as an inevitable part of mental disorder. Analysis of the data revealed frequent use of the term ‘relapse’. While all participants did not adopt this term, more detailed analysis of the data showed that all participants discussed the cycle of deterioration in patients’ health following a stable period, leading to readmission to hospital, sometimes referred to as the ‘revolving door’ as shorthand to explain this process. CTOs were seen as a means of preventing this cycle, and therefore offered justification for professional intervention. This process is evident in the following accounts by Norman, an RC, and Hope, an AMHP, interviewed separately. Norman’s comments came in the context of a joint interview when discussing a patient for whom he had agreed a CTO, and Hope, interviewed alone, was speaking about the impact of a CTO on a specific patient had it not been agreed.

> **Norman:** *The moment the CTO was lifted she came back in again and she gets unwell within a week in just seven days or less.*

> **Hope:** *If he were not under the CTO there would be that cycle of deterioration and going back into hospital under Section 3.*

Both accounts showed that CTOs were justified on the basis of their ability to prevent a deterioration in health and resultant readmission of patients to hospital. However, there was an exception in that Flora, an AMHP, when asked how she felt about the introduction of CTOs, questioned the usefulness of CTOs in preventing relapse and readmission to hospital, and argued that a MHA assessment might be more efficient in readmitting a patient to hospital.

> **Flora:** *I think as time goes on patients don't wake up in the morning and think 'I'm on a CTO and I need to take my tablets'. It becomes an irrelevance really, and then it becomes a difficulty when we do need to recall. Because recalling someone that is on a CTO is actually harder than recalling someone who is not on anything, than doing a Mental Health Act assessment.*

Flora was stating that CTOs do not engender compliance with treatment and that recall to hospital under a CTO is problematic - more problematic than convening a Mental Health Act assessment. Flora's perception indicates that CTOs do not fulfil their intended aims of engendering compliance with treatment and facilitating speedy recall to hospital. In any event, use of a CTO or MHA detention enables the enforced treatment of those considered mentally disordered; as such, professionals are simply choosing to utilise the most efficient power as opposed to avoiding the exercise of power.

The exercise of power by means of recall to hospital for the purpose of treatment was not, however, seen as necessary for all patients. The frequency of recall to hospital is cited as a relevant factor to CTO use. Mike, an AMHP, in interview with

Charity, his RC colleague, made a distinction between ‘clear-cut’ cases, referred to as ‘revolving door’, and those that are less clear, requiring infrequent recall to hospital. Mike saw little point in using CTOs for those with a mental disorder requiring infrequent admissions, stating ‘There is no point in doing one if you are going to just be recalling someone every few years’, to which Charity replied, ‘It doesn't feel right at all, does it?’. This suggests limits to the exercise of professional power. It is, however, probable that there is a relationship between frequency of recall and concerning behaviours as a result of mental disorder, not least because the statutory criteria for recall to a hospital includes the requirement of risk. This may indicate, as already discussed, that some mental disorders do not warrant intervention by means of a CTO.

Mental disorder

It might be anticipated that RCs and AMHPs, who instigate CTOs, would refer to the legal definition of mental disorder, as it provides the gateway to use of the MHA and is the first criterion to be met for use of a CTO. However, reference to this definition was rare. Mental disorder is defined by the MHA as ‘any disorder or disability of the mind’ (s1(2) MHA), setting the bar low. This definition is not dependent on the presence of a clinical diagnosis, and so the RC and AMHP when considering a CTO must be satisfied that the ‘patient is suffering from mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment’ (s17A(5)(a) MHA). Nature and degree are not defined within the MHA, but case law has defined nature as the particular mental disorder, its chronicity, its prognosis and the propensity of the patient relapsing, and degree refers to the current manifestation of the illness *(R. (Smith) v. MHRT for the South Thames Region [*1998] EWHC 832). The following excerpts by Tony and Ben, both RCs, and Sam and Jim, both AMHPs (all of whom participated in joint interviews), mentioned mental disorder, and other than Tony, who specifically referred to ‘nature’, other references to this criterion were implied.

> ***Tony:*** *He had a clear mental health disorder. I think it was clearly of the nature that it was relapsing and remitting which requires regular use of medication in order for him to stay well.*

> ***Ben:*** *But there must be a much clearer plan, especially for people, the kind of people whom CTOs, the CTO was designed for in the first place, who have got a clearly relapsing mental disorder, but there's fairly clear relationship between that and treatment and that you can be very sure that there's a fairly characteristic relapse signature.*

> ***Sam:*** *You're taking a wider picture about potential risks about the impact of their mental disorder from the past.*

> ***Jim:*** *Well, there isn't any sort of typical picture, it's just about revolving door patients isn't it, and compliance. Other than that, they come from various mental disorders with various risks and things.*

All the above accounts were given in the context of CTO consideration. Tony was discussing his decision to extend a CTO; Ben's account came as part of a broader discussion about what he hoped to achieve by use of CTOs; Sam was discussing the instigation of CTOs, and Jim was responding to my question about a typical case for CTO consideration. This shows that links to the legal criterion of mental disorder and 'nature' and 'degree' were made by participants when thinking about CTO consideration, as opposed to the more frequent use of diagnostic classifications when speaking more broadly or when describing patient characteristics. All the above accounts make direct reference to mental disorder and state or imply nature or degree. This data shows that CTO decision-making is justified on the basis of legal criteria being met, and therefore indicates that social control is exercised in response to legal criteria being met, as opposed to being driven solely by professional discretion. However, inclusion of legal criteria is limited to that of mental disorder and nature or degree. This is of particular interest in relation to the AMHP participants, Sam and Jim, as AMHPs, unlike RCs, are required by legislation to look beyond mental disorder to question the appropriateness of a CTO (s17A(4), MHA), thus retaining professional discretion to decline a CTO in the face of legal criteria being met. This lack of focus on professional discretion and greater emphasis on mental disorder also suggests that a formal knowledge is used as justification for intervention, and so legal knowledge, like medical knowledge, provides justification for professional intervention into the lives of those considered different.

The medical knowledge of diagnostic classifications and signs and symptoms of mental disorder (in the absence of other understandings of mental disorder) is, however, more commonly used among participants than the legal criterion of mental disorder, in spite of case law confirming that a clinical diagnosis of mental disorder according to DSM is not sufficient to establish mental disorder for legal purposes (DL (2010) UKUT 102). This suggests that a biomedical approach to mental disorder dominates other understandings of mental disorder. This propensity towards the biomedical approach suggests the subordination of social approaches to mental distress, which has been argued by Tew (2011) to run the risk of invalidating the experience and perspective of the individual. It is of note that patients' perceptions of their circumstances are seldom discussed by participants. In an exceptional case, Sam, an AMHP, during a joint interview, when speaking about a patient's mental disorder, articulated the patient's experience of mental disorder. However, the patient's perception was lost to the professional view of mental disorder:

> ***Sam:*** *She has no conception whatsoever that she had any mental disorder; it was a spiritual assault that she was experiencing, that was what it was all down to.*

Here, the patient's view of a 'spiritual assault' was dismissed in preference for the professional view that the patient 'has no conception' of mental disorder. Thus, the patient's view is subservient and dominated by a knowledge and language that serves to offer justification for intervention. Be it medical or legal language, this knowledge serves to separate out the normal from the pathological, elevates the status of the professional and justifies intervention for the purpose of correction.

Madness

While the dialogue of diagnostic classifications and symptoms of mental disorder were common to all accounts, and other labels and terms were used to differentiate from a normal state, there were some exceptional cases in which the less formal language of madness was used. Flora and Mike, both AMHPs used the term ‘mad’, albeit in differing contexts. Flora, interviewed alone, was talking about the success of a male patient living in the community. She was of the view that he was managing; in contrast, her colleague, a ‘recovery worker’, was of the view that the patient required more aggressive medication treatment. Mike’s comments came in the context of a joint interview, when speaking about the disparity between legislation designed to provide patient protections and a lack of provision to resource this.

> ***Flora:*** *There’s no risk [recovery worker name], just calm down a bit, because OK he’s very mad but he is not doing anything dangerous, so let’s just run with it … he’s not distressed mad.*

> ***Mike:*** *So, the system isn't really set up to be responsive, and all the time it's not just the waste of resources, that person is still ill in the community, and the police won't pick them up unless they are obviously mad and a lot of people are not, they are just quietly ill.*

Flora appeared to be minimising or normalising behaviours in an attempt to avoid over-intervention in the face of a colleague’s concern for a patient. While accepting that the patient’s behaviours differed from the norm, Flora was of the view that the patient’s behaviours did not present sufficient concern to warrant further intervention - for example, recall to a hospital under his CTO. This further suggests that while certain behaviours that occur as a result of mental disorder - whether labelled as diagnosis, symptoms, psychotic, mental disorder or madness - warrant intervention, but other less concerning behaviours do not warrant intervention. The perceived need for intervention may, however, increase where the patient is considered 'distressed mad'. This suggests that a combination of factors is influential to professional decision-making, supporting Castel's view that it is 'the effect of a combination of abstract factors which render more or less probable the occurrence of undesirable modes of behaviour' (1991, p. 287), justifying intervention. In contrast, Mike appeared to be making a distinction between 'ill', considered less concerning than that of 'obviously mad'. That said, Mike's account of illness was later clarified as 'quietly ill', suggesting less concerning behaviours, in which case the point being made by Flora and Mike is similar in that more concerning behaviours associated with mental disorder, however labelled, justify intervention.

Other than distinguishing between behaviours that warrant intervention on the basis of madness, it is difficult to establish the meaning of 'mad' in these contexts. Gilman (2014) explains that madness has had legal and medical meaning for centuries, albeit these meanings are ever shifting. However, central to its meaning is difference, and most commonly it carries negative connotations. Madness is thought to have medical, social, political and cultural understandings, and these might differ between those with a 'clinical' perspective and those with lived experience. Madness, as argued by Jeffs (1998) who herself experiences mental disorder, has stigmatising connotations; however, she seeks to subvert this dominant paradigm. As these accounts reveal, professional perceptions of 'mad' appear to be used to set patients apart. Those labelled with diagnostic classifications and associated symptoms or mental disorder, arguably adopting a professional language based on knowledge, warrant professional intervention. In contrast, use of the less formal language of 'mad' or 'madness', while setting patients apart from a normal state, denote less concerning behaviours, which are less likely to warrant professional intervention by means of a CTO. Professional language, as opposed to less formal language, therefore legitimises professional power to intervene, control and correct concerning behaviours. Professional perceptions of concerning behaviours as a result of mental disorder are discussed below.

Risk behaviours resulting from mental disorder

The findings in this section demonstrate how participants view the consequences of mental disorder. Analysis of the data revealed frequent use of the term 'risk'. This term is not clearly defined by participants, but is used as a common-sense term to denote behaviours that are considered to deviate from the norm. Some of these behaviours are viewed as unacceptable and in need of correction, and therefore legitimise professional intervention.

Risk behaviours broadly fall into two categories: those warranting intervention, and those considered less concerning. Less concerning behaviours may form part of CTO consideration, but do not appear determinative of CTO use. Data to support these assertions are set out under two main headings: 'Risk to others' and 'Risk to self'. Risk to others is presented first, as it dominated participant accounts and was influential to participant intervention. These risks typically include aggressive, assaultive behaviours. Risk to self was less dominant in participant accounts, but includes self-harm, neglect and reduced quality of life.

Some participants made reference to risk behaviours that had occurred in the past - for example, displays of aggression and assaultive behaviour; these risks do not, however, appear to be assessed by participants according to probability. Risk assessment therefore appears to be driven by an understanding of risks associated with mental disorder, as opposed to something measurable in individual patients. This suggests that analysis of risk has moved away from the individual to the group - the mentally disordered - a group perceived as presenting potential harm. This idea asserted by Castel (1991) may lead to greater use of coercive controls than is necessary, undermining patient autonomy.

According to Beck (2003, 2009), society is no longer structured in terms of distribution of 'goods', but is organised according to a preoccupation with 'bads' - potential harms. These harms - for example, nuclear accidents - arise from industrialisation and modernisation and are seen as a side-effect of success, engendering a belief that modern society can't control the dangers it has produced. These risks are seen as global and incalculable in terms of their consequences, and as a result we are more concerned by future uncertainty. Kemshall argues that risk failures quickly focus attention on the systems designed to regulate and control risk, and future failures must be avoided, 'driving defensive concern to be "safe rather than sorry"' (2002, p. 9). Warner *et al.* (2017), when discussing Beck's risk society, suggests that risk within the mental health sphere needs to be seen in the wider context of heightened levels of anxiety in society. As risk is open to social definition and construction; it is susceptible to change. One example of change in the mental health sphere came with the advent of community care, shifting the site of risk management from the institution to the community, with a focus on risk assessment and resource provision (Ryan, 1996). This shift to community care saw heightened concern for risk in the light of high-profile mental health enquiries, one consequence being the introduction of CTOs with risk reduction in mind (Fennell, 2010), the result being a professional responsibility to decide on acceptable risks in a climate of blame and accountability (Kemshall, 2002).

The following excerpt is illustrative of the broad range of behaviours arising from mental disorder that are viewed as risks. The excerpt is from a joint interview with Reg, an RC, and is his response to my asking 'How do you come to consider CTOs?'

> ***Reg:*** *It is how many relapses they have had, the impact that it has on their personal life, their responsibilities to family; risk is a big factor as well. There are people that relapse many times and the risks are mainly around vulnerability or self-neglect. There are periods when the patient relapses; they become really aggressive; the risk is quite high in terms of their safety or safety to others. There are people who have accumulated forensic*[35] *history who become very, very psychotic.*

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[35] Within the mental health sphere the term 'forensic' is used to mean mentally disordered offenders.

As the account is not concerned with a specific patient, it gives an indication of the breadth of behaviours considered risks - those of relapse, interrupted personal and family life, vulnerability, self-neglect, aggression, compromised safety and offending behaviours. The precise ‘danger’ as a result of these risks becomes an irrelevance; instead, a combination of risk factors with probable undesirable effects legitimises intervention in line with the theories of Castel (1991). Evidence of a hierarchy among risk factors was, however, evident in participant accounts concerned with individual patients. As risk is not defined by the MHA, or its supporting statutory guidance, despite the term being integral to both documents, professionals are left to make their own distinction between acceptable and unacceptable risks. Accounts concerning unacceptable risk detail assaultive and aggressive behaviours, including sexual disinhibition and carrying weapons, and risk as a result of dangerous driving or throwing items on railway lines. These risk behaviours are seen as potential ‘bads’ or ‘harms’ (Beck, 2003) that warrant intervention. This is in contrast to behaviours less likely to warrant intervention by means of a CTO - for example, self-harm, nutritional neglect, homelessness and vulnerability - for which the language of risk is less frequently adopted. Use of the broad term ‘risk’ therefore distinguishes unacceptable and acceptable behaviours, and serves to justify the governance of some mentally disordered patients by way of professional intervention. Risk to others, as the most dominant discourse, is discussed before addressing risk to self.

Risk to others

Risk to others, as experience of mental disorder was discussed by participants in relation to specific patients, and was either evidenced by examples of risk behaviours that had occurred or less frequently, was described as anticipated risk. In the following two excerpts, four participants discuss risks that had occurred in relation to two specific cases. The account by Mike, an AMHP, and Charity, his RC colleague, came in the context of describing the patient’s characteristics. Clear accounts of risks posed to others as a result of mental disorder were given. Similarly, the account by Siri, an RC, and Joe, an AMHP, during their joint interview, highlighted risks associated with the patient's paranoia, when asked about the purpose of treatment.

> ***Mike:*** *Yes, his younger sister was quite affected by his illness when he has been at home. Because he is quite disinhibited, could be quite aggressive. He went into her bedroom uninvited one night and she is a young teenager. Ends up in bed with his parents at one point. Attacks his father, assaults his father. So disinhibited, aggressive, very thought disordered. He was quite a high risk.*
> ***Charity:*** *High risk to himself and others, gets very unwell, very quickly as well, I think. It was rapid deterioration, wasn't it?*
> ***Mike:*** *Yes.*
> ***Debbie:*** *Was there drug involvement as well?*
> ***Charity:*** *Yes, drugs as well. But he was ill too long for it to be the only cause.*

> ***Siri:*** *I think he has been inappropriate with females.*
> ***Joe:*** *Yes, there is sexual assault.*
> ***Siri:*** *That is why he went to the forensic unit. He is on the sex offender register. He has been aggressive to staff and I think he punched someone, which is why he went to the PICU [psychiatric intensive care unit].*
> ***Joe:*** *He got very inappropriate language with some of the female staff on the ward and even when that was talked to him about, he didn't see this as inappropriate and it continued, and he actually assaulted a male staff on the ward that he got paranoid about, the fact that they were against him. You get a general feeling of paranoia generally in the community; he would feel that people were talking about him, looking at him, he would make reference to people throwing things at him when he was in the street. So the risks are more to others really than to himself.*

Both accounts made reference to aggressive, assaultive behaviours, and specifically sexual aggression, and these behaviours dominate the accounts. For example, during the conversation between Mike and Charity, reference was made to ‘disinhibition’, ‘aggressive’ behaviour and ‘assault’. These behaviours were seen as ‘high risk’, and emphasis was placed on the impact of these behaviours on family members. In contrast, risks to self were less dominant in that reference was simply made to the patient’s ‘rapid deterioration’ and becoming ‘very unwell’. Similarly, the account by Siri and Joe detailed numerous risks to others, yet reference to risk to self was simply by means of stating that risks were greater to others than the patient, and no attention was paid to the impact of these behaviours on the patient.

The elevation of violent and sexual assault, viewed as most concerning in society offers justification for intervention, as such risks to self does not require the same level of consideration. This was further evident during the conversation with Siri and Joe, in which they later made reference to the impact of mental disorder on the patient’s culture, family relations, and desire to marry and have children. These experiences of mental disorder were not, however, viewed as risks. This suggests that the impact of mental disorder on the patient is less likely to warrant intervention by means of a CTO than risks posed to others. While these accounts were given in different contexts, they are similar in their content. This shows that risk behaviours are considered a consequence of mental disorder, and that intervention is intended to correct these behaviours. Therefore, both mental disorder and its consequences provide justification for professional intervention.

The relationship between mental disorder and risk behaviours was extended within the following accounts to include links between risk behaviours and modes of control. Desmond, an AMHP, during a joint interview, made links between mental disorder and risk behaviours by explaining that the patient’s behaviours stem from his beliefs, which are a direct result of his diagnosis - that of Asperger’s Syndrome. These behaviours were then offered as justification for detention in hospital.

> ***Desmond:*** *When he came into hospital on the [ward name], he lacked insight and was not engaging and he assaulted members of his family repeatedly his mother. The night when he was detained he also assaulted members of his*

> *family and a member of staff on the ward … So we felt, given the risk, because of the Asperger's if he likes you he believed that you automatically liked him because he projected his feelings on to you. He was driving up the wrong side of a one-way street, breaking traffic lights and a huge long list of traffic offences that his mother had to pay for and all that kind of stuff. Of course, he was self-harming as well; he cut off his pinky, and so we had to detain him.*

In addition to the risks detailed above, intimidation towards his father, stalking and assaulting a female, and assaulting a police officer were all factors influential to CTO consideration, following detention in hospital. These factors took priority over risks to self - for example, the patient cutting off his little finger. Other consequences of mental disorder - for example, the patient's relationship with his parents, his desire for a relationship, his living environment and getting back his driving licence - were less prevalent within discussion, and were not central to CTO decision-making. Presenting risk to others is therefore prioritised above risk to self, and represents justification for professional intervention in the lives of those considered mentally disordered. This supports Castel's view of profiles within populations; these profiles are assessed by experts to label individuals and to determine a response (Castel, 1991).

Links between unacceptable behaviours and the need for containment were also evident within the account by Ben, an RC, in interview with Sam, his AMHP colleague. Ben's comments came in response to my asking about the patient for whom he and Sam had agreed a CTO.

> ***Ben:*** *Being on clozapine, which he has been on for about three or four years now, with a degree of improvement, less agitated, a bit less paranoid, and less risky. We were worried that he was heading towards a position of having to be in a locked place to try and contain the risk, which has been around inappropriate sexualized behaviour, having knives at home, carrying knives to protect himself from perceived risk from witches, and what have you. Throwing stuff onto the railway line.*

Ben’s account makes explicit reference to behaviours that had occurred in the past - for example, inappropriate sexualised behaviours, carrying knives and throwing items onto a railway line; these behaviours warranted intervention. In addition to these risk behaviours, Ben made reference to an arrest for indecent exposure as a result of the patient wearing inappropriate clothing. However, this behaviour, which had reportedly improved as a result of medication treatment, was not seen as a risk and was not central to CTO decision-making.

Ben explained that less negative attention as a result of the patient dressing ‘more appropriately … has an impact on his paranoia’ - that of alleviating it. This process, however, appeared to be described as an unintended consequence of treatment, as opposed to being central to CTO consideration. This further supports the idea of a hierarchy of risk behaviours, some warranting intervention by means of a CTO and others do not. Risk behaviours that may materialise as a ‘danger’ warrant preventive intervention, thus avoiding professional exposure to blame (Castel, 1991). Kemshall (2002) highlights this distinction by reference to low-frequency/high-impact risk - for example, homicide and suicide, and high-frequency/low-impact risks, which are largely neglected. Kemshall attributes this difference to the increasing focus on compliance and surveillance within community care, a side-effect of which is a disparity in care provision. The data supports the view that those posing low-frequency/high-impact risks warrant intervention by means of a CTO. In contrast, those posing high-frequency/low-impact risks do not justify intervention by means of a CTO and, as such, talk of risk is no longer necessary.

In all but one of the cases discussed above, the patients were made subject to a CTO. Mike and Charity discussed a 23-year-old male, described as a ‘revolving door’ patient. This cycle of repeat admissions to hospital as a result of relapse made the decision to place him on a CTO ‘pretty obvious’. Mike referred to the case as ‘clear cut’, in that the history of mental disorder and risks warranted intervention by means of a CTO. The patient for whom Siri and Joe agreed a CTO had a 10- to 12-year history of mental disorder. This included repeat admissions to hospital due to deteriorating mental health and resultant risks. Joe explained: ‘It got to the point where his forensic history was significant enough that we didn't want him to deteriorate too much otherwise it meant putting other people at risk’. Ben, having discussed a male patient aged 52, with a 27-year history of mental disorder, including many admissions to hospital, explained that the instigation of the CTO had ‘been very much about risk’. In contrast, Desmond, who initially agreed a CTO for his patient, described as having experienced repeat admissions - six admissions within six years - decided against a CTO extension. This decision was taken in response to the patient feeling ‘entrapped’ by the CTO. However, professional concern for risk remained and, as a result, the patient was made aware that a MHA assessment would be convened should the risks re-emerge. Risk to others, as perceived by professionals therefore drives use of compulsion (be it a CTO or detention), as opposed to risks to the patient.

In all the above accounts discussion about risks is used as shorthand to provide a common-sense justification for intervention. References to risk do, however, reflect statutory criteria relevant to CTO consideration, and in Desmond’s case, consideration of future detention. In both cases the Act requires the presence of mental disorder of a nature or degree, and use of statutory provision must be in the interests of the patient’s health or safety or that of others. These criteria do not require an assessment of the likelihood of risk behaviours occurring, which differs from the point of appeal against a detention section (*CM v. Derbyshire* [2011] UKUT 129 (AAC), and so it is perhaps unsurprising that participant accounts do not show an assessment of risk based on probability. However, assessment of risk for the purpose of the MHA should be person specific as opposed to population specific. The data, however, highlights the adoption of a loose interpretation of risk and risk factors when making decisions about compulsion, with an absence of equal weight being given to risks to the patient, suggesting that risk is more influential to CTO decision-making than statutory criteria.

The above excerpts were taken from joint interviews between RCs and AMHPs, and in all accounts participants were in agreement with one another about the risk behaviours posed by patients, and the need for a CTO or alternative legal framework to manage such risks. However, one exception to this arose in a joint interview between

Norman, an RC, and his AMHP colleague, Flora. Despite disagreement, and the AMHP's ability to decline a CTO, the CTO was agreed in the face of doubt about its necessity. Both acknowledged that the patient whom they discussed carried weapons; however, they were in disagreement about the risk arising from this behaviour. Norman asserted that the patient would use weapons to defend himself and that he had a history of assault. In contrast, Flora argued that he wouldn't 'hurt a soul', and asserted that the patient had 'no police record'. Flora, having previously been interviewed alone, said in relation to this patient, 'I mean a tiny little bloke, chronic dope smoker, yes when he gets paranoid, he's got a knife on him, but he really wouldn't say boo to a goose'. Flora did agree, however, to a CTO extension having been faced with a potential risk during a meeting with the patient for the purpose of considering a CTO extension:

> ***Flora:*** *I was the AMHP that went out with the RC, met him in a bus station in [place name] and saw that he had a big knife in his backpack. You know, I could see the handle of a knife.*
> ***Norman:*** *Hunting knife.*
> ***Flora:*** *I felt frightened. I couldn't say to him, you know, is that a knife?*
> ***Norman:*** *And also, one of the conditions is not to carry any object that can be used as a weapon, because he carries rolling pins.*

It is worth reflecting on Flora's account above. Flora, having maintained during two interviews that the patient posed no risk to others, felt frightened when faced with the patient in possession of a knife. She had, prior to this meeting, questioned the need for continued use of the CTO, and had considered the lesser community compulsion of guardianship (which does not allow forcible treatment); however, Flora then agreed to a CTO extension. This decision was perhaps prompted by the fear she expressed, although no real assessment of the risk posed by the patient was evident. This might suggest, as argued by Kemshall (2002), that risk decisions are influenced by many factors - for example, the consequences of risk and professional accountability. Flora, therefore, despite her assertions that the patient posed no risk, when faced with him in possession of a knife was driven by concern for accountability as opposed to the probability of risk occurring. As such, the language of risk was adopted as justification for the decision to govern in the face of previous protests against perceived risk to others. Also of interest, no immediate action was taken in relation to the discovery of the knife. Contacting the police was considered but ruled out, although the patient was later recalled to hospital. This interaction shows the lack of probability and patient-specific risk assessment, and highlights concern for problem populations. In this example, compulsion was used despite some reservations, although no immediate action was taken in relation to the stated risk which in turn raises questions about the effectiveness of CTOs in averting perceived risks resulting from mental disorder.

Concern for professional accountability is extended to include concern for public anxiety about behaviours associated with mental disorder in the following account by Mary, an AMHP. In interview with her RC colleague, Mary made reference to 'moral panic' when speaking about a patient for whom she had agreed a CTO.

> ***Mary:*** *The level of anger, mania and disruption to his life, it was up there really. There was also a lot of moral panic around. I don't mean that in a disrespectful way, but around the risks for him and the risks around women and what he was intimating about females next door. We know that he has held someone hostage before. So all these things have to be taken into consideration.*

The notion of moral panic is useful here as it recognises the process of labelling behaviours as socially deviant or problematic, allowing socially accredited experts to diagnose and find solutions to behaviours considered a threat (Cohen, 1980). Publicised concern about homicides by mentally disordered people fuelled the risk management and public safety agenda, culminating in legislative change[36] (Fennell, 2010). CTOs can therefore be seen as a repercussion of moral panic, and as such CTOs provide a

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[36] Mental Health (Patients in the Community) Act 1995, introducing Supervised Discharge (s25A), and The Mental Health Act 2007, introducing Community Treatment Orders (s17A), both introduced with risk management in mind.

response to such concerns. In turn, these concerns are maintained by professional use of compulsion to manage those considered problem populations.

Risk to self

While the above excerpts are dominated by concern for risk to others arising from mental disorder, there is evidence within these accounts of concern about risks posed to self, although this is not a dominant theme within the data. Charity made reference to the patient being a 'high risk to himself', but this is not explained in the same level of detail afforded to risk to others. Joe implied risk to self by stating 'the risks are more to others really than to himself', but again no further explanation was offered. Desmond, after a detailed account of risks to others stated, 'of course, he was self-harming as well; he cut off his pinky, and so we had to detain him'. This appears an afterthought, and the word 'risk' was not used in relation to this act of deliberate self-harm. Less detailed discussion of risk to self suggests a subordination of these risks in comparison to risk to others, and as a result they are not central to CTO decision-making. There was, however, an exception to this, in which a CTO was used for a young female patient following her first admission to hospital. Norman, an RC in conversation with Flora, an AMHP, discussed their agreement to a CTO for a patient who was described as 'vulnerable', having previously got 'on high buildings'. This behaviour, however, represents a potential 'danger' and as such warrants intervention by means of a CTO. This further supports the idea of a hierarchy of risk, with those considered more concerning (low-frequency/high-impact risks) offering justification for professional intervention.

Other experiences of mental disorder that have an impact on the patient - for example, neglect and reduced quality of life - were evident within participant accounts. However, they were seldom referred to as risks, and did not appear determinative of CTO decision-making. These behaviours, associated with mental disorder, were therefore not seen as problematic to the extent of needing control or correction by way of a CTO; as such, the language of risk was scarcely adopted.

In the following accounts taken from two separate interviews, links were made between mental disorder and nutritional neglect. The first account is by Norman, an RC, during a joint interview. Norman described significantly impaired health when explaining the professional oversight of a patient subject to a CTO. Similarly, Charlie, an AMHP, during a joint interview, made reference to difficulties with eating (referred to as a risk) in the context of explaining the factors relevant to CTO consideration.

> ***Norman:*** *I think when he doesn't take treatment he just stops eating because he doesn't cook for himself; he just will eat cold food out of tins and just survival eating almost … When he came in he was dehydrated, his kidney function was slightly deteriorated, he wasn't drinking enough.*

> ***Charlie:*** *Our main concern was the risk to his health, but he was saying that he would accept support from his care co-ordinator and from my team, the social care team and a care package to ensure that he was eating. A lot of that was around his OCD [obsessive compulsive disorder].*

Norman's patient was made subject to a CTO, whereas a decision was taken not to instigate a CTO for Charlie's patient. From the interviews, it is clear that Norman's patient presents many risks to others, and these risks dominate decision-making. Despite the patient's significantly compromised physical health as a result of mental disorder, this did not attract the label of 'risk' or the same attention when deciding on a CTO. In contrast, Charlie elevated nutritional neglect to the status of risk by his reference to 'risk to his health'; however, this did not warrant compulsory intervention. Instead, the language turned to 'care' as opposed to compulsion. This suggests that the loose language of risk means different things dependent on the perceived consequences of those risks. Where 'risk' is only to oneself, as is the case with Charlie's patient, the language of care as opposed to control is adopted, signalling a lessening in concern and need for control.

Other behaviours considered a consequence of mental disorder were evident in the data, but they too did not warrant in their own right intervention by means of a CTO. Homelessness as a consequence of mental disorder was common to Ben and Flora's accounts. Ben, an RC, in interview with Sam, an AMHP, made reference to a female patient when explaining that CTOs should be used for the purpose of 'reducing risk and enhancing that person's quality of life', and Flora, an AMHP in interview with Norman, an RC, made reference to homelessness when discussing a patient for whom she had agreed a CTO.

> ***Ben:*** *I mean the risk is, I guess, of someone coming into hospital is bottom of the list, the risk for health, safety and protection of others, … the risks were that she was electively homeless, that her health was really awful, that she found herself in awful situations of terrible vulnerability and had been hurt because of that, directly because of her illness and that's the risks we were focusing on.*
>
> ***Flora:*** *Treatment resistant, he constantly feels that he is being persecuted and watched and he is under threat and he has got to keep moving because of this threat … He has to be anonymous, he cannot have an address, he doesn't want anyone to know his address … He cannot have any benefits, he wants to cancel all of his benefits and not have a bank account or anything so we had to put him under the Court of Protection to give him some money … He is so frightened all the time, but he has never hurt anyone.*

Ben's account is peppered with the term 'risk', albeit a hierarchy appears evident in that readmission to hospital appears of least concern. In contrast, Flora does not make reference to risk, yet the account indicates clear risks to the patient. Both patients were made subject to a CTO, albeit Flora's patient had earlier in conversation been described as posing 'significant' risk to others, and these risks were central to CTO decision-making. Initial reference to the patient being 'treatment resistant' is also likely to cause concern about the management of such risks. The basis of Ben's decision-making is less clear as he did not elaborate on risks to others, and so it is unclear whether risk to self, in this case, warranted intervention, on the basis of offering 'care' as opposed to control. However his use of the term 'electively homeless' is of interest, as it implies choice on the part of the patient. Had this been the case, it brings into question the appropriateness of coercive intervention for those able to make decisions about their living arrangements, and assumes the power of CTOs to ameliorate social problems associated with mental disorder.

Discussion about the poor living conditions of patients as a result of mental disorder is evident in the following accounts by Alice and Flora, although this was in the context of other concerning behaviours, including alcohol and illicit drug use. Alice, an AMHP, interviewed alone, first made reference to a diagnostic classification, alcohol and illicit drug use, and aggressive and hostile behaviours, before mentioning a neglected home environment, when describing a patient for whom she agreed a CTO. Flora, an AMHP, interviewed alone, made reference to illicit drug use among other concerning behaviours, when speaking about a patient for whom she had agreed a CTO. Use of alcohol and illicit drugs was common to participant accounts; however, Flora's reference to illicit drug use differed in that she saw CTO use as enabling continuation of this behaviour. She explained the CTO 'allow[s] him to smoke cannabis'**.** Her argument being 'if he doesn't have the depot and he smokes cannabis he gets really poorly', as such a CTO was instigated, in part, to facilitate 'safer' cannabis use, to prevent pain as a result of arthritis, 'squalor' and disengagement from those trying to 'help' him.

> ***Alice:*** *It was a 55 [year old] gentlemen with a diagnosis of schizoaffective disorder and he has a long history of mental health difficulties which he struggles to accept, and he finds it very hard. When he becomes unwell, this is usually in the context of excessive use of alcohol and illicit drugs, then he doesn't take his medication and then things start to drift and he becomes unwell. When he becomes unwell he becomes very aggressive and hostile, self-neglects, neglects his home and he becomes very paranoid and has delusions, or just spirals very badly out of control.*

> ***Debbie:*** *If he didn't take his depot, and smoked his dope, what happens then?*
> ***Flora:*** *Then he is not functioning, the squalor gets far worse. Nasty people get more invasive. He disengages from anyone trying to help him, yet the bad people are all there smoking their dope.*
> ***Debbie:*** *Are they real people?*
> ***Flora:*** *They are real people, and then he is tooled up, he's got knives on him and we're aware of that and we can't have him wandering around with knives, that potentially he could have used against him, so then it all unravels.*

As with other participant accounts, a hierarchy of risks appears evident. However, use of alcohol and illicit drugs does not appear elevated to that of a risk, and in Flora's account, use of a CTO facilitates these behaviours. While CTO conditions[37] may be made to prevent such behaviours, a lack of enthusiasm for conditions was expressed by Norman, an RC, when speaking generally about CTOs. He stated, 'I don't put [in the conditions], don't go to the pub and all of that rubbish'. This lack of enthusiasm might be a result of the difficulty in enforcing such conditions (Smith *et al.,* 2014), or as a result of the difficulty in restricting concerning behaviours by the means available to professionals - that of medication treatment (discussed in Chapter 6 below). The potential consequence is that the patient and the pubic are not protected from potential harms.

Conclusion

In summary, this chapter has presented data that shows the dominant use of medical discourse among RC and AMHP participants. This medical dominance is evident in participant accounts of mental disorder and its consequent behaviours, and is offered almost to the exclusion of any other understandings of mental disorder. This discourse serves to separate out the normal from the pathological, assumes a need for

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[37] CTO conditions may be made to ensure the patient receives medical treatment, to prevent risk of harm to the patient's health or safety, or to protect others (s17B (2), MHA).

intervention and correction, and offers justification for professional intervention by means of compulsion. This approach is consistent with Foucault’s ideas of governmentality, in that professional knowledge is accepted as truth. Thus the person becomes ‘subject’ for the purpose of manoeuvring ‘populations into “correct” and ‘’functioning” forms of thinking and acting’ (McHoul and Grace, 2002, p. 17), bringing about useful obedience. The final stage of Foucault’s ideas of governmentality concerns the bringing about of self-regulation; however, this is not evident within the data. Emphasis on compliance as opposed to agreement and the ‘revolving door’ cycle indicates that patients don’t arrive at the position of self-regulation, as such patients remain subject to the control of others.

In relation to the factors influential to CTO decision-making, it is clear from the data that understandings of mental disorder and its associated behaviours influence professional decision-making. The official knowledges of medicine and law are used to label and define patients. This serves to determine a response to mental disorder and in some cases offers justification for professional intervention. Behaviours associated with mental disorder, often referred to as ‘risks’, also serve to set patients apart. Thus, the mentally disordered are seen as a problem population, in need of correction. Risk, therefore, like mental disorder, serves to justify professional intervention. However, hierarchies are evident within the data, showing that some mental disorders, and some risks do not warrant intervention by means of a CTO. Where this occurs, less formal language is used and concerning behaviours are minimised.

In relation to how participants account for CTO use and what they aim to achieve, prevention of ‘risk’ behaviours associated with mental disorder and compliance with treatment were the most dominant themes. However, concern for professional protection was also evident. Risk was not, however, assessed according to probability, and some concerning behaviours were not elevated to that of risk, and as a result did not justify intervention by means of a CTO. Where intervention was justified, bringing about self-regulation was not offered as an explanation for use of coercive controls.

In relation to the balance of care and control, and notions of personal autonomy and professional power, a greater degree of control and professional power is evident within the data. The adoption of expert knowledge, not understood or shared by patients, elevated the status of professionals. This adoption of expert knowledge also served to dismiss or make subservient other understandings of mental disorder. Patient understandings were often labelled as a lack of understanding, which was responsible for poor decision-making. As such, professionals exercised their power over patients, with regulation in mind. This approach did little to engender patient engagement and encourage self-determinism, albeit accounts were not devoid of concern for patient engagement, and discharge from hospital onto a CTO could be interpreted as less restrictive of patient freedoms than remaining a detained in-patient.

CHAPTER 5 Interdisciplinary dynamics and resources

Introduction

This chapter builds on Chapter 4, in that it moves beyond concepts of mental disorder and associated risks as justification for professional intervention, to consider other factors influential to CTO decision-making. Having identified that medical discourse dominated participant understanding of mental disorder, this chapter shows that other, more socially orientated considerations form part of CTO consideration. These social considerations are not, however, concerned with the patient, but with interdisciplinary dynamics and resources. This chapter therefore provides an analysis of the data showing the influence of interdisciplinary dynamics and resources on the CTO decision-making process.

The data within this chapter is presented under two headings 'Interdisciplinary dynamics' and 'Resources'. Data presented under the heading 'Interdisciplinary dynamics' shows that AMHPs introduce and enforce administrative and practice processes as a means of asserting authority to influence CTO decision-making, although there is variance in how this is achieved in different geographical areas. In respect of RCs, interdisciplinary dynamics are less evident, but hierarchical relations are evident between those responsible for, and in receipt of professional risk assessments, and this is influential to CTO decision-making. The data presented under the heading 'Resources' illustrates that resources are critical to the operation of CTOs, most notably hospital beds and human resources. A lack of hospital beds has an impact on the ability of professionals to instigate, recall and revoke CTO patients, and results in early discharge from hospital to free beds. This can have an impact on the over- and under-protection of patients, and as a result is ineffective in managing the risk behaviours that CTOs seek to ameliorate. A lack of human resources to operate the alternatives to MHA compulsion serves to favour CTOs, despite the deficits identified by participants. However, CTOs are seen in a positive light by some and specifically, their ability to ensure continued contact between services and patients is seen as beneficial.

Interdisciplinary dynamics

Professional hierarchy

The data revealed that professional hierarchy is influential to CTO decision-making. This was evident among AMHP and RC participant accounts. While numerous professional groups are able to train to become either AMHPs or RCs,[38] participants were limited to social workers, fulfilling the AMHP role, and to registered medical practitioners, fulfilling the RC role. Within these two professional groups, registered medical practitioners are viewed as higher up the hierarchical structure than social workers (Griffiths, 1998). However, the role of the AMHP carries distinct statutory responsibilities which can be argued to elevate their status[39] above RCs.[40] AMHPs may decline to make an application for detention in a hospital in the face of supporting medical recommendations, and may refuse agreement to a CTO in the face of an RC's request - put another way, AMHPs are able to trump medical and RC decision-making in respect of Mental Health Act compulsion.

The data showed a number of ways in which AMHPs asserted their status and in doing so influenced CTO decision-making. The most common ways in which AMHP participants influenced CTO decision-making were by imposing administrative and professional practices, and by asserting their legal knowledge and position. Hierarchical relationships between medical practitioners were also evident, although this was a less dominant theme.

First, in respect of AMHPs, the introduction and enforcement of administrative and practice processes is a means by which they exert power and influence CTO decision-making. This power was evident in two ways: first, the introduction of localised, sometimes informal policies, imposing timeframes in which RCs must operate

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[38] RCs must first undertake training to become approved clinicians (ACs) before being eligible to act as RCs.

[39] *See R. v. East London and the City Mental Health NHS Trust and Another (Respondents) ex parte Von Brandenburg* [2003]

[40] For the purpose of detention in hospital, recommendations may only be made by registered medical practitioners. This is in contrast to CTOs that may be instigated by RCs from a number of professional disciplines.

when requesting CTO consideration; second, the refusal to consider CTOs until the RC had first trialled leave of absence under s17 MHA. The following accounts by Charlie and Jim, both AMHPs, working in different geographical areas, show the requirement of a notice period before they were willing to consider a CTO. Charlie, in interview with Hugo, his RC colleague, when speaking about their roles in the CTO process said:

> ***Charlie:*** *They [RCs] are not expecting us to come around and do it that day.*

Charlie went on to explain that consideration of a CTO is a 'good day's work'; as such, this expectation of time is to allow for meeting the patient to 'justify the decision'. Jim, an AMHP, similarly explained the need for time to consider a CTO when in discussion with Charity, his RC colleague. His comments came in response to my questioning how they come to consider CTOs, to which they replied:

> ***Jim:*** *We normally ask ideally for two weeks' notice that the CTO meeting is being organised, especially with the new ones. I think it is reasonable to respect that on the ward it could be a bit tighter. Although we had requests coming on the same day [laugh] the doctors [had] forgotten about it.*
> ***Debbie:*** *So a little bit more of a rush sometimes?*
> ***Jim:*** *Yes. Not with [Charity].*
> ***Charity:*** *Not on the same day, no. We try for at least a week.*

Jim made clear the timeframe in which referrals can be processed, and identified that RCs do not always abide by these timeframes. His use of laughter, having stated that some requests are made on the same day, may indicate his withdrawal from co-operation where RCs fail to follow the timeframes. Griffiths (1998) argues that humour may be used by subordinates in the presence of superordinates as a means of negotiating roles and influencing decisions. This is seen as significant in signalling dissent without a direct challenge to authority. Thus, in the context of Jim's conversation, his influence over CTO process is displayed without making a direct challenge to the RC.

James, an AMHP, like Charlie and Jim, exercised power by imposing administrative timeframes for CTO consideration, but he too asserted the expectation of direct communication with the patient's RC. This was evident in James's response to the question, 'How do you come to consider CTOs?' (when interviewed alone).

> ***James:*** *It is not uncommon for a consultant to send a minion of one kind rather than attend themselves. We are keen to get more direct conversations with consultants over these issues. It is quite common that we might receive a written referral in the first instance and I feel slightly ambiguous about that because actually face-to-face conversation achieves a better triage from my point of view … I think it is well known now that because we refuse in excess of 50% of the requests that actually you are going to have to think about your strategy for getting a CTO out of the AMHP workforce. But it is not predominantly negative, all we are saying is, let us take rather longer than you are envisaging to look at it.*

This account extends the ways in which AMHPs assert their power to influence CTO decision-making. The imposition of timeframes is extended to include direct contact with the referrer. James's use of the word 'minion' implies a hierarchical structure among medical practitioners, but also implies an expectation of speaking to an equal, thus asserting his authority. His preference for 'face-to-face' contact to achieve 'better triage' suggests systematic working and the imposition of these systems on medical colleagues. Reference to his refusal of 'in excess of 50% of the requests' shows a clear exercise of power in his role of AMHP lead, and the statutory ability of AMHPs to decline agreement to CTOs. Even where local processes are adhered to by RCs, the potential refusal of a CTO was made clear, as is evident in James's account of a CTO he was asked to consider, to which he responded, 'I sent the word back that a certain degree of scepticism might be anticipated, and that the consultant to desist from the process'.

James's scepticism is based on the utility of CTOs. His preference is for a trial period of s17 leave of absence to establish the patient's ability to work within a community-based statutory framework. As such, CTO consideration is delayed, and the additional requirement of interim measures before a CTO will be considered are imposed.

> **James:** *If you are pressing to make a decision now we are saying no … observe how this [s17 leave of absence] goes. We could change our mind because the experience might change our mind.*

This approach forces the hand of RCs to conform to his requirements, as the alternatives are less desirable: either the patient remains a detained in-patient (unnecessarily occupying a bed) or is discharged from hospital (in the absence of any coercive power). As such, AMHPs are able to exercise their power and influence CTO decision-making by the introduction of administrative and practice processes. Less overt use of power to purposefully delay CTO use was also evident within the data. Flora, an AMHP, during her individual interview, in response to my asking whether CTOs are common in her area of work (a different geographical area to that of James), replied:

> **Flora:** *They are almost weekly, it is almost weekly when [Norman] is talking about putting someone on a CTO. I quite often delay it as well, rather than say no, it is not appropriate. I quite often think you are in too much of a hurry here … I really don't like it, but if I think someone's being set up to fail, I'll refuse, but I won't say I'm not doing a CTO, I'll just say I'm not doing one today.*

Unlike James, this exercise of power was covert. One explanation for this might be her less senior position, in that she is not responsible for an AMHP service, policy or allocation of work. However, her approach has the effect of asserting power through inaction. Flora's references to RCs being in 'too much of a hurry' and concern about patients being set up to 'fail' suggests that she too is concerned by inadequate care planning. These accounts show that administrative and practice processes are used as a means of exercising power over the CTO decision-making process. These processes varied in differing geographical areas, and were overt and covert, but the commonality was the imposition of terms by which AMHPs are willing to operate, thus delaying and in some cases declining CTO use, most notably as a means of establishing the appropriateness of a CTO.

In addition to the imposition of administrative and practice processes, a number of AMHPs asserted their professional ability to act as arbiter of CTOs, based upon their legal knowledge and position. In the following excerpts by Flora, an AMHP, interviewed alone, and Desmond an AMHP, interviewed with his RC colleague, they made reference to, or implied legislative authority. Flora's comments came in the context of being asked her view of CTOs, and Desmond's comments came in response to a critique of CTOs by Reg, his RC colleague, to which Desmond asserted the AMHP's role as arbiter of CTOs.

> ***Flora:*** *It is a good thing for an AMHP to be part of the process because we are able to challenge the doctor and advocate for the patient and understand the legal side of it … I have the legal knowledge to understand why it might be necessary and less restrictive.*

> ***Desmond:*** *That should be with the AMHPs because ultimately AMHPs have the final say whether the application goes through or not.*

The above excerpts by Flora and Desmond show that the possession of legal knowledge and authority elevates their status and affords them a decisive say in CTO consideration. Flora showed this by explaining her ability to 'challenge the doctor' and by asserting her 'legal knowledge'. Desmond made clear his status in response to his colleague's statement, '[It is] just a myth that CTO controls reduces everything', by replying 'this should be with the AMHPs', suggesting AMHPs will determine the usefulness of CTOs, and by asserting AMHPs ‘have the final say’, something not afforded to the RC. These statements clearly lay claim to greater authority over their RC colleagues in the context of CTO decision-making, and as is evident in a statement (above) by James, AMHPs may need to be persuaded to change their minds in order to agree to a CTO. The motivation behind this assertion of legal knowledge from Flora’s perspective is to ‘advocate for the patient’ and to consider ‘less restrictive’ options, as such concern for patient care and autonomy takes precedence over RC professional power.

Hierarchical relations were also evident among registered medical practitioners, and these relations influenced CTO decision-making. A conversation between Norman, an RC, and Flora, an AMHP, revealed the greater power of a forensic medical practitioner than his acute in-patient medical practitioner colleague (Norman). This power became evident during a discussion about a patient for whom a forensic report had been requested. The recommendations within this report, although not shared by the in-patient medical practitioner, were influential to decision-making, as is evident in the following account by Norman when speaking about the forensic report:

> ***Norman:*** *Once a forensic request is asked, I have to go with what the recommendations are … I couldn't then go back and say I am ignoring this.*

Flora, Norman’s AMHP colleague, agreed, stating, ‘You couldn't ignore that could you?’ As a result of the forensic report, the patient was made subject to a CTO, as opposed to guardianship (a less restrictive provision) that had been considered by Norman and Flora. This demonstrates a hierarchical structure within the medical profession, with more power afforded to those making assessments of ‘risk’. While not a dominant theme within the data, concern for the repercussions of failing to follow a risk assessment and management plan recommended by a forensic specialist was evident. Given Norman and Flora’s view that the less restrictive alternative of guardianship would have been an appropriate approach, their concern for repercussions appears driven by concern for professional reputation as opposed to the interests of the patient, suggesting that defensive practice may influence CTO decision-making ahead of patient considerations in some circumstances.

In summary, this section has shown that AMHP participants assert and exercise their power through a variety of means, and these influence CTO consideration and implementation. RC participants are less concerned to assert their power, yet hierarchical structures are evident, which also influence CTO decision-making. AMHPs assert their power with patient protections in mind, and RCs assert their power with professional protections in mind.

Ownership or avoidance? Absolving responsibility

Having established that power relations between professionals influence CTO decision-making, the data within this section highlights a tendency for AMHPs to minimise their role when considering CTOs, while RCs are keen to distribute their power. Analysis of the data shows that RC and AMHP participants absolve responsibility for patients, and this influences decision-making. This is most evident at the point of CTO consideration and instigation, but the ways in which this is done differs between RC and AMHP participants. The absolving of responsibility for patients is most common amongst RC participants, and is most evident during their justification for use of CTOs as opposed to s17 leave of absence, and by their approach to CTO consideration and implementation. AMHPs are less inclined to absolve responsibility for patients than their RC colleagues (albeit this may be attributed to their transient role), but there is evidence of AMHPs minimising their role when considering CTOs. The reasons for this are discussed below.

Section 17 leave of absence v. CTOs

At the point of discharge from hospital, RCs are able to choose between means of community compulsion where it is considered necessary. Where the compulsory administration of medication treatment is indicated, their choice is limited to s17 leave of absence or a CTO. Section 17 leave of absence, as explained in Chapter 1 above, provides a more powerful means of community compulsion than that of CTOs due to its ease of recall to hospital and the ability to treat resistant patients in the community.[41] Despite these potential advantages, s17 leave of absence is rarely seen as a viable alternative to CTOs. The data shows that the reason for this is related to professional responsibility as opposed to factors relevant to patients. The following accounts offer an insight into why professionals are concerned to absolve responsibility for patients by use of CTOs. The first two accounts relate to the same RC (Norman). First, Flora, an AMHP, during an individual interview explained why her colleague, Norman, is reluctant to use s17 leave of absence, when asked how common CTOs are, and second, Norman, during a joint interview with Flora, confirmed her opinion, when speaking about s17 as an alternative to CTOs.

> ***Debbie:*** *So who doesn't like section 17 leave?*
> ***Flora:*** *The in-patient doctor.*
> ***Debbie:*** *Why is that?*
> ***Flora:*** *Because he doesn't feel he can guarantee a bed because of the bed management system … He feels responsible for them out in the community. He is the RC, they are out there, he can't give them a recall bed because it's gone to someone else. He doesn't want to risk it. He wants to hand the responsibility over to the community RC. [Laughter]*
>
> ***Debbie:*** *Would you consider section 17 leave as an alternative?*
> ***Norman:*** *No. Would be good, wouldn't it?*
> ***Debbie:*** *You don't?*
> ***Norman:*** *Because there is no resource to inform me or link with me in their management. The way we work, we are so functionalised, once they go out of the door I have no say.*

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[41] The recall grounds under s17 MHA are less stringent than those under s17E, and Part 4 MHA, unlike Part 4A, allows for forcible treatment of capacitous, resisting patients in the community.

Both accounts show a clear desire on the part of this in-patient RC to pass responsibility for patients discharged from hospital to community colleagues, Norman's justification being his inability to manage patient's due to the 'functionalised' way of working. Put simply, this means that the identity of the RC shifts from that of the in-patient clinician (during the patient's detention in hospital), to the community clinician (once the patient is discharged from hospital and detention). Patients subject to 17 leave of absence remain liable to detention and therefore remain the responsibility of the in-patient clinician. This poses a number of problems, most notably the in-patient clinician's inability to manage patients in the community, a 'risk' Norman was not willing to take. As such, he was keen to pass responsibility to his community colleagues. A similar theme was evident in an exchange between Charlie, an AMHP, and Hugo, his RC colleague, when asked their views about the introduction of CTOs during a joint interview. However, Hugo's concern went beyond the logistics of managing community patients at a distance to include concern for professional protection.

> ***Charlie:*** *We don't really use extended leave any more, do we?*
> ***Hugo:*** *No, I think from the functionalising of the service it does have all sorts of implications like this because if I have a lot of patients on Section 17 leave it kind of ties me to people that might be spread all over the place and keeps their numbers on the possible beds, and that has all sorts of implications. Just kind of makes me responsible for people that may be very difficult for me to follow up. So I am quite keen at the point of discharge to get a CTO in place to lessen build and bias partly so as to protect myself and my workload, and partly to address practicalities with the service.*

Hugo's reference to protecting himself and his workload, along with Flora's reference to Norman not wanting to 'risk it', suggest that professional concern for the management of patients is closely connected with concern for the repercussions, and therefore professional accountability, should risks materialise as a result of hospital-based clinicians being unable to maintain contact with community patients. Concern for the management of patients therefore appears secondary to a professional desire for self-protection, as such CTOs are used to shift responsibility for patients from in-patient to community RCs. Even where responsibility for patients is about to be relinquished, in-patient RCs adopt a hands-off approach to CTO consideration and instigation. This approach and the reasons for it are discussed below.

CTO consideration and implementation

The authority to make a patient subject to a CTO rests with the patient's RC and an AMHP, albeit, as already established due to working practices, responsibility for the patient, in most cases, shifts from the in-patient clinician to the community clinician once the patient is discharged from hospital. Analysis of the data showed that this change in clinician brings with it a reduced sense of responsibility for patients among RC participants. AMHPs, too, showed a lessening in responsibility for CTO consideration. This is evident by their minimising or ignoring statutory powers, and by avoidance. There are, however, some exceptional cases in which an RC and AMHP claim responsibility for CTO consideration.

In the following accounts by Charity and Hugo, both in-patient RCs, interviewed separately from one another (but jointly with AMHP colleagues), a lessening in responsibility for those being made subject to a CTO was evident. Charity's account was in the context of being asked how she came to consider CTOs, and Hugo's account was his response to my asking how he felt about the CTO element of his work.

> ***Charity:*** *I go a lot with what the community consultant wants, which is why I try and get them there. Because they're the ones managing the patient long term, then my feeling is that they have to have the biggest say in a way. We want to be sure that's where they want to go with it, because it's not going to be my responsibility for very much longer.*

> ***Hugo:*** *Well, it is not an onerous part of the role. I am more conscious that actually as the in-patient psychiatrist by completing the form with my colleagues, we kind of think we are walking away from it and leaving a lot of other people with a lot of work to maintain the CTO to deliver the care.*

This lessening in responsibility was evident by Charity explaining ‘it's not going to be my responsibility for very much longer’ and Hugo’s statement ‘we are walking away from it’. Charity as a result showed deference to her community colleagues in deciding whether a CTO was appropriate by stating ‘I go a lot with what the community consultant wants’. This process of passing responsibility between clinicians was, however, dependent on the acceptance of responsibility by those working in the community. As Norman, an in-patient RC, explained, ‘I have to have some agreement [about the CTO] because I have to transfer the RC and cannot transfer to someone who says I am not having it. I have to really start to get them on board’. This statement showed the need to get the buy-in of the community clinician, and suggested a lack of enthusiasm to accept clinical responsibility for CTO patients. The following accounts taken from three separate interviews demonstrate that this process of handing over responsibility is less than seamless. Hugo and Ben, both RCs, were speaking about the passing of responsibility between clinicians, and Tony, a community clinician, was responding to my asking about his role in CTO consideration. Hugo, Ben and Tony made the following comments during joint interviews with AMHP colleagues.

> ***Hugo:*** *One thing I notice and in this Trust is that often the voice of the community psychiatrist is often remarkably absent or remote … I get almost no information from people about how they would like the patients treated.*

> ***Ben:*** *One way or another, there will be a discussion at some point as that person is nearing discharge, if they are on a s3 and they are far distant, about ‘Well, what do you want with this person? What do you think? Where are you going? and I might get an email asking me to ring an RC in [far distant location], or*

> *wherever saying, 'Oh, do you think this person needs to be on a CTO?', if I am lucky, and I might say, 'Well, yeh, that has been our view, thank you very much', which is so far from ideal it's not true.*
>
> ***Tony**: The CTOs are started in hospital, l so we would obviously liaise. It's a bit hit and miss really.*

Hugo, Ben and Tony were referring to poor communication between in-patient and community clinicians, albeit Ben was referring to the specific problem of patients being placed in hospitals out of area due to bed shortages. This poor communication runs counter to statutory guidance which states, 'If a different responsible clinician is to take over responsibility for a formerly detained patient, it will be essential to seek the agreement of that clinician … it is good practice for the clinician who will be the community responsible clinician … to be present at CPA assessments before and after discharge' (DoH, 2008a, p. 363). This Government guidance in relation to the Care Programme Approach, which was initially instigated to ensure that community patients receive the health and social care they need (DoH, 1990) by imposing communication between different stakeholders and clear accountability for patients, is not being adhered to. This suggests that some participants are resisting Government guidance designed to facilitate the governance of problem populations. These perspectives act in contrast to those of RCs and AMHPs who prioritised a biomedical understanding of mental disorder within interviews (discussed in chapter 4 above), which offers justification for intervention on the basis of disorder and risk. One explanation for this might be the reluctance of community clinicians to take responsibility for CTO patients, which is discussed below under the heading 'The protection imperative'. This lessening in responsibility for patients at the point of CTO consideration and instigation was not, however, common to all accounts. Siri, a community-based RC, highlighted good communication when asked how she came to consider CTOs.

> ***Siri:*** *Normally, the decision around CTO is held by the in-patient consultant with the AMHPs … I would be inclined to speak to the in-patient consultant and ask them to consider a CTO … we have very good communication I believe between all the consultants and AMHPs.*

The above accounts show that communication between clinicians is variable, and therefore clarity about responsibility for patients is not reduced in all cases. Siri, however, works in a different geographical area from that of the other participants discussed so far in this chapter, and of note, working practices differ in that area. The practice of trial leave of absence, accompanied by a shifting of responsibility from hospital to community-based clinicians in advance of CTO consideration has been introduced. This approach has bought with it an acceptance of community clinician responsibility for patients subject to s17 leave of absence, as is evident in the following account by James, the AMHP lead for the geographical area in which Siri works. James's comments were his response to my asking whether community clinicians are reluctant to take responsibility for patients subject to s17 leave of absence in the community.

> ***James:*** *There is a perception that you have got to retain a bed for a patient and then there is the issue about the RC status. The RC for patients on a ward does not wish to remain the RC for people on 17 leave and until comparatively recently other consultants were not willing to accept that, the RC responsibility, they have now.*

This change in working practice was reported (by James, above) to have resulted in a 50% reduction in CTOs. These changes were viewed by Joe, an AMHP (during interview with Siri, his RC colleague), to have resulted in more thoughtful consideration of CTO suitability.

> ***Joe:*** *I think in the past … they [CTOs] have been used a lot more regularly and quickly, and I think nowadays it is much more about actually seeing people on*

> *Section 17 leave to see if that is working to see how they are working in the community … The testing period is a lot bigger now where before we used to just sort of sign off the paperwork a bit quicker and just hope for the best that they would adhere to it*.

While an exception within the data, this shift in working practice to that of trialling extended s17 leave of absence, with the community RC assuming responsibility for the patient before a CTO is considered, appears to engender better communication and a greater sense of responsibility for patients between clinicians. The reason for this might lie in greater certainty of a successful outcome. Joe, when referring to their previous practice of instigating CTOs straight from detention without the intervening period of s17 leave of absence, explained: ‘we used to just sort of sign off the paperwork a bit quicker and just hope for the best that they would adhere to it’. This implies greater uncertainty of CTO success, and therefore greater concern that problems may occur. This supports the idea that professionals are more likely to take clinical responsibility for patients where risk behaviours are seen as manageable, and by implication are less likely to take responsibility where risk behaviours are viewed as unmanageable and unsafe. This conclusion may be argued to undermine the earlier assertion that the imposition of administrative and practice processes by AMHPs is driven by concepts of patient protections and autonomy. Rather, AMHPs, like RCs, may be reluctant to take responsibility for situations of uncertainty, and so are keen to delay CTO decision-making until the potential success of a CTO has been established.

Unlike RCs, AMHPs rarely have ongoing responsibility for CTO patients, as their role is limited to CTO consideration, revocation and extension. Their lessening in responsibility is therefore limited to these processes and is evident in two main ways, first by the effort invested in their role, and second, by wishing to remove themselves from the role. The data showed that AMHP participants viewed CTO consideration as less demanding than that of MHA assessments. For example, Charlie, during a joint interview, when asked about the CTO element of his work commented, ‘you haven't got the pressure of time that you have on a Mental Health Act assessment, so it’s the same kind of decision-making but over a long period of time, so you can relax a bit more about it'. Similarly, Joe, during a joint interview, when asked whether CTOs are a common part of his role, answered, '[CTOs are] a bit more planned. It doesn't feel like a big part because we are often dealing with crisis type of stuff. It is quite good to have a planned bit of work to do in a way'. These accounts showed CTO consideration to be less pressurised and more planned than that of MHA assessments, and this was welcomed. However, this can lead to AMHPs taking their role less seriously when considering CTOs, as was evident in Jim's account (during a joint interview with Charity, his RC colleague) when asked how he felt about the CTO element of his work.

> ***Jim:*** *Well, in some ways I enjoy it because I don't have to organise all of that [setting up a MHA assessment], so it takes away some responsibility. I just turn up and we agree or disagree basically [amused]. So in that sense, it's fairly sort of nice to be in that position.*

Jim's account shows a minimisation of the seriousness of CTO consideration. His statement 'I just turn up and we agree or disagree', does not reflect the significance of curtailing a patient's freedoms beyond the confines of detention in hospital, and is at odds with AMHP assertions of their definitive role in CTO decision-making. This move away from the significance of their legislative role was not unique to Jim. Mike, an AMHP, when discussing a specific patient and his role in the CTO process, explained that he spoke to the patient's nearest relative, although, as he acknowledged, 'there is no requirement that I do that, but I think it is good practice'. However, he went on (speaking more generally) to explain why he communicates with nearest relatives,[42] stating, 'a nearest relative can discharge, there is no point in doing it [a CTO] if they say no I am going to discharge him straight away'. Here, Mike is referring to the NR's right to discharge the patient.[43] However, he is ignoring his statutory power to agree a CTO (even where a NR wishes to discharge the patient), and the ability of the RC to prevent

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[42] The identity of the NR is legally defined in s26 MHA.

[43] The NR is able to order the discharge of CTO patients – see s23 MHA.

discharge.[44] This approach of ignoring statutory powers also appears at odds with AMHPs' assertions of their legal knowledge and independence. One explanation for this might rest in Joe's comparison with the 'crisis' nature of MHA assessments. This indicates that while MHA assessments were viewed by AMHPs as crisis events in need of an immediate response, CTOs were viewed as being less immediately concerning. This concern for risk, as identified in Chapters 4 and 6, may therefore (when compared to MHA assessments) result in a lessening of concern, and therefore responsibility for CTO patients.

Another way in which AMHPs lessen their responsibility is by their attempts to avoid CTO consideration for fear of damaging therapeutic relations with patients. Desmond, an AMHP, during a joint interview, when speaking about the allocation of AMHP work, and specifically, the process of CTO consideration, said:

> ***Desmond:*** *Sometimes even the care co-ordinator AMHP doesn't have the capacity and sometimes it is good to have an objective to prevent any kind of a therapeutic relationship breaking down, so the AMHP would ask for an objective, although it is not always accommodated. Because some of us believe it is a get-out clause for not doing the business, you know if you are open, you're honest and let the person know what the situation is, then it doesn't always damage the therapeutic relationship.*

This account differs in that Desmond was speaking about the less frequent occurrence among AMHP participants of being asked to consider CTOs for patients with whom they had an ongoing relationship as care co-ordinator. Nevertheless, these accounts showed variance in AMHP approaches to CTO consideration, with some minimising their statutory role, while others evaded it. In contrast, Desmond viewed CTO consideration as part of the 'business' of managing patients. These different stances adopted by AMHPs is likely to have an impact on the decision-making process. Minimisation of the AMHP role runs the risk to failing to provide a counterbalance to

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[44] The RC is able to prevent discharge on grounds of dangerousness – see s25 MHA.

the dominant medical paradigm, or to properly consider the range of options available to patients, before deciding whether coercive control is warranted. As a result, patient protections may be lost. These accounts show a lessening in responsibility for CTO consideration and implementation among RC and AMHP participants. However, accounts also show concern for professional protection which drives and maintains CTOs.

The protection imperative

While the above accounts show a general lack of ownership of CTO decision-making among participants, a degree of ambivalence is evident, as some accounts show a desire to instigate and maintain CTOs as a means of protection. This protection is not, however, always aimed at patients, but at professionals, most notably RCs. Analysis of the data showed that in-patient clinicians were keen to discharge patients on to CTOs and, although ambivalent, community RCs failed to exercise their power of discharge, suggesting that they too were concerned to protect themselves, and sometimes their in-patient colleagues. AMHP participants were less inclined to protect themselves, but where this was evident, it was not achieved by CTO consideration or instigation, but by avoidance.

Flora, an AMHP, during her individual interview, spoke about the localised rise in the use of community compulsion, highlighting her RC colleague's enthusiasm for community compulsion. I asked Flora whether her colleague, Norman, liked to 'discharge people on to something', to which she replied, 'Yes, bless him'. This enthusiasm for community compulsion, and specifically CTOs, was also acknowledged by Reg, a community clinician, working in the same geographical area as Flora and Norman. Reg, during a joint interview, showed less enthusiasm for CTOs when speaking about their potential for hindering therapeutic relations with patients:

> **Reg:** *I think a very interesting thing for me is this functionalised system that we work, because there are a lot of in-patient consultants [who are] quite keen to put a person on a CTO while the community consultant is reluctant.*

Reg questioned the effectiveness of CTOs, arguing that they had not reduced the rate of admissions to hospital, and said he would be interested to see whether the same number of CTOs would be used if the same RC had responsibility for patients throughout their in-patient and community treatment. Overall, Reg appeared critical of CTOs and the enthusiastic uptake of them by in-patient RCs. However, later in conversation he explained that he attended Managers' Hearings and Tribunals for those subject to CTOs and that patients did not want to be involved. This statement indicated that he did not exercise his power of discharge once he became the RC. This failure to discharge CTOs is of interest given his reservations. Reg's account did not reveal why he failed to exercise his power of discharge, but Flora's account offered an indication when speaking about the difference a CTO makes to medical oversight. Flora's comments came during her individual interview when she was asked to distinguish between the doctor's role for patients free from compulsion, in comparison to those subject to a CTO.

> **Flora:** *Someone who is not on a CTO has a Consultant Psychiatrist that they see for their outpatients [appointments] but, when they are on a CTO they have an RC [responsible clinician] and there is responsible in the word [laughter] … They don't feel the weight of duty on them in the same way if they are not under a CTO.*

Responsibility here is synonymous with 'duty', and this duty carries with it accountability. On one hand, the absence of a CTO means that the clinician is less responsible (and therefore less accountable) should a problem occur, but in contrast, the CTO may offer some professional protection should a problem occur; better to have a framework in place than not, representing a 'better safe than sorry' approach. This approach is evident in the following excerpts by Desmond, an AMHP working in the same geographical area as Reg and Flora. First, Desmond, in interview with Reg, offered an explanation for the high uptake of CTOs in response to my asking why they had been grasped so readily:

> **Desmond:** *They [patients] will struggle to be managed, and sometimes I think that is possibly a factor in the use of CTOs, using a CTO to reduce the risk and also protect themselves if something goes wrong and investigators say 'Why didn't you consider CTO to manage the risks given the circumstances?' That may be one of the reasons why people end up using it more as an agent of control in that respect than civil liberties.*

Desmond's references to 'managed', 'agent of control' and 'civil liberties' gave a clear indication that the balance of power rests with the professional as opposed to the patient, and this served to protect the professional, at the expense of patient autonomy. This balance of power was not only evident at the point of CTO consideration, but also at the point of recalling patients to hospital. Desmond went on to explain that RCs exercised their power of recall where risks[45] did not appear to be that great.

> **Desmond:** *It might reflect the fears of the individual if something goes wrong – the professional – if something goes wrong, how will they look at me and I'd rather recall this person.*

This account revealed that AMHP participants think concern for the repercussions of risk behaviours drives RC decisions to recall patients to hospital, thus curtailing patient freedoms further. This desire for professional protection was also evident in an account by James, an AMHP from a different geographical area from that

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[45] Recall must be on the basis of a breached mandatory condition (s17E(2)), or as a result of the patient requiring treatment in hospital, and there being a *risk* of harm to the health or safety of the patient or to others if not recalled (s17E(1)).

of Reg, Flora and Desmond. James's comments came in an individual interview, in response to my asking what might indicate that a CTO is not needed.

> ***James:*** *[where] there is no substantive care plan to actually cement together with the CTO and it's there basically to reassure professionals rather than prevent relapse for the patient.*

These accounts by Desmond and James suggest that concern for professional protection may be the same as, or greater than, concern for the risk that patients may pose. However, despite this professional desire for self-protection, it seems that CTOs both act to provide a protection and a burden. Flora, during an individual interview, when speaking about AMHP allocation for CTO consideration, stated that community RCs are less enthusiastic about CTOs:

> ***Flora:*** *These community doctors don't really want it, they don't like it, it's a lot of responsibility … I don't think that they are gagging to do them really. Maybe [Norman] a bit more because he wants people out [of hospital]. He's got an agenda for that, but the community doctors do feel the burden of responsibility with it.*

In this account, the driving force behind CTO instigation seems to be that of discharge from hospital, and this view is supported during a joint interview between Norman and Flora. Flora stated, 'there is pressure to get people out, isn't there?' to which Norman replied, 'pressure or what!'. These accounts by Flora and Norman show that the pressure to discharge patients from hospital influences CTO consideration and trumps the community clinician's ambivalence. These differing agendas between clinicians does not, however, appear to cause professional tension. Flora, when asked whether problems arises as a result of in-patient RCs instigating CTOs in the face of community clinicians' ambivalence, answered, 'They do all get along ok. They are pretty supportive of one another'. Later, when asked whether she thought the number of

CTOs might differ if community RCs were involved at the point of CTO consideration, she answered, ‘I guess the community RC's are sympathetic to [Norman] knowing he has only got a few beds and want to help him get people out. They never rescind them, though’.

These statements suggest a mutual understanding of the job to be done which appears to be the administrative instigation of CTOs. One such purpose is the protection of professionals, whether against the repercussions of risk behaviours or organisational pressures. This professional protection is acknowledged to be at the expense of therapeutic relations. As Norman put it, it ‘fractures the therapeutic relationship’ and prohibits ‘engagement’. Despite these conflicting views and interests, CTOs are agreed with little evidence of dynamic discussion, arguably interrupting the potential to safeguard the interests of patients (DoH, 2015a). In the following exceptional case, an AMHP reflects on her avoidance as a means of protecting herself.

Flora, an AMHP, was interviewed alone, and then on another occasion with Norman, her RC colleague. During the joint interview Flora reflected on her earlier individual interview with me in which she had been unable to recall any CTO considerations for which she had ‘disagreed with [her RC colleague]’. Flora explained that this was a result of her avoidance when faced with a CTO consideration, to which she disagreed. She reflected, ‘Well, actually [Flora] you know what you do, you avoid it. You walk away when you can see a CTO coming and I'm not with the programme. I walk away, I give it to another AMHP, I avoid it, which is a terrible thing to admit but it is true'. Flora went on to describe herself as someone who ‘disagree[s] all the time about all sorts of things’, and questioned why she was not in ‘conflict’ with her colleague. She acknowledged that she ‘get[s] out of the way’, and referred to herself as a ‘coward’, and as having ‘abandoned the patient’. Flora explained that this was not something she was ‘personally proud of’, but thought her response was a result of being a ‘minority report’. By this Flora, was referring to the fact that others considered a CTO a good idea. When her views differed from that of others, it led to her ‘doubting’ herself, and feeling a need to ‘survive’, and ‘look after [her]self’. During interview, Flora referred to her job as ‘difficult’, and said she could not ‘win every war’, and therefore needed to ‘choose [her] battles'. Flora felt that it was important for me to know this and suggested that other AMHPs would be doing the same, stating, 'those that don't agree [with a CTO] are somehow manoeuvring themselves out of the frame' [laughter].

This account was exceptional in that no other participants described removing themselves completely from the decision-making process. This is not to suggest, however, that avoidant behaviour did not exist among other decision-makers, as is evident in RC and AMHP accounts of CTO consideration (above). Norman, Flora's colleague, had not made reference to these behaviours, but once shared by Flora, acknowledged them by saying, 'I know what [Flora] is like! If she doesn't agree with me she will just hide away. I know what she is doing'. Despite this avoidance, Flora at another point during conversation, when speaking about AMHPs' consideration of CTOs, argued, 'we are all pretty even on whether or not we'll sign the CTO because most of us will if it's all looking correct'. However, if other AMHPs are avoiding CTO consideration for those they are in disagreement with (as suggested by Flora), it is perhaps unsurprising that decision-making is 'pretty even', as AMHPs would only involve themselves in CTOs to which they agree.

Flora's account, while exceptional, showed her avoidance of conflict as a means of self-protection. This protection appears, however, to differ from that of RC participants who were more concerned to protect themselves from blame. Flora's concern for self-protection was motivated by her need for self-preservation, especially where she saw her views as differing from others. Where this was the case, she removed herself from what she described as a 'difficult' job, due to her need to 'survive'. This avoidance has implications for professional decision-making in the context of CTOs. As Flora put it, she 'abandoned the patient'. Had Flora been less concerned with professional protection, her differing views from that of others may have served to protect patients from continued compulsion, affording them greater autonomy.

In summary, RC, and less frequently AMHP participants were motivated by a desire to protect themselves. This, however, was not always achieved by CTO consideration, instigation or maintenance. In-patient RCs, in response to organisational pressures, were keen to use CTOs as a means of discharging patients from hospital. In contrast, community RCs showed a degree of ambivalence about CTOs; they viewed them less favourably, as a burden, yet maintained them, as they provide professional protection (better to be safe than sorry). This acceptance of CTOs does little to enhance professional debate, resulting in their instigation and maintenance. AMHPs were less inclined to protect themselves (the likely result of their transient role in the CTO process), but where professional protection was evident, it served as self-preservation against interdisciplinary conflict and the difficult job.

Resources

CTOs were introduced as a means of managing a problem population, but their success in achieving this policy aim is dependent on resources. Analysis of the data revealed that hospital beds and human resources are most critical, yet most problematic, when trying to manage the CTO patient population. Data is presented under the headings 'Hospital beds' and 'Human resources' to demonstrate their role in the management of CTO patients, and to illustrate the problems posed by their limited availability. Finally, the impact of these resource shortages on professionals is discussed.

Hospital beds

Given the reduction in the number of psychiatric hospital beds over many years (CQC, 2018a, 2018b), it is unsurprising that the unavailability of hospital beds impacts CTO use. Analysis of the data showed that bed shortages have an impact on professionals' ability to property instigate, recall and revoke CTOs.

The patients discussed by participants were most commonly in hospital at the time of their CTO consideration; as such, professionals should be able to meet with them for the purpose of CTO consideration. However, a shortage of hospital beds can result in patients being moved to far-distant hospitals, making CTO consideration problematic. Ben, an RC, in conversation with Sam, an AMHP, explained that it's 'getting increasingly difficult' as the service 'progressively lose local beds' resulting in patients being 'transferred out of area'. He explained that this has implications for the 'governance' of patients and for 'communication' (with patients and professionals). This problem is not sporadic, affecting a few, but is commonplace as a result of a new policy initiative to manage the 'bed crisis'. Sam explained that the response to this crisis is 'to admit [any] new admission locally, and to facilitate that more well patients will be moved out of area'. Ben commented that this approach is far from ideal as patients coming to the end of their admission 'want to spend more time at home and have leave'. Further concerns were voiced by Sam, who went on to explain that where patients are far distant, it 'prohibits the AMHP from visiting the patient, their family and introducing them to accommodation in the community'. This account made clear the difficulties faced by professionals in trying to facilitate a planned discharge from hospital of patients warranting community compulsion.

Another response to managing this shortage of hospital beds is early discharge facilitated by use of a CTO. Reg, an RC, explained that the high uptake of CTOs in his area of work is a result of a desire to facilitate early discharge from hospital as a result of bed shortages. He explained, 'people have used more CTOs because some of them sent patients half-cooked'. Reg's reference to 'half-cooked' implied that patients are not sufficiently well when discharged from hospital. Should this be the case, CTOs are less likely to be able to achieve their intended aim of protecting patients or the public. This concern was raised by Flora, an AMHP, who said, 'My concern sometimes is that we might set someone up to fail if it's not all properly thought through and this is just to free up the bed situation'. RCs, too, shared this concern, which is evident in Tony's account when speaking about the characteristics of patients for whom a CTO was indicated (during a joint interview with his AMHP colleague).

> ***Tony:*** *I think people sometimes, again because of the pressure on resources, are quick to decide [that] this person needs to be on a CTO, even when they are not 100% well, people do not wait … I think people rush into putting patients on to CTOs.*

This concern was consistent with RC and AMHP participant accounts. While a degree of frustration was evident, participants were not empowered to change the situation and were constrained by policy initiatives. Sam, an AMHP, did however question whether 'a CTO is worth doing if you can't recall'. Sam went on to explain:

> ***Sam:*** *We have somebody just now out in the community who we are worried about and we would like recall, but we need to identify a bed and we haven't been able to identify a bed. So I think there is some frustration among RCs that what's the point if the main, one of the main provisions is rapid recall to hospital and there's no beds available, and it might be a bed in [far-distant area].*

Similar frustration at the recall process was evident in Tony, an RC's account, during a joint interview with Mary, his AMHP colleague.

> ***Tony:*** *Recalls, for example, can be quite difficult at times because we need to identify a bed first before you can recall somebody, and if you haven't got a bed, then that could drag on. At that time it feels very frustrating really that you have got somebody that is on a CTO and all the indicators are that they need to be in hospital at that point and you can't recall them because of the lack of resources.*

Recall to hospital was seen as especially problematic by participants, presenting numerous problems with the management of patients. First, as identified by Charlie, an AMHP, a recall notice cannot be served until the receiving hospital is identified. Charity, an RC, similarly identified problems with CTO recall when speaking about a specific patient, during interview with her AMHP colleague, Jim:

> ***Charlie:*** *They are dependent on bed availability. So you cannot submit a recall notice without a bed, so then you have got to find a bed, and then you have got*

> *to find the person at the same time that you have found the bed. If the person's missing … the bed gets given to somebody else.*
>
> ***Charity:*** *I don't think the CTO has helped. When there are no beds, it just doesn't do what it should do, so I think it is pointless … You can recall somebody and then not have a bed.*

Charity, in conversation with Jim, went on to explain: 'This goes back to real world doesn't it? In the real world we never have any beds, so actually this isn't the smooth process it ought to be, or the rapid process it ought to be.' This showed that necessary resources to facilitate the operation of CTOs intended to manage problem populations are not available to participants. Alternative means of managing this problem were explained in response to my asking what happens then:

> ***Debbie:*** *So what happens then?*
> ***Jim:*** *[Laughter] That's a good question. I wish I knew.*
> ***Charity:*** *It's a nightmare. Whereas if you have a Mental Health Act and he goes on a [section] 3, then they get priority …*
> ***Jim:*** *What happens is they get arrested on a [section] 136.*

Jim's comment 'I wish I knew', although said in jest, reflects the void created by a lack of resources. His later statement, 'they get arrested on a [section] 136', indicates an unplanned response as a result of an immediate need to intervene to prevent problematic behaviours.[46] This suggests that professionals are not in control of CTOs as a means of management; rather, they are driven by poor resource provision and rely upon other mechanisms of control - for example, police powers of arrest under s136 MHA. Charity's comments also indicated that MHA assessments are more efficient in

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[46] The grounds for s136 include the immediate need for care or control in the interests of the person or the protection of others. Where this is the case (among other grounds) the police may remove the person to a place of safety for the purpose of a medical examination and an interview with an AMHP and the making of necessary arrangements for treatment or care.

managing patients than CTOs, as admissions under s3 MHA are prioritised for bed allocation above CTO patients. These problems are made worse by hospitals refusing to accept recalled CTO patients, as is evident in the following account by Siri, an RC during a joint interview with her AMHP colleague, when describing problems with recall:

> ***Siri:*** *Having the bed when the warrant becomes available, finding a local bed because some units out of area will not accept someone if it is a recall … They will ask if they are on a section. If they are just going to be recalled, they won't accept and that has become the norm.*

The refusal of hospitals to accept CTO patients subject to recall was sometimes resolved by professionals moving from recall to revocation. This process has the effect of bringing patients back onto their initial detention section - for example, s3 MHA - and as such they are prioritised for bed allocation. This process is evident in the following account by Sam, an AMHP (in interview with his RC colleague, Ben) who said, '[we are] having to revoke people because private hospitals won't accept a recall where it will accept a revoked CTO'. A similar problem was evident for patients requiring a psychiatric intensive care unit (PICU), as identified by James, an AMHP interviewed alone, in the following account:

> ***James:*** *The private sector acute bed, or a PICU, will take someone if they are revoked but not for recall. So you have got a situation where you can only revoke someone by getting them recalled to a hospital, but you can't find a hospital to recall them … Bizarre situations where, because in the particular circumstances a recall has seemed implausibly difficult to achieve, then people decided to give up.*

James's account revealed the difficulty in achieving readmission. Patients may only have their CTO revoked once recall to hospital has been achieved, but in the absence of a hospital bed, recall is problematic. The potential consequence, as James indicated, 'people decide to give up', or where this is not an option, Joe, an AMHP, in interview with Siri, his RC colleague, explained, ‘a leave bed gets used, juggling, which you shouldn't really be doing’. This in effect means that a patient subject to potentially short-term leave of absence who retains a hospital bed, will not be able to return to it, as it will be taken by a CTO patient. The effect of these approaches are that patients remain in the community, even where their behaviours are considered sufficiently serious to warrant treatment in a PICU. This further illustrates the inability of professionals to operate mechanisms of control as a result of a lack of resources. Overall, the potential impact is an inability to provide adequate care to patients and the possibility of risk behaviours arising, leaving the patient, and possibly the public and professionals unprotected. On the occasions that recall and revocation are effected, Hugo, and RC (in interview with Charlie, an AMHP), explained that movement between hospitals is likely to have a detrimental impact on assessment:

> ***Hugo:*** *They may be coming in through [x hospital] or [y hospital] on a Thursday and by Friday I am having to make a decision. So that 72 hours fine in theory, but it doesn't really work in the patients’ favour in terms of having a period of assessment.*

This movement between hospitals results in clinicians having to make decisions about patients for whom they have little knowledge. This too raises questions about the level of care provided to patients, and the potential for defensive decision-making as a means of protection. Despite these evident problems with recall, not all participants saw them as a barrier to CTO consideration. Jim, having been a party to Charity’s less favourable view (above) said, ‘I feel fairly positive about it in general, if they can prevent admission’, and Hope an AMHP, interviewed alone, argued a number of positive attributes to CTOs, including the provision of a ‘quick process of recall’, and stated that recall ‘doesn't necessarily need the AMHP for the recall bit either’. This account by Charity starts to stray away from the resource of hospital beds to human resources as a means of managing patients. This shift to consider human resources, unlike the resource of beds, operates to favour CTOs over MHA detention. Data to illustrate this is presented below.

Human resources

Despite these evident problems with the recall process which is largely associated with the dearth of hospital beds, CTOs were still seen by participants to have a place, but this place was cited to be a result of the lack of human resources to properly manage patients. This lack of human resources operates to counter-balance the deficits caused by the lack of hospital beds, and is evident in participant accounts of a more streamlined process and reduced community-based mental health services.

Mike, an AMHP, in interview with Charity, an RC, showed a preference for CTOs as a result of the more human resource-intensive approach of convening a MHA assessment. This view materialised in response to my asking his view about the introduction of CTOs, to which he answered:

> ***Mike:*** *The legislation is built for perfection and doesn't really work in the real world very effectively. Actually, for me being able to recall someone to hospital when they need to be recalled with a simple letter and then a simple order for either police or ward staff is really good. The number of times I have turned up at people's houses with lots of - I won't say highly paid professionals! - but you know we are all paid, and it costs money and it's people's time, and that can take a day of my time to arrange, it's several hours of the doctor, it's ambulance, and then they are not in. Now is that crazy? We can go back the next day and do the same thing again, and they won't be in.*

Mike's account puts human and financial resources ahead of other considerations, but of note Mike referred to the effect of these processes on himself as well as others. CTO recall is seen as 'simple' and saves him and others time. His frustration with a process that fails to provide a tool for the effective management of patients was evident in his statement, that the legislation ‘doesn't really work in the real world’. This account does not, however, take account of the time that is necessary to issue a CTO recall notice, serve it, gain a warrant if access is denied and convey the patient to hospital, assuming there is a bed (not to mention the potential for having to convey the patient out of area due to their lack of priority status). Portraying the CTO recall process as ‘simple’, is far from reality, but this view may be influenced by the absence of an AMHP in the recall process. The absence of an AMHP in this process might make it a more attractive proposition for some AMHPs than the MHA assessment for which they are responsible (and from earlier accounts is seen as more burdensome). Mike clarified this later in conversation when he was asked how he felt about the CTO element of this work, to which he replied:

> **Mike:** *I think CTOs are very useful myself. Not everybody does, I know, but I think for the right person they are really good and save us an awful lot of chasing around people, time after time, to do Mental Health Act assessments.*

Mike’s reference to saving an ‘awful lot of chasing around’, offered a clear indication that the reduced involvement of the AMHP, and with it reduced responsibility, makes CTOs a more attractive means of management.

In addition to the attraction of a less burdensome process, reduced specialist community services, with time available to maintain contact with patients, was also cited as reason for CTO use as a means of management. In the following account by Reg, an RC, in interview with Desmond, his AMHP colleague, the stripping away of human resources offered CTOs a role in the management of patients:

> **Reg:** *I think there is a role for CTO because of how services are organised at the moment. There are so many different teams and constraints of resources. There is a core of people that I think possibly like previously we had flexible working with service users in a more engaged manner, like we should have AO (Assertive Outreach) teams who have a very limited caseload and they could see patients*

> *twice or thrice in the week, and we don't have those provisions, the services have been stripped down.*

Unlike Mike, Reg did not see this in a positive light, but as pragmatic. Reg went on to say, ‘so I would only use CTO as an excuse for lack of resources’. Reg made clear earlier in conversation, when asked his view of CTOs, his dislike of them by stating, ‘personally, I don't like CTOs’. Reg, however, as a community RC maintained CTOs despite his views, in part to ensure some means of management. Charity and Hugo, both RCs, participating in separate joint interviews, similarly cited lack of resources as a reason for CTO use, but their accounts differ as they state the usefulness of CTOs in ensuring contact between services and the patient, as opposed to the other way about.

> ***Charity:*** *I think a lot of the family's issues with not doing the CTO before are actually about the level of support CMHT offered as opposed to not having the CTO.*
> ***Debbie:*** *Does a CTO help get the services?*
> ***Charity:*** *Well, that's the bit that concerns me since I came here, is the fact that I think that some of my colleagues in the community, and one actually said this, if we put them on a CTO it will make the CPN see them. It is because they are overwhelmed in the community and they are not seeing their patients like my old CMHT [community mental health team] did.*

> ***Charlie:*** *I think there is a service issue. I think that the amount of people that get discharged from mental health services completely when they have got a chronic psychotic illness and are refusing to engage with CMHT, if those people are on CTOs, the CMHT cannot discharge them, but they seem to be more than happy to discharge them if they are not on a CTO.*

> ***Hugo:*** *I absolutely agree with that, but I think that some of the community teams have been very depleted in terms of their resources and I think in morale, and it*

> *has been difficult to engage clients. Clients are discharged far too freely, with the loss of AO [Assertive Outreach] and so forth. You know, this has really led to some absolutely appalling cases of readmitting [to] hospital [patients] who are very well known with major illnesses and untreated for long, long periods of time.*
>
> ***Debbie:*** *So the CTO might be beneficial?*
>
> ***Hugo:*** *Yes … For keeping services in contact with the patient, and I do that quite explicitly. I don't know if it is wrong to say that, but I do think that … and I know that is not what a CTO is for, but actually that is in many cases the main benefit or an arguable benefit, to keep services in contact with the person.*

These accounts show a reversal of what was intended by the implementation of CTOs, which were intended to keep patients in contact with services (DoH, 2008a), not to ensure that services stay in contact with patients. This results in CTOs being used in the face of professionals’ criticism of CTOs, resulting in contradictory behaviours. This position, however, appears to be accepted by participants, as only two spoke of CTOs as a transition towards something better. Ben, an RC, and Sam, his AMHP colleague, spent some time speaking about alternative models of working - for example, Trieste, an open 24 hour, 7 days a week service, replacing pre-existing hospitals. This system has seen good outcomes from initial crisis, low relapse rates, and improved long-term outcomes (Mezzina and Vidoni, 1995). Ben and Sam spoke favourably about this approach and hoped they were moving away from ‘fragmented’ and ‘atomized’ services, and were in a ‘transition to something better’. Sam referred to services as ‘compartmentalised’, resulting in ‘delays’ and ‘disagreement’, and explained that the ‘sense of holding somebody gets reduced’. Sam, having later discussed his concerns about CTO consideration for two young people following first admissions to hospital, said, ‘it seems a shame that we may resort to something like a CTO as a substitute for that kind of better aspiration’. These statements, while recognising service deficits, serve to justify decisions to impose CTOs against their better judgement. However, s17 leave of absence is another means of allowing continued contact between patients and professionals, and prevents discharge from services, but this means of providing continued care is also beset with problems as a result of the way in which resources are managed.

Conclusion

In summary, this chapter has presented data that shows hierarchical relations among RC and AMHP participants. AMHPs are more inclined than their RC colleagues to claim and assert their position of power, and this is done by imposing administrative and practice processes, and asserting their legal position. However, at the point of CTO consideration and implementation, the data revealed a lessening in their responsibility by minimising their role and, in rarer cases, avoiding it. Minimising their role was evident by the playing down of the significant curtailment of civil liberties as a result of CTO instigation. This occurs as a result of making a comparison with the more difficult role of MHA assessments, and as such participants saw CTOs as easy work. Avoidance of CTOs, although rare, occurred as a means of avoiding conflict and self-preservation. RC participants were less concerned to display their status; however, they were more concerned by the distribution of power. In-patient RCs were keen to pass power to their community colleagues, and during this process showed a lessening in responsibility for patients. Community clinicians in contrast were less keen to accept responsibility for patients, although a degree of ambivalence was evident.

Analysis of the data shows that resources are considered necessary to the successful exercise of professional power in the context of community compulsion, specifically hospital beds and human resources. Yet the unavailability and location of hospital beds clearly hindered the utility of CTOs at all stages - instigation, recall and revocation. Despite this, questioning of the usefulness of CTOs was rare. Alternative means of control were used in some cases - for example, police powers and CTO revocation to secure a bed (even where redetention was not indicated) - but more commonly the lack of human resources served to counterbalance the evident problems with the operation of CTOs. These were explained as less human-resource intensive and as providing a means of keeping services in contact with patients - a reversal of

Government intention. This stated preference for CTOs, however, is contradicted within the data, with equal concern for their inefficiency in achieving their aims.

Both professional groups can therefore be seen to make use of differing knowledge and devolved power to influence CTO consideration and instigation. However, some decisions were influenced by concern for professional protection and less frequently self-preservation, as opposed to the interests of the patient. This use of knowledge and devolved power accords with Foucauldian ideas of governmental management, however, the focus on professional protection departs from the purpose of divesting power as a means of managing problem populations. The data therefore indicates that concern for professional protection (made worse by limited resources) and the adoption of working practices challenges the utility of theories of governmentality in fully understanding professional decision-making in the context of CTOs. Indeed, the data in respect of resources indicates that professionals are not in control of CTOs; as such, the successful governance of problem populations is problematic.

In respect of what influences decision-makers, RC participants saw CTOs as both a burden (a responsibility, bringing accountability), but also as a protection (better to be safe than sorry); as such, CTOs were made and maintained. Hierarchical relations were less evident between RCs, although there was evidence of hierarchical relations between forensic and acute clinicians, with acute clinicians deferring to forensic colleagues in fear of the repercussions of a failure to act in accordance with their advice; thus, professional protection influenced decision-making. Overall, AMHPs saw themselves as a counterbalance to their RC colleagues, offering some patient protections, although CTOs offered ease of work by comparison to MHA assessments, which in some cases led to AMHPs taking less responsibility or absolving responsibility for community compulsion. Working practices and resources also had an impact on CTO decision-making, most commonly leading to the making and maintaining of CTOs.

In respect of how professionals account for CTO use and what they seek to achieve, maintenance of contact between professionals and patients, risk and resource management (hospital beds and human resources) were all cited as reasons to make and maintain CTOs. RCs most commonly used CTOs as a means of professional protection and this was most evident in the making of CTOs and failure to utilise discharge powers.

In respect of the balance of care and control, and professional power and personal autonomy, use of control and professional power was most evident within the data. CTOs were utilised despite some participants viewing them as interrupting therapeutic relations and engagement. In some areas, working practices were seen to interrupt the opportunity for dynamic discussion to protect patient interests. In respect of AMHPs, the rare avoidance of CTO consideration also acted against patient autonomy. There are, however, examples of mutually respectful working relations, good communication and claiming of responsibility for patients. This is attributed to different working practices and has reportedly resulted in a reduction of CTOs, albeit increased use of s17 leave of absence as an alternative might counterbalance any perceived increase in patient freedoms.

CHAPTER 6 The dominance of medical discourse 2:

The response to mental disorder

Introduction

This chapter builds on Chapters 4 and 5. Chapter 4 was concerned with participant perceptions of mental disorder showed the dominance of medical discourse, both in the understanding of, and behaviours associated with, mental disorder. Chapter 5 showed consideration of other factors relevant to CTO consideration; however, these were socially, rather than medically orientated. These social considerations were not concerned with patients, but with interdisciplinary dynamics and resources. It is therefore perhaps unsurprising, given the dominance of medical discourse, and the absence of social considerations concerned with patients, that the response to mental disorder is, almost without exception, medical treatment. This chapter therefore presents data illustrating the dominant view that treatment should be the response to mental disorder.

The data presented in this chapter first illustrates the perceived need for treatment, before offering an explanation of how treatment is understood. The justification for compulsory treatment (even in the face of patient resistance) is explored, before addressing the preferred means of treatment administration. Finally, exceptional cases in which participants questioned the effectiveness of treatment are presented. The data is presented in this way in part to follow a logical order, but it also represents a scale of dominance within the data, starting with the most dominant theme - that of treatment necessity - and concluding with the infrequent questioning of treatment efficacy.

The data supporting these findings shows the prioritisation of a biomedical approach to mental disorder, and as a result legitimises the exercise of professional power over patients to enforce treatment. Analysis of the data shows that participants link the re-emergence of behaviours associated with mental disorder with the stopping of treatment. In response to this, participants are keen for patients to continue with treatment, and in the face of patients’ reluctance, enforced treatment provides a means of achieving their aim. While this is a dominant theme among participant accounts, there are some exceptions, in that some participants question the benefit of treatment.

The perceived need for treatment

Analysis of the data showed that treatment is considered necessary to ameliorate, or eradicate, behaviours associated with mental disorder. This perceived need for treatment was evident throughout participant accounts and dominated other emerging themes. This need for treatment was intrinsically linked with the need to ensure compliance with treatment and CTO consideration to achieve this aim. The following excerpt from Hope, an AMHP, interviewed alone, brings together these concepts: the need for treatment, the need to ensure compliance with treatment, and the role of CTOs in achieving both. Hope's comments came in response to my question, 'How do you come to consider CTOs?' As such, Hope was speaking generally about the purpose of CTOs.

> ***Hope:*** *Usually when somebody is coming to the end of their period of Section 3 and going back out into the community, where people are considering treatment and medication care, and treatment maintenance in the community.*

This excerpt is illustrative of the participant's view that treatment is the response to mental disorder, and as a result professionals are concerned to maintain treatment beyond the confines of hospital. Use of a CTO is seen as a means of engendering and maintaining such compliance with treatment. While the language of 'care' is used, CTOs provide for compulsory treatment; as such, they offer a means of exercising control over patients, who, without this provision would disengage from treatment. Further examples of the perceived need for treatment are set out below before exploring the need to ensure compliance with treatment.

The need for treatment is implied within the following accounts by five RCs, during joint interviews with AMHPs. All excerpts are RC responses to my asking about

CTO consideration; as such, they give a broad view of the factors influencing CTO decision-making. While the term ‘non-compliance’ is only evident in one account, the other accounts are concerned with compliance with treatment. Use of the terms ‘revolving door’ and ‘coming back thus far’ indicate the cycle of deteriorating mental health leading to readmission to hospital as a result of ceasing treatment. These behaviours are viewed as something to be addressed by means of a CTO. Use of the words ‘managed’, ‘non-compliance’ and ‘disengage’ in the accounts imply disobedience with treatment, and therefore offer justification for intervention to engender treatment compliance.

> ***Charity:*** *Currently, I am an in-patient doctor, so if we have somebody on Section 3, particularly if you are considering depot or they have had more than one admission, I would actually discuss with their care co-ordinator and community consultant, as I feel very much it is about how they are managed in the community.*
>
> ***Hugo:*** *It is often suggested by staff on the ward, particularly for folk who are revolving door patients.*
>
> ***Siri:*** *It depends on the history of the patient, especially if they have a very severe mental illness and there have been issues of non-compliance.*
>
> ***Tony:*** *If we are worried about somebody and we know there is going to be issues in the community and they might disengage.*
>
> ***Norman:*** *Two main things are the nature of the illness really and whether they have been coming back thus far.*

All the above accounts are concerned with a population of patients known to services, this is evident by use of following phrases and words: ‘more than one admission', 'revolving door patients', 'history', 'we know' and 'nature', offering a degree of certainty on the part of professionals of their disengagement with treatment. This disengagement therefore justifies professional attempts to encourage engagement, but it also suggests that previous attempts to engender compliance with treatment have failed in some way. This failure is, however, seen to be that of patients, as a result of their disengagement, as opposed to a failure on the part of professionals. While service deficits were identified by participants (see chapter 5 above) accounts that explanation patients as the problem and treatment as the solution dominated. The need to administer treatment is therefore the response of professionals, as opposed to a reconsideration of their approach to mental disorder. As such, a biomedical approach to mental disorder is maintained and offers justification for continued intervention.

A response concerned with the need for treatment might be anticipated from RCs, all of whom are registered medical practitioners. However, AMHPs also consider treatment necessary, as is evident in the following excerpts. Charlie, an AMHP, in interview with Charity, his RC colleague, when asked about the purpose of a CTO for the patient he was discussing, answered:

> ***Charlie:*** *Well, in the case I was just thinking of then, it was about treatment, they would only accept treatment if it is under a CTO.*

Here, the response to mental disorder was that of treatment and use of a CTO was intended to encourage the patient to 'accept' such treatment. Similarly, the account by Joe, an AMHP, in interview with his RC colleague, explained the ability of treatment to make patients 'well', and highlighted the need for its regular administration. Again, CTOs provide a means of achieving this.

> ***Joe:*** *I think it [CTO] is often for people where you can see that when they do take their treatment they are really, really well. They function really well and so actually I feel less happy to do it if that wasn't the case. It is for those people you can see a real difference when they are regularly taking their medication.*

Joe’s comments were made in the context of responding to my question, ‘How do you come to consider CTOs’? Joe, unlike Charlie, was therefore expressing a general view that regular treatment has the potential to make patients well. His account does, however, suggest that treatment may not always improve mental health. This idea is considered further under the heading ‘The ill effects and inefficiency of treatment’ below.

A more nuanced consideration of CTOs is seen in the following account by Mary, an AMHP, during interview with her RC colleague. Here, the CTO was justified on the basis of bringing ‘benefit’ to the patient. Mary’s accounts came in the context of explaining her role in the CTO process:

> ***Mary:*** *What is the benefit to the patient? That's my first question. Looking at all the criteria and then what's the benefit to the patient really.*

While direct reference to treatment is not made in Mary’s account, reference to ‘criteria’ is made in addition to ‘benefit’. The statutory criteria for a CTO includes five grounds, four of which ensure either the appropriateness, necessity or provision of treatment, and one of which refers to the need for recall, the grounds for which include the requirement of treatment in a hospital. Treatment is therefore central to the statutory criteria for a CTO. However, AMHP decision-making is not solely dependent upon criteria being met. In addition, AMHPs must consider all relevant factors, the necessity or appropriateness of conditions and the appropriateness of a CTO; thus, the AMHP retains discretion even where statutory criteria are met. Benefit is therefore a relevant factor when considering a CTO and its absence may dissuade an AMHP from CTO agreement. However, the dominance of treatment can be seen in Mary’s response below, when asked about a CTO extension to which she agreed:

> ***Mary:*** *For me, the deciding factor was that I know that when he has been on medication before he has been stable*.

A link may therefore be made between treatment, benefit and stability, as such stability as a result of treatment offers justification for intervention. However, it became apparent that the CTO was extended in the face of evidence to support the patient's ability to remain well for prolonged periods of time without treatment. Mary justified the decision to extend the CTO by stating:

> ***Mary:*** *I certainly felt that I could see a Mental Health Act assessment coming along very shortly if we had not continued with the CTO and continued with his medication and he ended up in the [hospital] very shortly after that.*

Mary's agreement to a CTO extension was on the basis of an anticipated rapid deterioration in the patient's health as a result of not complying with treatment. This was evident in her description of a MHA assessment 'coming along very shortly'. However, Tony, her RC colleague, later in the conversation explained, 'He [the patient] then decided that he did not want to take medication. I think that he was OK, he was not acutely unwell for probably about a year'. This patient, for whom Mary agreed a CTO extension, was described as having paranoid schizophrenia, experiencing paranoia and displaying disinhibited behaviour. These behaviours had, in the past, resulted in the patient 'pushing one of the other residents in the back', with the consequence of detention in hospital and a CTO, as the patient 'was refusing to comply with medication'. This suggests, in this case, that treatment provides a means of risk management, and this takes precedence over benefit to the patient.

As with Mary's account, Flora, an AMHP, considered other factors relevant to CTO consideration, but in this case, they too were secondary to the need for treatment. Flora, in conversation with Norman, her RC colleague, when speaking about a patient from whom she had agreed a CTO, described the CTO as a 'very positive use'. This statement was based on her view that a CTO provided a less restrictive option to that of a 'low secure placement'. As the CTO progressed, Flora considered guardianship, as a less restrictive alternative to extending the CTO. In the event, she agreed a CTO extension on the basis that the patient was in possession of a knife at the time of their meeting to consider future options.

These accounts by Mary and Flora show that the need for treatment (as a result of perceived risks) outweighed notions of ‘benefit’ to the patient and using ‘less restrictive’ options. In both cases, CTO extensions were agreed, although risks appeared minimal, if at all existent. Mary’s patient had in the past remained well for a prolonged period of time in the absence of treatment, and Flora, with knowledge that her patient carried weapons, maintained throughout interview that he posed no risk to others, and yet continued use of CTOs was imposed in both cases for the purpose of treatment. These accounts further illustrate AMHPs’ adoption of a biomedical approach to mental disorder, to the exclusion of alternative approaches. This is illustrated by Mary stating, ‘there was very little option in terms of how else do we cover this’, when offering justification for her decision. This response might be a result of a lack of alternative means of managing behaviours associated with mental disorder and professional concern for accountability. Given the account by Tony (above) in which he explained the ability of the patient to stay well for a prolonged period of time in the absence of treatment, it suggests that Mary’s intervention was motivated by a greater desire to protect professionals as opposed to the patient.

Overall, the perceived need for treatment was evident in RC and AMHP participant accounts, although differences in approach were evident among the professional groups. RC participants were more inclined to limit their justification for CTO consideration to the need for treatment to prevent behaviours associated with mental disorder, while some AMHP participants showed consideration of broader issues - for example, benefit to the patient and using the less restrictive options. However, the desire to prevent some risk behaviours by the administration of treatment prevailed. An exception to this was, however, evident in the account by Reg, an RC, during interview with Desmond, an AMHP colleague. In contrast to the above accounts (of joint interviews), Desmond, the AMHP, was first to answer the question ‘How do you come to consider CTOs?’, with concern for treatment, while Reg was more concerned with patient perceptions:

> ***Desmond:*** *I explore whether the person has clearly displayed revolving door syndrome.*

Desmond's reference to 'revolving door syndrome', used as short-hand to describe deterioration in mental health as a result of disengagement with treatment, resulting in readmission to hospital, indicates reliance on a biomedical approach to mental disorder. In contrast, his medical colleague started his response by expressing the patient's view of CTOs:

> ***Reg:*** *I think that CTO has got a very negative perception by patients, so the key for us is to have a therapeutic engagement with the patient so that is something we always have to keep in mind how the person will take that on board. But I think that the underlying factors are the same: one is what the pattern of illness has been, the other areas around the severity of current relapse and the risk to them and others, and I think the other important thing is when we see, at the point of discharge, more or less we tend to have a clearer picture around whether the person has got good understanding, good insight, because I think the two protective factors are insight and engagement, so if there is good insight from the person, then there is a chance that they will engage better and then we don't necessarily have to use those kind of additional safeguards of the CTO to prevent relapse.*

While mention is made of the patient's view and the need to engender a 'therapeutic engagement', his later comments suggest that engagement needs to be in accordance with a biomedical approach. This was evident in Reg's use of the terms 'take on board', 'pattern of illness', 'good insight', 'protective factors', and use of the words 'relapse' and 'risk'. Reg later went on to speak of his 'responsibility', in the context of discussing emergent risks and the need for CTO recall.

These factors are predominantly linked to the need for a CTO to prevent relapse and associated risk behaviours, thus indicating that the management of risk behaviours prevails over other factors relevant to CTO consideration. This, as with Mary's account (above), suggests that professional responsibility is likely to drive risk-averse practice, resulting in greater controls being exercised by professionals over patients than may be necessary. Having established the need for treatment, and the driving force behind this, data is now presented to illustrate how treatment is understood by participants.

What is treatment?

Discussion about treatment was dominant in all participant accounts. However, participant accounts showed a narrower interpretation of treatment than that of the MHA. Medical treatment, for the purpose of the MHA, is defined as including, 'nursing, psychological intervention, and specialist mental health habilitation, rehabilitation and care … the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations' (s145, MHA). This definition includes a range of possible interventions. However, analysis of the data showed that treatment is narrowly construed as medication treatment. Treatment is described by participants as 'medication', and less frequently by use of drug names. Consideration of other forms of treatment was less evident within participant accounts.

Reference to medication as treatment for mental disorder was common across RC and AMHP conversations, and was evident in professional accounts of different stages of intervention into the lives of patients. The following account by Alice, an AMHP, interviewed alone, offers her explanation of initial CTO consideration.

> **Alice:** *Because he has this longstanding history and he has had frequent admissions, we were wondering whether a CTO perhaps might provide a framework to ensure that he takes his meds.*

Here, behaviours associated with mental disorder were explained, and administration of medication as part of a CTO was seen as a response. The imposition of treatment is achieved by the use of CTO conditions. Flora's account (below) showed the dominance of medication administration as a condition of CTOs. Unlike Alice, Flora, during her individual interview, was speaking broadly about CTO conditions, as opposed to an individual patient; therefore, she was expressing the commonality of treatment to CTO conditions:

> ***Flora:*** *I suppose they usually say something about medication first - to continue to take your medication as prescribed.*

The importance of medication compliance was also evident when considering the necessity of recall to hospital. Siri, an RC (during a joint interview) when explaining her role in the CTO recall process highlighted the relationship between medication compliance and recall to hospital:

> ***Siri:*** *For some reason, if they are on a CTO, some patients accept their medication and we have not had to recall many of them.*

The relationship between compliance with medication treatment and the exercise of power is evident within these accounts. CTOs are used to ensure and maintain compliance with medication treatment. This operation of power may be continued by means of extending the order, as was evident in the following account by Reg, an RC, who was explaining his justification for a CTO extension, during a joint interview:

> ***Reg:*** *Depot medication was not his cup of tea and I think without that [the CTO extension], I don't think we would have sustained his engagement.*

These accounts show the importance of medication treatment from the perspective of participants at all stages in a patient's treatment. CTOs are therefore used as a means of enforcing such treatment, with the intention of correcting concerning behaviours, bringing about a normal state. In fewer instances, drug names were used by participants, as opposed to the generic term of medication. However, like the term 'medication', drug names denote the need to intervene for the purpose of compliance and correction. James, an AMHP, interviewed alone, when speaking about a patient with whom he worked, explained that a crucial factor in deciding between statutory provisions was the 'prescription of depot Olanzapine'. Here, the most powerful provision (s17 MHA) was utilised to ensure its administration. In contrast, Desmond, an AMHP, during an interview with Reg, his RC colleague, when speaking about the decision to end a CTO explained, 'We felt the Clopixol was capturing the negative effect of the cannabis as well as dealing with the mental illness and he has remained well for quite a while'. Here, treatment was seen as having achieved its aim. However, the decision to end the CTO was on the basis of the patient's voluntary continued compliance, with a clear message that MHA assessment and detention were available to professionals should the patient stop his medication. In this case the CTO was removed, but professional power was retained. The patient was free from compulsion but his personal autonomy was under threat.

As with use of the term 'medication', reference to drug names was common to both professional groups. This focus on medication treatment within participant accounts further demonstrates the dominance of the biomedical approach to mental disorder and assumes the ability of medication treatment to alter concerning behaviours considered a 'risk'.

Some participants who referred to medication as treatment for mental disorder, also made reference to alternative means of treatment, but this was rare. Reference to alternative treatments included occupational therapy and psychological support. In the following excerpts by Norman, Joe and Hugo, reference was made to specific patients during separate interviews. Norman, an RC, spoke about occupational therapy when discussing a patient's care plan, within a joint interview. Joe, an AMHP, referred to psychological support when discussing a patient’s hostility towards treatment, during an interview with Siri, his medical colleague, and Hugo was making reference to a patient’s demeanour, described as ‘invading’ of other’s ‘space’ during a joint interview. Tony, an RC, in contrast, was talking more broadly about what the use of CTOs aims to achieve, during an interview with Mary, his AMHP colleague.

> ***Norman:*** *He sees an occupational therapist [OT] here on the ward and he sees him almost every week in the community even if he is very, very unwell, he will somehow meet with him. So there is some engagement.*
>
> ***Joe:*** *He had a lot of psychology in the secure unit around social cues and social things.*
>
> ***Hugo:*** *He didn't seem to want to use psychology. There wasn't a sense that he was wanting any part of the ward, it was complete rejection.*
>
> ***Tony:*** *If they have got other things like Personality Disorder, it is not useful because you cannot force them to engage in psychological work.*

Norman’s account stands apart as the only account in which a patient was receiving an alternative means of treatment as a community patient. In the accounts by Joe and Hugo, reference to alternative means of treatment were made in the context of patients while detained in a hospital, prior to CTO consideration. Norman’s account also differs in that he implied a willingness on the part of the patient to engage. This is evident in Norman’s use of the phrase ‘there is something there for him to keep coming back’. In contrast, the accounts by Hugo and Tony suggest by reference to ‘complete rejection’ and ‘force’ that their patients were unwilling to engage in alternative treatment. The purpose of these alternative treatments was not evident within the accounts other than Joe’s, in which it is clear that altering concerning behaviours was the focus of treatment.

It is of interest that only one community patient, discussed among participants, was described as engaging with an alternative treatment to that of medication, although this patient was also prescribed medication treatment and was subject to daily monitoring by staff to ensure its administration. It is clear from Norman's account, along with Flora, his AMHP colleague, that the patient remained 'paranoid', and so he might, as a result, lack capacity to understand the requirements of a CTO. His engagement might therefore be a result of a misunderstanding about what is expected of him, although this is not clear from the data. Overall, the data showed little concern for alternative treatments, and where they were referred to, the purpose of these alternative approaches was not clearly explained. This is in contrast to frequent references to medication, the purpose of which was clearly articulated. In the exceptional case in which Tony, an RC, referred to the need for interventions to enhance 'activities of daily living', finding a 'purpose', and 'meaningful occupation', he explained, a 'CTO isn't going to change that … all those things fall by the wayside and the CTO, giving them treatment becomes the main purpose'. This account offers an understanding that use of CTOs, as is evident within participant accounts, is for the purpose of medication treatment administration. Alternative treatments that may be beneficial in addressing symptoms and behaviours resulting from mental disorder, or indeed the underlying problem, are seldom discussed and their purpose is not clearly defined. The result is the maintenance of a biomedical approach, based upon expert knowledge, offering justification for professional intervention.

Ensuring compliance with treatment

Having established the need for treatment, and participant understandings of treatment, the following accounts illustrate the dominant theme of ensuring compliance by means of compulsory measures. Alice, an AMHP, interviewed alone, makes clear the need for CTOs in managing treatment maintenance when asked about typical cases for CTO consideration:

> **Alice:** *There were concerns about people having difficulties to maintain medication and things deteriorating, some slower but some quite quickly without that framework well without the medication.*
> **Debbie:** *So do you think medication is one of the key issues for using CTOs from your experience?*
> **Alice:** *From my experience, yes.*

Here, deteriorating mental health is solely attributed to an absence of 'medication' treatment; as such, CTOs provide a means by which to ensure compliance. Alice's comments came in the context of a broad question, as opposed to a discussion about a specific patient. Her account therefore indicates her general view that enforced treatment is necessary to prevent poor mental health and, as such, CTOs are justified as a means of achieving this. Similar views were evident among participants when discussing specific patients. In the following accounts by Norman and Tony, both RCs, and Sam, an AMHP (all of whom participated in joint interviews), the need for CTOs for the purpose of ensuring medication compliance is evident. Norman and Sam were offering justification for CTO use, and Tony was explaining what would determine an extension of a CTO for a patient with whom he was working:

> **Norman:** *There is no way you could manage him without a CTO. He just stops treatment.*

> **Sam:** *To me, if he didn't have his CTO he wouldn't take his medication, he would be back in hospital.*

> **Tony:** *If it is clear-cut that the risks are high, and they are not going to comply with treatment, then I think there is probably quite a strong argument to use a CTO in that case.*

Each of these accounts, while making explicit the need for treatment, show professional concern for the governance of patients: Norman, by use of the term 'manage', Sam, by his explicit links between non-compliance with treatment and the consequent need for confinement in a hospital, and Tony, by his explicit links between risk behaviours, compliance and the need for a CTO. All accounts therefore highlight the perceived need for treatment as a means of governance of problem populations by means of a CTO.

There are, however, some exceptions to the idea that CTOs provide sufficient power to ensure treatment compliance. The following excerpts by James and Charlie, both AMHPs, illustrate concern for the limitations of CTOs in achieving their policy aim, that of ensuring treatment compliance. James, an AMHP, interviewed alone, in contrast to the above accounts, declined a CTO in favour of s17 leave of absence. Patients subject to s17 MHA remain liable to detention (under their detention section); as such, they remain subject to compulsory treatment and may be recalled to hospital with greater ease than those subject to CTOs. His argument for use of s17 leave of absence was the greater power it offered to ensure treatment compliance. In this case, the administration of depot[47] medication needed to take place in a hospital, and James was of the view that the patient would not accept this. He explained: 'there was no way that I thought he was going to voluntarily do this unless he really felt there were hard-edge sanctions of the actual Mental Health Act, of the actual s3 rather than CTO'. When asked what s17 leave of absence would achieve, he answered:

> ***James:*** *I guess what was trying to be achieved was to keep him concordant with medication above all.*

Of interest is James's use of the word 'concordant', implying agreement. Clearly, from the accounts given, the patient was not in agreement with treatment - quite the opposite - s17 was being used in preference to a CTO because of the patient's unwillingness to comply with the proposed plan, that of depot medication treatment in

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[47] Treatment by means of injection.

a hospital. It is unclear form the account whether use of this word is intended to soften what is an obvious exercise of power. James described the patient as having been frequently recalled to hospital (even when taking medication), as a result of risk behaviours consequent to mental disorder. These behaviours included ‘self-neglect’, ‘not being locatable’, ‘assault’ and ‘historic suicide issues’. Assault and suicide if materialised could be argued to represent ‘danger’ and as such legitimise the use of greater power over the patient.

Concern for the lack of power afforded by CTOs was shared by Charlie, an AMHP, interviewed with his RC colleague, Hugo. Charlie’s comments about this lack of power came in response to Hugo’s assertion that he had narrowed his view about the usefulness of CTOs to those with a schizophrenia-type illness, who have sufficient understanding of the limits to CTOs, to which Charlie replied:

> ***Charlie:*** *It's not powerful enough, is it? I mean, if we narrow it down, then the people that should be on a CTO it works for, then we take into consideration the view about it being potentially deceitful with people for thinking they have got to have treatment. Wouldn't it be better if it actually did mean that they had to have treatment?*

Here, Hugo was expressing concern about the potential for patients to think that CTOs are more powerful than they are, seeing this as an inappropriate exercise of power. Charlie, however, rather than wishing to shy away from CTO use, expressed a desire for greater powers. In these accounts, James was speaking about a specific patient, while Charlie and Hugo were speaking more generally. It is, however, of interest that neither of the patients they had chosen to speak about in interview were made subject to a CTO. James declined a CTO in favour of the greater power afforded by s17 leave of absence, and Charlie and Hugo decided against a CTO on the basis of the amount of force necessary to administer treatment and the pleasure the patient appeared to derive from force:

> ***Charlie:*** *There was a sense that he enjoyed the physical contact, possibly even on a sexual level.*

The distinction between these two cases is perceived risk; James's patient posed a risk to others and a potential risk of suicide, while Charlie and Hugo's patient was viewed simply as posing insignificant risk to himself. As Charlie explained, 'the stuff around aggression was very much more intimidation, verbal, there were no physical assaults on anybody … the main thing was around neglect'. In this case Charlie and Hugo were prepared to take the 'risk' that 'he might say no to everything and end up spiralling down very quickly'. However, as these risks were largely to himself, as opposed to others, the patient was discharged from detention and hospital, with no community compulsion. This disparity of approach further supports theories of governmentality in which populations considered a risk are in need of correction (Castel, 1991), yet those considered less concerning in their behaviours fall from professional oversight and any notions of care are lost. These accounts also lend weight to the argument that compulsion is used to protect professionals from the repercussions of risk to others; better to intervene on a preventive basis by enforcing treatment compliance.

Means of treatment administration

Having already established medication as the preferred means of treatment for mental disorder and the need to ensure compliance, the method of its administration is also important. Frequent use of the term 'depot' showed a clear preference amongst participants for medication to be administered by injection. Participant accounts showed that patients cannot be trusted to take oral medication. As a result, treatment administered by injection is preferred, as it provides certainty of its adherence. Depot medication, ensuring regular administration, is also seen to be successful in preventing hospital admissions. This preference for depot medication is not however shared by patients.

The following accounts illustrate a lack of trust amongst participants in patients taking their medication. Reg, an RC, in interview with Desmond, his AMHP colleague, explained that depot medication was necessary for a patient for whom he had agreed a CTO extension:

> ***Reg:*** *I don't think he was trialled on depot medication before and I think that made a difference because we could be more sure that he is getting the medication so there is more likelihood that whatever work we would do would not fall on deaf ears and he could engage.*

Reg's use of the phrase 'more sure' implies a lack of trust, and the word 'engage' appears at odds with one another. Reg first indicated a lack of trust in the patient's willingness to take treatment, and then made mention of engagement. Use of the word 'engage' is of interest as it implies agreement, yet it is clear from Reg's account that the patient was not of his own volition accepting a depot. Reg, during discussion explained: 'I think we used CTO proportionately to sustain his engagement, develop the relationship and also to get him on our side'. Here, the professional expectation is that the patient will comply with the CTO and all it entails. This approach is at odds to Reg's earlier assertion when explaining his role in which he said, 'so the key for us is to have a therapeutic engagement'. This statement was, however, general, as opposed to being patient specific. This might suggest greater reliance on coercive power where professionals feel the weight of responsibility for specific patients.

Participant preference for depot medication was driven by their concern about reliance on oral medication. The following accounts from separate interviews with Hugo and Norman, both RCs, and Joe, an AMHP, made clear their reluctance to rely on oral medication. Hugo's comments came in the context of talking generally about a typical CTO case during a joint interview. Joe was speaking about a patient's dissatisfaction with treatment, during an interview with Siri, his RC colleague, and Norman, during interview with Flora, was speaking about an exceptional case in which he agreed oral medication for a CTO patient, for fear of losing contact with him.

> ***Hugo:*** *Oral treatment it is a waste of time.*

> ***Joe:*** *I wouldn't be really keen to put them on a CTO if they are on oral medication. You cannot really monitor it very well.*

> ***Norman:*** *I have not even considered CTO for anyone who is on oral medication. For me, I don't think there is any point … people won't take their treatment and there is no way to monitor that apart from they can become unwell, so what is the point in having a CTO, you might as well use a Section 3?*

Concern for reliance on oral medication rests on the inability of professionals to properly monitor its adherence, as such medication administered by injection allowing gradual absorption is the preferred means of administration. An exception to this was evident in Norman's account in which he agreed oral medication for a patient subject to a CTO. This agreement was based on concern for losing contact with the patient due to his vehement objections to an injection, and the ability of staff in the residential establishment in which the patient lived to monitor him taking medication 'five days a week'. Norman, an RC, explained during a joint interview, 'at least we know he is taking his treatment'. In this case, the means of administration differed to depot, but the effect was the same: professionals have certainty that treatment is adhered to, thus maintaining power over patients.

There is, however, evidence that some consideration is given to altering the means of medication administration as a result of patients' reluctance to accept depots. Desmond, an AMHP, when speaking about a patient for whom he had agreed a CTO, during a joint interview explained:

> ***Desmond:*** *He [the patient] is consistently asking for oral medication, and there is a fear that if he went back to oral, he may not comply and we may then lose the good things we have gained, and that's a dilemma.*

Use of the word ‘fear’ gives some indication of professional concern for the re-emergence of behaviours associated with mental disorder as a result of medication changes. Charlie, an AMHP, in interview with Hugo, his RC colleague, discussed what he called a ‘dressing down’ by a Second Opinion Appointed Doctor (SOAD),[48] who questioned continued use of depot medication in the face of a patient’s willingness to accept oral medication. Charlie explained: the SOAD ‘gave a timeline and said you need to get them off the depot and on to oral because they are accepting oral’. In response to this, Charlie advocated making changes to treatment while patients were subject to a CTO (as opposed to after discharge from community compulsion). Hugo referred to this approach as providing a ‘safety net’.

> ***Charlie:*** *If somebody is clear that they will stop their medication on ending the CTO, then probably the thing to do is to change or stop the medication while the person is still on the CTO to see and assess their response. Then, if they don't relapse, you discharge the CTO at that point, rather than discharge it and then they stop their medication.*

While showing some willingness to consider changes in line with patient preferences, the positions of Charlie and the SOAD differ. Charlie’s approach involves a trial while retaining power to treat. This is in contrast to the reported approach of the SOAD, who said: ‘you need to get them off the depot and on to oral because they are accepting oral, even though history would suggest that they are going to relapse every time on oral; you need to manage it and get them back on the ward’. These differing approaches are of interest as both SOADs and AMHPs are intended to offer safeguards to patients subject to the MHA. Here, Charlie appears more concerned with managing relapse and readmission and the SOAD with patient preferences. This might be a result of their differing responsibilities for the patient’s ongoing care, as SOADs simply offer an

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[48] SOADs offer independent oversight of medication treatment for CTO patients, either lacking in capacity to consent to treatment, or those making capacitous refusals of treatment.

independent view, with no ongoing responsibility for the patient, whereas AMHPs, being employed by the care provider, may have ongoing responsibility for the patient, and if not, at least carry professional accountability. The result is greater exercise of professional power as opposed to emphasis on patient choice and autonomy.

This concern to maintain depot medication to avoid hospital admission was not, however, unique to Charlie. The following accounts by Ben and Charity, both RCs, interviewed separately, but as part of joint interviews with AMHPs, showed a professional perception that depot medication 'works', insomuch that it prevents readmission to hospital. Both accounts are given in the context of discussing specific patients.

> ***Ben:*** *I have got one person who's on a depot. As a result, she has been out of hospital I think as a direct result of the fact that she is having treatment after a lot of readmissions. She has been out of hospital for over a year.*

> ***Charity:*** *[The in-patient doctor] had commenced a depot which had worked well for him, so he was mentally settled when we saw him, although insight was only partial still. So we felt to keep going with the depot would be the best way of him staying well and out of hospital, so the extra regulation of the CTO was a good idea.*

While the data supports the idea that depot medication prevents readmission to hospital, refusal of a depot was cited by participants as the main reason for CTO recall. The operation of recall allows patients to be returned to hospital and be kept there for up to 72 hours, during which time they may be forcibly treated. As Norman, an in-patient RC explained, this leads to doctors who are less familiar with the patient, making decisions about forcible treatment. The following exchange between Norman and his AMHP colleague highlights this difficulty:

Norman: *It (CTO 11 form)*[49] *also said if this person comes into hospital on a recall and is still refusing treatment, treatment can be given in that circumstance. So I check the certificate, so I give the treatment that they have missed and send them home within the 72 hours.*

Flora: *Can you do that?*

Norman: *Yes.*

Flora: *Doesn't it irritate the community RC?*

Norman: *No, they are happy as long as the person has the depot.*

Flora: *Oh, yes, of course they are.*

This exchange suggests that depot medication, preventing readmission to hospital 'works' by coercion. Failure on the part of patients to comply in the community results in recall to hospital for the sole purpose of enforcing treatment by means of injection in the face of resistance. This biomedical approach therefore legitimises professional intervention, but does little to engender partnership working, patient autonomy or self-regulation. Further evidence of treatment in the face of resistance is set out below.

Treatment in the face of resistance

Analysis of the data shows that participants consider compulsory treatment necessary as a result of patient objections, and that a desire for patients to be able to self-manage mental disorder is rare. As a result, use of CTOs, or alternative compulsory measures, ensures the administration of treatment in the face of patient objections. In the following excerpts by RC and AMHP participants, patient objections to treatment are made clear. The first two excerpts are by Hugo, an RC. First, he makes reference to patient objections when discussing the range of MHA options available to professionals - for example, sections 3 and 17 of the MHA; as such, his comments are general. The

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[49] Certificate of appropriateness of treatment to be given to community patient.

second extract from conversation with Hugo is concerned with a specific patient. Both accounts were given during a joint interview with his AMHP colleague.

> ***Hugo:*** *Some [patients] are implacably opposed to any form of treatment.*

> ***Hugo:*** *He really was not prepared to accept treatment.*

Hugo went on to explain that while patients are opposed to treatment, they 'will accept the idea of a CTO'. This, however, was in the context of discussing alternative means of imposing treatment (ss3 and 17 MHA), which may be viewed as more restrictive of patient freedoms. These accounts suggest general and specific patient objections to treatment, albeit patients may accept treatment as part of a CTO, if viewed as a lesser restriction than remaining liable to detention. The following excerpts, concerned with specific patients, taken from separate interviews with Hope, an AMHP, and Tony, an RC, similarly show reluctant acquiescence. Both accounts are taken from joint interviews.

> ***Hope:*** *He was complying with everything, although he didn't agree with it.*

> ***Tony:*** *He didn't want to take medication, but he accepted it.*

Hope's account, by use of the phrase 'didn't agree', suggests a difference of opinion on the part of the patient. This was later clarified in conversation with Hope, who stated, '[he] did not agree about his diagnosis'. Disagreement with treatment is therefore on the basis of a differing view from that of professionals. This was evident in the following account by Charlie, an AMHP, when speaking about a specific patient during a joint interview with his RC colleague.

> ***Charlie:*** *He was very anti-psychiatry and he wrote a 45-page letter to Dr [name], his community psychiatrist. He just had a different interpretation of his issues and they didn't involve having medication.*

These accounts show differing perspectives of mental disorder between patients and professionals, and a professional expectation that patient perspectives should mirror that of professionals. While some participants show a desire to engage patients, professional perspectives prevail. Ben, an RC, in interview with an AMHP colleague, indicated his efforts to engage with patients. However his and other participant accounts showed that professional control is unlikely to be relinquished unless patients subscribe to a biomedical approach to mental disorder, and in doing so, accept treatment.

> ***Ben:*** *[We] try to engage with that person, but if there is that area which is very often about medication, erm, of having to agree to differ, if there is a way of generalising it, it can be difficult to have that space to agree to differ.*

Here, Ben is making clear the dominance of the medical paradigm. This dominance and the subordination of alternative perspectives of mental disorder is a common theme within the date. This approach brings with it an inherent inequality, but concern for this inequality is rare. Flora, an AMHP when interviewed alone suggested that she would be less inclined to agree a CTO for a patient vehemently objecting to it. However, she couldn't recall a patient making such a staunch objection, commenting, 'Maybe they wouldn't be honest with me, though. They wouldn't be saying "well, I'm not taking these tablets anyway". I don't think they would say that. They are trying to get out [of hospital]'. This data therefore shows evidence of coerced consent; better to accept treatment in the community, as opposed to forcible treatment as a detained in-patient, representing Hobson's choice.

Patients are therefore coerced into compliance. This professional coercion (governance), according to Foucault's theory of governmentality, would then lead to patient self-regulation. However, data did not, in the main, support a professional desire or expectation for this outcome. Few participants expressed a desire for patients to take control of their mental disorder, thus freeing patients from the exercise of professional power. Where this desire was articulated, it appeared that taking control of their illness meant subscribing to the biomedical understanding of mental disorder. The following excerpts by Reg, an RC, during a joint interview with Desmond, and Flora, an AMHP, interviewed alone, showed some inclination towards patients taking control of their mental disorder.

> ***Reg:*** *My philosophy is to work with them as it is their illness that we are supposed to support them in understanding and it is for them to take charge. We share the range of options that are available to manage. I feel it is their responsibility and we should encourage them to take it. But CTO has been used to good effect in some situations.*

Reg, while expressing a desire to 'work with' patients, used the terms 'support them in understanding', and 'manage', suggesting an expectation that patients accept the professional perspective and manage their mental disorder according to that perspective. The likelihood of patients accepting this professional perspective was discussed by Flora, when asked whether she hoped patients would see the benefit of treatment, to which she replied, 'Is that naive, yes … maybe that's a hopeless hope, isn't it, but I still hope'. However, Flora later in conversation went on to suggest that patients often stop treatment for good reasons, describing some treatment as 'nasty', and so showed some sympathy for the patient's perspective. This sympathy was, however, later undermined when she was asked about the benefit of CTOs, to which she explained that they provide, 'a little bit of coercion to stick with the programme'. This again showed an expectation that patients subscribe to a biomedical approach to mental disorder, and in doing so give themselves over to governance.

These accounts, while on the face of it are concerned with patient engagement, autonomy and wishes, are all fundamentally concerned with the governance of patients within a medical paradigm, even where, as is evident in Flora's account, the negative aspects of treatment are recognised. Flora is not alone in recognising the ill effects of treatment, as is evident in the data presented below.

The ill effects and inefficiency of treatment

Despite the overwhelming evidence in support of enforced medication treatment among participants, there is evidence within the data that medication treatment has ill effects and may be ineffective in fully managing the symptoms and associated behaviours of mental disorder. Ben and Hugo, both RCs in separate interviews with AMHPs, considered the potential ill effects of treatment when speaking about CTO use generally and in relation to specific patients. Ben, when speaking more generally, talked about the need to reduce medication for those being considered for a CTO. Ben's account reflects his discussion with patients as a contract, a trade-off between acceptance of a reduced amount of medication (sufficient to avoid readmission to hospital) to avoid the inevitable increase in treatment in response to an acute phase of illness, administered as an in-patient. Hugo's account, although less explicit, is concerned with patient engagement and treatment. In both accounts the potential ill effects of treatment were evident.

> **Ben:** *I guess what you are talking about there is a framework where you are saying, 'Look, our contract with you is to make sure you are on as little as possible, this is as gentle as possible', rather than being in that acute situation where you are just hammered with loads and loads of stuff and you are stiff as a board and dribbling and shuffling up and down, but it might be 'Well, I'll listen, okay, if that's going to keep you guys away from me and just let me get on with my life, alright then'.*

> **Ben:** *What are the compromises we have got to make in the treatment plan that are going to make it acceptable to the patient? You know, are they going to take this damn stuff when they go out? What about side effect profiles?*

> **Hugo:** *Personally, I suppose what I welcome is that it does mean a slightly more in-depth conversation than we might routinely have with patients, with other people, about their attitude to care, their likely ongoing engagement, the likely benefits from treatment, the likely drawbacks from treatment.*

> **Hugo:** *As the years had gone by I had become more and more of the view that medication had actually been unhelpful to him rather than helpful, with both a mixture of really some quite valid concerns plus possibly delusional concerns to some extent.*

These accounts differ in that Ben's account appears as leverage to engender compliance, as opposed to Hugo's account which appears less concerned with leverage. This difference in approach might be reflective of the differing outcomes of their respective CTO consideration. Ben instigated a CTO for his patient who was perceived as posing a risk to others; in contrast, Hugo decided against a CTO for his patient for whom treatment had been considered unhelpful, while Hugo's patient was not seen as presenting risk to others. Treatment therefore, despite the potential ill effects, will be enforced, albeit in potentially reduced amounts in the face of patient objections, for those considered sufficiently concerning in their behaviours.

Enforced treatment as part of a CTO was seen as unhelpful by Charity, an RC, when discussing a patient for whom she and her colleague Jim had agreed a CTO. When asked whether in hindsight they would make the same decision, she explained that both the treatment and CTO had been problematic:

> **Jim:** *I don't know what happened afterwards.*
> **Charity:** *He's been back in like a yo-yo ever since.*

> ***Jim:*** *Has he? Recall, then?*
> ***Charity:*** *He's had recalls. He's been recalled a number of times and then agreed to stay informally with us. This time he was redetained and is back on a [section] 3 anyway …*
> ***Charity:*** *So it [the CTO] really hasn't made an impact on him. Part of that is actually the fact that it has been really difficult to get his medication right. He was on such a big dose and he had side effects, so although we tried to reduce it, it just flattened him, so he has been really low and unmotivated. So was more of a suicide risk. He hasn't gone back to ICU [intensive care unit], but realistically it is the medication that has been the problem and he is back on a [section] 3. I'm not sure the CTO has made any difference.*

The response to these stated difficulties with medication was to 'change his medication again'. Charity went on to explain that the CTO, and the time necessary to operate its recall mechanism, had delayed their ability to make such changes. She argued, 'we could have probably done all of this sooner' had the patient been detained under a section 3 MHA as opposed to subject to a CTO. This showed that medication is the response to mental disorder, whether imposed under a CTO or detention in a hospital. The response to the ill effects of treatment is not therefore to reconsider the biomedical approach to mental disorder, but to find an alternative medicine.

Further evidence of the ill effects of treatment can be seen in Tony's account when speaking about a patient for whom he had agreed a CTO, and in the accounts by Flora, an AMHP, when speaking generally about patients stopping treatment, and when speaking specifically about a patient for whom she supported a reduced medication regime to avoid a reduced quality of life. These accounts are from separate interviews. Tony's account forms part of a joint interview, while Flora's accounts are from her individual interview.

> ***Tony:*** *I then started reducing his medication as I thought he was on too much medication. Whether these falls that he had in his flat was anything to do with*

> *medication I could not establish, so we reduced his medication and then once he arrived in the residential home his behaviour started to escalate again.*

> ***Flora:*** *I think they stop it for really good reasons a lot of the time. I think that the drugs are nasty.*

> ***Flora:*** *I think he would be massive and dull, you know. I don't think he would be playing tennis. I don't think he would be going out and about, and doing what he is doing necessarily if he was back and strongly medicated.*

These accounts chart potential falls, nasty effects, being overweight and dull, and a general reduced quality of life as a result of the ill effects of treatment, yet all but one of the patients discussed above were made subject to a CTO for the purpose of enforcing medication treatment. Ill effects and inefficiency of treatment do not therefore stand as a barrier to its continued use under the CTO regime. This is another example of the dominance of a medical discourse and professional power dominating patient autonomy.

Conclusion

In summary, this chapter presents data that shows that participants consider treatment the response to mental disorder for the sample studied – male patients, subject to s3 MHA. This perceived need for treatment is shared among RC and AMHP participants, and is most influential to participant decision-making when considering the use of CTOs or other means of ensuring treatment compliance. While participants did refer to other considerations - for example, RCs referred to engagement, and AMHP participants referred to benefit and less restriction, the imposition of treatment dominated decisions. Treatment was narrowly defined to mean medication treatment, with consideration of alternative approaches being rare. The means of medication treatment was also important, with medication administered by injection being preferred. This was due to the reluctance of patients to take medication of their own accord and a consequent lack of trust of patients among participants. Most commonly, treatment was considered necessary to prevent risk behaviours arising from mental disorder and to make patients well. This desire to impose coercive compulsory treatment was maintained in spite of evidence showing the potential for ill effects and inefficiency in achieving its intended aim. Despite these shortcomings, participants prioritised the biomedical approach, with the expectation that patients either conform to this approach or, more likely, remain subject to long-term compulsion as a result of their resistance.

As with Chapter 4 above, the data presented in this chapter can be understood by reference to Foucault's ideas of governmentality. References to mental disorder, concerning behaviours and the need for corrective interventions to bring about a normal state lend themselves to this theory. The official discourse of mental disorder (to the exclusion of other understandings) and law is adopted by agents with regulatory responsibility. This knowledge becomes 'truth' and is used to separate out the normal from the pathological, thus making people 'subject' for the purpose of manoeuvring 'populations into 'correct' and 'functional' forms of thinking and acting' (McHoul and Grace, 2002, p. 17), bringing about ''useful' obedience' (ibid., p. 68), and self-regulation. This final stage of self-regulation was not, however, evident within the data. This narrow understanding of mental disorder and its consequences, and the limited response of professionals has implications for policy and practice. These implications will be discussed in Chapter 7, below.

The factors influencing CTO decision-making are therefore based on a biomedical understanding of mental disorder and the associated need for treatment. Trust was also influential to participant decision-making. Whether CTOs, s17 leave of absence or the threat of MHA detention was relied upon, coercive treatment was justified on the basis of patients' failure to comply. Concern for risk behaviours resulting from mental disorder were cited most frequently as justification for intervention. Less frequent emphasis was placed on adherence to statutory criteria when making decisions. However, when this was considered, participants placed greater emphasis on 'risk' criteria as opposed to the appropriateness and proportionality of intervening.

Use of enforced treatment therefore sought to achieve risk reduction and improved mental health, yet these justifications were undermined by participant accounts. Frequent references to risk and relapse suggested that the intended aim was not always achieved, and use of CTOs where neither of these appeared imminent highlighted that CTOs may, in some cases, be used to protect professionals as opposed to patients.

This concern for professional protection is one of many factors that points to greater exercise of professional power and control, as opposed to concern for patient care or autonomy. This exercise of professional power was evident in a number of other ways. First, by the dominance of a medical discourse, leaving little room for alternative perspectives. Patients were expected to agree with proposed treatment in order to get out of hospital, and to avoid recall and readmission. On the rare occasion that MHA compulsion was not used (but professional concern for risk remained), the threat of compulsion in the face of non-compliance firmly placed power with the professionals, not patients. Second, consideration of CTOs, either initially or at the point of extension, placed greater emphasis on risk, as opposed to notions of being ‘well’, ‘benefit’, ‘less restriction’ and ‘engagement’, again showing greater exercise of professional power as opposed to concern for patient autonomy. While use of compulsion in the community was viewed as a lesser restriction than that of detention in a hospital, and as a result patients may reluctantly accept treatment, any consent is coerced, ultimately leaving power with professionals as opposed to patients. This appeared to remain the case, as there was little evidence of professional concern for patient self-regulation, other than for those who present minimal risk or risk solely to themselves, in which case they were allowed to fall from professional oversight.

PART 4 Implications for practice, policy and legislation

The final part of this thesis discusses the research findings and offers a number of conclusions through building on the analysis contained within the three preceding empirical chapters. It does this first, by addressing each of the subsidiary research questions and summarising the answer to the main research question. Second, three key themes are discussed in the light of literature and theory. This is followed by recommendations for practice, policy and legislation, before concluding with the contribution to knowledge that the thesis brings and the study limitations alongside areas for future research.

CHAPTER 7 Discussion and conclusion

This chapter begins by addressing the three subsidiary research questions, before addressing the main research question. This is followed by consideration of three key themes emerging from the analysis: the impact of the dominant medical paradigm; risk as justification for intervention; and the protection imperative and its consequences. These themes lead to recommendations for practice, policy and legislation, which have relevance for the mental health professionals charged with responsibility for CTO decision-making.

The research questions

This thesis has used theories of governmentality in order to explore the exercise of power over the psychiatric patient. These theories informed the research questions that inform this study.

Question 1: What influences (conceptual, theoretical and professional) come to bear on those deciding whether to agree to a CTO?

The findings highlight conceptual, theoretical and professional influences on the CTO decision-making process for a specific group; male patients, subject to s3 MHA. Chapters 4 and 6 highlight the dominance of biological concepts of mental disorder, in preference to social perspectives. This dominant biomedical concept of mental disorder was shared by RC and AMHP participants, and was evident in the ways that mental disorder was understood and responded to. Mental disorder was most commonly understood through the use of diagnostic classifications, although use of the terms ‘psychotic illness’, ‘insight’, ‘relapse and readmission’, and ‘madness’ were used. These terms were used in preference to social understandings of mental disorder and were used to define patients and to denote difference, and as a result offered justification for intervention. Intervention was most commonly by use of medication treatment as opposed to other routes, for example, psychological interventions or improved social circumstances. Mental disorder was also understood to result in concerning behaviours that were sometimes seen to indicate ‘risk’ (Chapter 4). While participants did not use formal risk theories, their accounts showed that the label of risk was used for specific groups - for example, those diagnosed as having ‘psychotic illness’. This identification of risks accords with ideas of risk in relation to problem populations through which particular groups of people are targeted for health interventions (Castel, 1991; Kemshall, 2002; Beck, 2003, 2009). Reference to legal criteria was evident at times of CTO consideration, but, like biological understandings of mental disorder, it served to define and legitimise intervention.

Professional influences were also evident within the data. Chapter 5 shows the use of overt processes by AMHPs either to slow down or halt the consideration and implementation of CTOs. This was achieved by imposing time frames in which AMHPs were willing to operate, or by refusal of CTO consideration until a period of s17 leave of absence had been trialled. These administrative and practice processes were reported by participants to have been introduced as a means of allowing adequate time for CTO consideration, to establish the appropriateness of a CTO and to facilitate less restrictive alternatives. However, AMHP accounts showed a preference for CTOs as opposed to MHA assessments, as CTOs were viewed as easier work. That said, an exceptional case showed covert avoidance of CTO consideration as a means of self-preservation against a difficult job. In respect of RCs, hierarchical relations and working practices showed the potential for influencing CTO use. This was evident in two ways: first, those with responsibility for risk assessment influenced those responsible for risk management - for example, assessment of risk by forensic specialists influenced RC decision-making - and second, working practices involving the passing of responsibility between in-patient and community clinicians influenced the making and maintenance of CTOs. These professional relationships and working practices were driven by a better ‘safe rather than sorry’ approach (Kemshall, 2002, p. 9) focused on professional protection. This approach was exacerbated by the unavailability of resources – specifically, hospital beds - and alternative means of providing care and treatment, as is evident in Chapter 5.

Question 2: How do professionals account for use of CTOs and what are they seeking to achieve by their use?

Both RC and AMHP participants justified CTO use for the specific sample studied on the basis of avoiding behaviours associated with mental disorder, by encouraging compliance with treatment to reduce the symptoms of mental disorder (Chapters 4 and 6). These anticipated behaviours for patients refusing treatment broadly fell into two categories: risk to others and risk to self. Risk to others dominated accounts and typically described aggressive, assaultive behaviours from patients: risk to self included self-harm, offending behaviours, neglect and reduced quality of life. However, not all mental disorders or consequent risk behaviours were seen as warranting intervention. Intervention was seen as justified in cases of low-frequency/high-impact risks - for example, assault and suicide. Where these behaviours warranted intervention, Chapter 6 showed a dominant view among participants that the imposition of medication treatment was the means by which risk behaviours could be ameliorated or eradicated. Enforced medication treatment administered by injection was viewed as necessary as a result of patient objections, and in fewer cases was seen as necessary in the absence of any alternative means of treatment. However, despite this dominant view, some participant accounts highlighted the ill effects and inefficiency of CTOs in achieving this aim, although this did not result in treatment being stopped.

Aside from considerations relevant to patients and the public, interdisciplinary dynamics and resources were also offered as reason for CTO use. Interdisciplinary dynamics were demonstrated through in-patient RC participants passing responsibility for patients to their community colleagues, thus freeing hospital beds (Chapter 5). While participant accounts indicated that community clinicians were reluctant to accept responsibility for CTO patients, they maintained them on the basis of a better to be 'safe rather than sorry' approach (Kemshall, 2002, p. 9). Both processes highlighted participants' desire to protect themselves from repercussions should adverse incidents occur (Rose, 2009). An alternative justification for CTO use was to ensure that services maintain contact with patients. This was acknowledged to be a reversal of what

Government intended, but was seen as necessary given the propensity for secondary services to discharge patients back to primary care. Finally, notable by its absence, neither RC or AMHP participants accounted for CTO use to enable patients to move to a position of self-regulation. The balance of care, control, patient autonomy and professional power are discussed below.

Question 3: How do these accounts reveal the balance of care and control over the psychiatric patient, and reflect notions of personal autonomy and professional power?

Inevitably, there are overlaps between concepts of care, control, personal autonomy and professional power. For example, it may be argued that the exercise of control is necessary in order to provide care. However, an attempt has been made to draw a distinction between these concepts to assist in revealing the dominant themes. The less dominant themes of care and personal autonomy are presented first, before addressing professional power and control. The data is presented in this way as a growing picture of professional power and control emerges before restating the main research question, and it is this dominance of professional power and control that most clearly helps address the main research question.

Care

Participant references to notions of care were rare. However, when discussing treatment, the imposition of medication treatment was justified as ‘care’, ‘benefit’ and offering patients a chance to maintain stable mental health, thus avoiding hospital admission (Chapters 4 and 6). However, these notions of care were undermined by the acknowledgement of the ineffectiveness and ill effects of treatment. For example, Charity, in Chapter 6, referred to the effects of medication treatment as leaving a patient ‘flattened’, ‘really low’, ‘unmotivated’ and resulting in ‘weight gain’. Despite these effects, the response was to find an alternative medication treatment, as opposed to adopting another approach. Similarly, the absence of care was evident in participants’ lack of response to the social effects of mental disorder. For example, references were made by participants to the negative impact of mental disorder on a patient's culture, the removal of a patient's driving licence, poor familial relationships, patients' desire for a relationship and poor living environments, but these were not central to CTO decision-making. These accounts indicated a lack of concern for behaviours not elevated to that of 'risk'. At best, these social factors were improved unintentionally; at worst, they were simply neglected. Similarly, illicit drug and alcohol use (common to accounts) was not elevated to that of 'risk' and as a result did not warrant intervention.

The lack of resources also led to reduced care. The dearth of hospital beds results in detained patients being moved to far distant places, impacting on their ability to maintain social contacts and to be granted leave from hospital. Alternatively, premature discharge from hospital onto a CTO may be facilitated to free hospital beds. As Tony, an RC, put it, patients are sent out 'half-cooked', resulting in patients being set up to fail. Similarly, the lack of hospital beds was reported to cause problems at the point of CTO recall to hospital. Recall cannot be effected without the identification of a hospital bed. In the absence of this, patients were reported to be left in the community (when in need of hospital admission), were admitted to leave beds (preventing patients liable to detention from returning to hospital) and were moved to a different geographical area (resulting in treatment by staff unfamiliar with the patient). In an exceptional case, use of police powers under s136 MHA was discussed as a response to an inability to recall CTO patients to hospital. All of these responses raise questions about the quality of care and indicate a lack of reciprocity for those subject to coercive controls.

Patient autonomy

The use of CTOs was argued by RCs and AMHPs to be a less restrictive means of providing care than that of patients remaining detained in-patients, and this relative freedom was argued to engender greater autonomy. For example, in Chapter 5 the involvement of an AMHP at the point of CTO consideration was argued by Flora, an

AMHP, to provide an ‘advocate for the patient’ and to enable the consideration of ‘less restrictive’ options. Similarly, when speaking about the purpose of CTOs, RCs talked of sustaining ‘engagement’ and advocated CTOs as a less restrictive alternative to remaining a detained in-patient. This concept of least restriction was not, however, greatly elaborated by participants, other than as a means to get patients to leave and stay out of hospital through enforced treatment. Aside from this perspective, it was not clear how ‘greater autonomy’ was defined. What is clear from the findings is that such autonomy is subject to restrictions and comes at a price to the patient. Irrespective of patient perspectives of mental disorder and their views of their own needs, treatment is enforced, as the primary purpose of CTOs is to enforce medication treatment (Chapter 6). The amount of medication given may, however, be reduced, as Ben, an RC, explained, as a trade-off against readmission to hospital and the inevitable increase in treatment as response to an acute phase of illness. Such a compromise is unlikely to be rejected, representing Hobson’s choice. Thus consent is coerced.

Professional power

The findings showed use of professional power to define patients, to intervene in their lives and to treat against their wishes (Chapters 4 and 6). In some instances, participants showed a desire for more power either by utilising other MHA measures, by discussing the inability to forcibly treat resistive, capacitous, CTO patients in the community, or by suggesting working practices to exert power. While there was evidence of participants lamenting the loss of less restrictive interventions, aspiring to better service provision, and raising concern about patients being misled about CTO powers, these did not act to counterbalance the use of coercive powers.

Use of expert knowledge, whether medical or legal, served to set patients apart from a ‘normal’ state and to elevate the status of mental health professionals above patients, thus placing them in a position of power. This knowledge was not shared by patients, and divergent patient views were labelled as showing a ‘lack of insight’. Furthermore, this lack of insight was seen to lead to poor decision-making by patients

(Chapter 4). This then legitimised professional power through showing that the 'right' decision had been made, yet CTO decision-making commonly lacked consideration of less restrictive alternatives. Decisions were taken to act coercively, either by instigating CTOs, maintaining detention (through s17 leave of absence), or by making clear the threat of a MHA assessment, with the potential outcome of detention in a hospital. All were intended to ensure the continuation of compulsory treatment (Chapter 6). This power to treat was rarely questioned by participants, and in fact some articulated the view that CTOs were not powerful enough.

Control

The exercise of control was not considered necessary for all patients. This was dependent upon the type of illness identified by professionals and the behaviours that were associated with the specific diagnostic classification. Where control was considered necessary, it was exercised in a number of ways. These controls were justified on the basis of providing protection to patients, the public and professionals. Controls were most commonly considered necessary for those with psychotic-type illnesses as opposed to personality and eating disorders, and behaviours seen to identify a 'risk'. These controls came in the form of statutory powers or the threat of detention in hospital. Where statutory powers were used (in the vast majority of cases discussed, as the sample comprised male patients, subject to s3 MHA, commonly diagnosed with psychotic illnesses), conditions were imposed upon patients. These conditions concerned the acceptance of compulsory medication treatment, and accounts revealed a preference for depot medication to ensure its administration (Chapter 6). Whether patients agreed with or understood the need for treatment was irrelevant, so long as they complied (Chapter 4). The means of intervention and medication administration showed control of patients, and this was maintained despite accounts suggesting the ineffectiveness of these controls.

Despite the use of CTOs or other MHA measures to control what were often referred to as 'high-risk' situations, including disinhibition, aggression, assault, stalking, intimidation, inappropriate sexualised behaviours, carrying knives and throwing items onto a railway line, frequent references to recall to hospital and the reference to use of police powers suggests that CTOs did not achieve their intended aim for this group of patients. In fact, difficulties with recall and the need to rely upon police powers suggest that participants were not in control of CTOs; rather, their responses were driven by poor resource provision and, as a consequence, CTOs acted primarily to offer professional protection.

The main research question

The findings enable the answering of the following overall research question:

> Community treatment orders: what do they tell us about the exercise of power over the psychiatric patient? Are they protecting the patient, the public or the professionals?

The findings have presented the numerous and detailed ways in which participants are influenced when considering CTOs, what they seek to achieve and how they account for CTO use. While concern for patients and the public was evident within the data, CTO use acted primarily to protect professionals.

Key themes

This part of the chapter moves beyond demonstrating how the findings answer the research questions to reflect on the three key themes emerging from the data that have implications for practice, policy and legislation. The discussion under these themes entitled ‘The impact of the dominant medical paradigm’, ‘Risk as justification for intervention’ and ‘The protection imperative and its consequences’ will briefly restate the main findings before examining them in the light of existing literature to review commonalities and differences. This is followed by consideration of how theories of governmentality assist our understanding of the exercise of power over the psychiatric patient, and how the findings differ from governmental understanding of the exercise of power over the patient. The chapter will then set out recommendations for practice, policy and legislation, before concluding with the limitations of this study and the contribution to knowledge.

The impact of the dominant medical paradigm

Amendments to mental health legislation in 2007 set out statutory criteria enabling certain patients to be made subject to community compulsion by way of a CTO. This statute devolved power to professionals to determine which patients meet legal criteria and to decide on the appropriateness of imposing community compulsion. To do this, professionals are advised to draw from their own professional knowledge and discourses - for example, legal, ethical, medical and social considerations (discussed in Chapter 1, above). Discussions with participants revealed the dominance of medical discourse among both professional groups charged with CTO consideration and implementation, RCs and AMHPs. This dominance was evident in two ways: how mental disorder was understood and how it was responded to (Chapters 4 and 6). Consideration of social causation and social responses to mental disorder were rare among participant accounts. This was most surprising for AMHP participants who are required to bring a social perspective to bear (DoH, 2015a). Reliance on biomedical understandings of mental disorder is recognised as having the potential for making social perspectives subordinate, and invalidating the perspectives and experiences of patients (Tew, 2011). This narrow view of mental disorder therefore has important implications for practice - that is, the successful treatment and engagement of patients is unlikely (Fawcett and Karban, 2005).

First, in respect of how mental disorder is understood, the shared biological concept of mental disorder among RC and AMHP participants is consistent with findings by Roberts *et al.* (2002) when exploring psychiatrists’ and social workers’ perspectives of the need for compulsory treatment prior to the introduction of CTOs. Since the introduction of CTOs, Doughty *et al.* (2013) and Jobling (2015) have highlighted the dominance of medical discourse when examining practitioner perspectives of community compulsion by way of CTOs. The perhaps more surprising finding that AMHPs subscribe to biomedical understandings of mental disorder, despite their role in bringing a social perspective to bear, is consistent with findings by Peay (2003) who established that ASWs did not counterbalance the dominant medical desire to treat, suggesting an acceptance or buy-in of the dominant medical paradigm. A more recent study by Buckland (2014) concerned with AMHP decision-making similarly found that AMHPs prioritised medical discourse by rating concepts of mental disorder and the appropriateness of medical treatment as the most significant determinants to the use of compulsory powers under the MHA, despite having raised concern about increased medicalisation. The findings in this study therefore confirm previous research findings that have highlighted the dominance of medical discourse among Mental Health Act decision-makers. In addition, this study has built on these previous research findings by showing that consideration of social causation, and responses to mental disorder, are rare among RCs and AMHPs. This is especially important in respect of the AMHP role, which is intended to bring a balance to the dominant medical paradigm.

Second, having adopted a medical discourse of mental disorder, it is perhaps unsurprising that the response to mental disorder by participants within this study was almost without exception treatment. Treatment was most frequently referred to as medication treatment, and administration by injection was preferred, most commonly as a result of patient objections. This perceived need for treatment is consistent with research findings (presented in Chapter 2 above), which show that community compulsion was viewed as a means of ensuring treatment adherence (Crawford *et al.,* 2000; Manning *et al.,* 2011; Doughty *et al.,* 2013; Jobling, 2015 and Lawn *et al.,* 2016), and this concern for treatment adherence remains relevant at the point of CTO discharge and renewal (Stroud *et al*., 2017). Within this study, a failure to adhere to medication was closely linked with the need to recall a CTO patient to hospital, a finding similar to that in an earlier study by Stroud *et al.* (2015) which highlighted the link between a failure to attend appointments and the resultant return to hospital for the purpose of medication administration. The administration of treatment via a CTO was most frequently described by participants as bringing benefit to patients (as opposed to being seen as coercive), as such CTOs were viewed as empowering, a finding consistent with Banks *et al.* (2016). In respect of medication administration, a preference among participants for depot medication was evident, and this is consistent with findings by the CQC (2010), which highlighted a professional preference for either depot, or a combination of oral and depot medication, even though patients had expressed a preference not to be treated in this way. As this study did not gain the views of patients, it is not possible to reflect their views. However, Jobling identified that some patients do not subscribe to biomedical understandings of mental disorder, yet one was reported to have said in respect of his CTO '[with the] right medication I'll conquer it' (2015, p. 138), like the study by Lawn *et al.* (2015) suggesting an internalisation of biomedical understandings of mental disorder. Given the potential for divergent patient views about treatment for mental disorder, it is clearly important for professionals to establish their views as part of the CTO decision-making process.

Aside from the type and mode of medication administration, its purpose is also of relevance and this is discussed below under the heading 'Risk as justification for intervention'. However, in respect of the dominant medical paradigm, it is relevant here to identify that participants did not articulate a desire for patients to arrive at the position of being able to self-regulate. Whether patients subscribed to biomedical understandings of mental disorder was irrelevant so long as they complied with treatment. This finding is consistent with that of Jobling who found that medication treatment was viewed by all practitioners as 'an end in itself' (2015, p. 143) suggesting the continuation of community compulsion unless patients subscribe to the biomedical understanding of mental disorder and, as a result, adhere to treatment of their own accord. This desire for the continued administration of treatment as the response to mental disorder was consistent among RC and AMHP participants despite their concerns about its inefficiency and ill effects, a finding consistent with Moncrieff's (2009, 2015) and Moncrieff et al.'s (2013) critiques of drug action, and the risk of iatrogenic death as a result of treatments for mental disorder highlighted by the CQC (2016).

This acceptance of a biomedical understanding of mental disorder, both of how mental disorder is understood and responded to left little room for participants' consideration of social causative factors or responses to mental disorder. This finding has some support in that biomedical understandings of mental disorder dominated in this and the above studies, and findings by the CQC reported a failure of AMHPs to consult 'any wider than reading the medical file and the responsible clinician's statement' (2010, p. 103) when considering CTOs. However, more recent contradictory evidence suggests that AMHPs are informed by social factors (Doughty *et al.,* 2013; Stroud *et al.,* 2017) and that CTOs do improve social outcomes (Rawala and Gupta, 2014). That said, more recently Vergunst *et al.* (2017) argued that longer term use of CTOs does not correspond with improvements in patients' longer term social situations. Finally, reliance on biomedical understandings of mental disorder may result in under-intervention, as opposed to over-intervention. Of note within the data, alcohol and drug use was prevalent, yet it was not viewed as causative of, or consequent to, mental disorder, and as a result did not warrant intervention. This finding mirrors that of Roberts *et al.* (2002) and Manning *et al.* (2011) when exploring clinician views of the need for treatment and use of CTOs (respectively), in that drug addiction/substance misuse were not viewed as warranting intervention. From a practice perspective, this is potentially problematic as homicides committed by those with mental disorder have been found to be related to 'co-existing drug or alcohol misuse rather than mental illness itself' (The University of Manchester, 2017, p. 6). Therefore, an over-reliance on biomedical understandings of mental disorder to the exclusion of other understandings may result in the emergence of the very risks that CTOs seek to address.

From a theoretical perspective, the findings in this study exemplify ideas of governmentality; however, a departure from these ideas is evident. This thesis illustrates the relationship between sovereign command, discipline and governmental management, a concept referred to by Foucault as the triangle analytic. Amendments to statute introducing CTOs devolved power to professionals enabling them to deploy mechanisms of discipline and governmental management. Authority was therefore extended to individuals to employ techniques to guide problem populations. This authority to intervene is based upon expert knowledge, aimed at defining and altering behaviours associated with problems (Foucault, 1978) or problem populations (Castel, 1991). The findings show that both RC and AMHP participants have adopted biomedical understandings of mental disorder (to the exclusion of other knowledge), and this understanding serves to set patients apart and offers justification for intervention. Intervention is by means of community compulsion (a disciplinary mechanism) to guide patients' behaviour. However, from a Foucauldian perspective, the defining of problem populations (making subject) is intended not just to discipline by means of governmental management, but to bring about self-regulation. In the mental health sphere this would mean that patients (having become subject) arrive at the position of being able to discipline themselves into correct ways of being. The data shows, however, a departure from ideas of becoming subject and self-regulation, and this does not appear to be the aim of professionals for this group of patients. Instead, there is an acceptance that patients will refuse treatment, become unwell, and as a result will require readmission to hospital; a view confirmed by national statistics (CQC, 2016).[50] This cycle shows that patients are likely to remain subject to governance, as opposed to arriving at a position of self-regulation and autonomy. The effect of biomedical understandings of mental disorder in respect of which labels warrant intervention is discussed below as the impact of a focus on medical discourse and risk as justification for intervention have a similar effect on theoretical understandings of problem populations.

Risk as justification for intervention

When deciding whether to make a CTO, RCs and AMHPs should consider risk, as risk is integral to the statutory criteria (explained in Chapter 1 above). Concern for risk was also cited by the Government as the driving force behind the introduction of community compulsion, and so it is perhaps unsurprising that the concept of risk is

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[50] The last reliable statistics collated by the Health and Social Care Information Centre (2016) showed that 4,361 CTOs were issued during the period 2015/16, with 2,294 recalls to hospital, and of those 1,557 resulted in revocation (returning the patient to detained in-patient status).

evident in all three findings chapters. Risk is therefore a dominant theme within the data. In Chapter 4, risk behaviours are understood to be a consequence of mental disorder. Some mental disorders are viewed as presenting more risk than others, and as a result some warrant intervention and some do not. Risks are therefore assessed according to populations as opposed to individuals. Where participants spoke about specific patients, they detailed risk behaviours that had occurred in the past, and more generally spoke of anticipated risks related to mental disorder. Participants did not, however, question the relationship between risk behaviours and mental disorder, and past risks were not used as a determinant to predict future risks; yet past and anticipated risks offered justification for CTO use. CTOs were therefore assumed to be a means of managing risk behaviours, and this was achieved by making and maintaining CTOs to engender contact between patients and professionals, primarily for the purpose of medication administration. Risk was also relevant to protection. In Chapter 6, risk to the patient, the public and professionals offered justification for the imposition of compulsory community treatment. CTOs were therefore articulated as a means of preventing risk to the patient or to the public, or to provide professional protection in the event of risk behaviours materialising. This part of the chapter therefore considers literature and theory in respect of risk behaviours associated with mental disorder as justification for intervention to prevent harm to patients and the public. The literature and theory in respect of risk as a means of providing professional protection is discussed below under the heading ‘The protection imperative and its consequences’.

First, the finding that risk is associated with mental disorder is consistent with findings by Buckland (2014) who found that AMHPs linked risk with illness when making decisions in respect of MHA detention. However, this study illustrates that not all mental disorders produce risk behaviours warranting intervention. For example, personality disorder and eating disorder were not viewed by participants as warranting intervention by means of a CTO. This finding builds on previous research that showed divergent views, with social workers being significantly more inclined to endorse treatment for this group than their psychiatrist colleagues (Roberts *et al.* 2002).

Like mental disorders, participants were of the view that not all risks warranted intervention. Risk behaviours viewed as low-frequency/high-impact (Kemshall, 2002) did warrant intervention in contrast to risk behaviours viewed as high-frequency/low-impact, a finding consistent with previous research in respect of psychiatrists' views (Roberts *et al.,* 2002) and AMHP perspectives (Morriss, 2015, 2017). The assumption that CTOs ameliorate such risks is, however, potentially problematic given the finding by The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) that '33% of those who died [through suicide] were not receiving care as intended despite CTO powers' (University of Manchester, 2017, p. 39).[51]

Despite such statistics, participants articulated CTOs as a means of managing mental disorder and avoiding readmission to hospital, but at the same time articulated the need for recall to hospital. This contradictory view is consistent with previous research findings. For example, CTOs have been viewed by stakeholders as a means of preventing a deterioration in mental health resulting in a return to hospital (Doughty *et al*., 2013; Jobling, 2015; Stroud et al., 2015, 2017), while other evidence suggests that CTOs are not successful in achieving this aim (Steadman *et al.,* 2001; Churchill *et al.,* 2007; Kisely *et al.,* 2009; Burns *et al.,* 2013; Lepping *et al.,* 2013; Smith *et al.,* 2014). These divergent findings may however be the result of the populations studied. In respect of CTO studies, little attention has been paid to how risk is assessed by professionals. This study showed that risk is assessed according to anticipated risks related to mental disorder, and that treatment is justified as bringing 'benefit' in reducing risk. This finding adds to research concerned with MHA decision-making, which found that risk was assessed according to conceivable risk as opposed to foreseeable risk, with thresholds set low, informed by best interests as opposed to non-maleficent (Peay, 2003).

From a Foucauldian perspective, risk behaviours arising from mental disorder, like diagnostic labels (discussed above) serve to set patients apart from a normal state. This is referred to by Foucault as binary division and branding - for example, the normal

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[51] Of 66 reported suicides in patients subject to a CTO in England between 2009 and 2015, ten patients were non-adherent with drug treatment in the month before their death, 15 missed the last appointment with services, and three had both refused treatment and missed the last appointment.

and pathological, and the dangerous and harmless (discussed in Chapter 2 above). This binary division and branding sets patients apart (made subject) for the purpose of employing and justifying techniques of disciplinary control to alter behaviours. This study shows that some mental disorders were articulated by participants to produce more risk than others, and as such justified intervention by means of a CTO. Similarly, as a result of medical discourse, some mental disorders warranted intervention while others did not (discussed above). Within the study, those with drug and alcohol use, and those labelled with personality or eating disorders were not viewed as warranting intervention by means of a CTO. This finding is of interest in light of Castel's (1991) assertion that strategies of control relocated from the individual to problem populations considered a risk. These findings suggest that the above groups are not viewed as sufficiently risky to warrant modes of surveillance, yet the statutory scope of mental disorder and the execution of preventive policy and legislation in the sphere of mental health brings these groups within their remit (discussed in Chapter 1 above). As such, it appears that Government legislation and policy designed to provide mechanisms of control for problem populations is not always acting to regulate professional power to bring about the regulation of all problem populations. Castel's view does not therefore help our understanding of professional power over patients in this respect. These distinctions between mental disorders and consequent risk behaviours do however lend weight to the idea that concepts of recovery may be disposed of, or reframed to mean short-term coercion to aid long-term recovery for those considered most concerning, while the concept of self-led recovery may be maintained for those presenting less concern (discussed in chapter 2 above).

The protection imperative and its consequences

This chapter has already considered the potential detrimental effects of the dominant medical discourse and risk as justification for intervention. Aside from the influence of biomedical understandings of mental disorder and associated risk, it is clear that professional responsibility and the accountability this engenders influences professional decision-making, and this has consequences for patients.

Consideration of responsibility and resultant accountability by participants was most concerned with the repercussions should adverse incidents occur. This concern for accountability and responsibility was evident in the use of CTOs for patients presenting low-frequency/high-impact risk, the making and maintaining of CTOs against participants' reservations (given their views about the ineffectiveness of CTOs), the propensity for some participants to share or pass responsibility for patients to colleagues, and in doing so lessen or avoid responsibility and accountability, and less frequently by the avoidance of CTO consideration by an AMHP when in disagreement with her RC colleague about the appropriateness of a CTO, thus failing to act as a legal break to CTO use. Concern for professional protection was made worse by risk assessment based on the presumed characteristics of problem populations, as opposed to individuals (discussed above), and a lack of resources (Chapter 5). Taken together, these factors show the potential for disproportionate intervention into the lives of those considered mentally disordered as a means of professional protection.

These findings align with that of Peay (2003) who found that risk and a fear of failure dominated MHA decision-making. Similarly, in keeping with findings in this study, Peay (2003) established that those with legal responsibility for decision-making were most influential in the decisions made, yet a desire to share decision-making was also evident, a finding later supported by Curtis (2014) when exploring CTOs. These findings have been developed within this study as data showed that where clinical responsibility for patients was passed (from an in-patient to a community-based RC once a CTO had been made), those acquiring responsibility maintained CTOs despite their criticisms about their effectiveness. This desire to appear to be doing the right thing is consistent with findings by Lawn *et al.* (2015) and Jobling who established that practitioners wanted to appear to have 'ticked all the boxes' as a result of being 'terrified' about risk (2015, p. 159), thus serving professional interests to manage risk to their reputation despite their questioning of the usefulness of CTOs in managing such risks. These findings concerned with professional responsibility and accountability have been built on by establishing that some AMHP participants who were unlikely to have clinical responsibility for CTO patients, but who have a determinative role in whether a CTO is made (Chapter 1) either took their role less seriously (than that of MHA detention decisions) or, in a rare case, avoided responsibility by absolving themselves from decision-making.

The use of CTOs founded on a better to be 'safe rather than sorry' (Kemshall, 2002, p. 9) approach runs the risk of utilising CTOs as an automatic discharge mechanism, irrespective of their necessity or proportionality. This approach may go some way to explain the higher than anticipated uptake of CTOs outlined in Chapter 1 and the low discharge rate (CQC, 2016). This way of working runs counter to the requirements of human rights, mental health legislation and Government guidance set out in Chapter 1, which require RCs and AMHPs to balance often competing rights. The data, however, shows a propensity towards greater protection of professionals as opposed to patients or the public and, as a result, it may be argued that use of CTOs, in some cases, represents a disproportionate interference with patient freedoms.

Having established above that the divesting of power from Government does not always result in the governance of accredited experts (in this case RCs and AMHPs), which in turn is intended to govern problem populations, professional concern for the repercussions of adverse incidents does have the effect of encouraging accredited experts to utilise their powers as a means of providing professional protection (as opposed to controlling problem populations and engendering self-regulation). To draw from Rose (1999) who refers to the 'genealogy of freedom' as a means of justifying coercive controls, the findings show that CTO use is not always justified to protect the patient (to reform and accept the rights and responsibilities of freedom), or the public (against a threat to moral order), but instead CTOs are put to work to protect professionals, providing freedom from the repercussions of adverse incidents.

Practice, policy and legislative recommendations

The following section outlines recommendations based on the three key themes identified above. First, four practice recommendations are justified and explained, and this is followed by a description of the wider implications for policy and legislation.

Recommendations for practice

First, it has been established that medical discourse dominates participant understandings of, and responses to, mental disorder, leading to the subordination of social perspectives when considering community compulsion for the sample studied – male patients subject to a s3 – the predominant CTO population. This approach runs the risk of invalidating patient perspectives, failing to properly address the diverse needs of those with mental disorder or work towards a position of greater patient autonomy. Therefore, when assessing for a CTO, decision-makers should consider social factors and the patient's perspective of their own circumstances and needs. Consideration of social factors should include both potential causative factors and those considered consequent to mental disorder. Consideration of these broader factors and patient views may open up the possibility of offering alternative or complementary means of treatment (to that of medication treatment), and may prompt intervention in instances of need that may otherwise have been ignored. Consideration of the patient's perspective may also promote better engagement and the ability of patients to manage mental disorder without coercive controls.

Second, the findings show that risk was assessed according to mental disorder (commonly, diagnostic classifications) and anticipated risk, and that causative links between risk behaviours and mental disorder were not questioned. Participants were also more inclined to focus on low-frequency/high-impact risks, often ignoring high-frequency/low-impact risks. This approach runs the risk of over- or under-intervention, which in turn may run counter to human rights. Consequently, risk should be assessed according to individual patient need, as opposed to anticipated risks in problem populations. Risk assessment should occur irrespective of the mental disorder, and assessment should focus on both low-frequency/high-impact and high-frequency/low-impact risks. Where risks are evident, professionals should question whether they are related to mental disorder and, if so, whether the imposition of compulsory community treatment by way of a CTO will in any way address the risks. Where this is not the case, professionals should question the proportionality of imposing such controls.

Third, the desire for self-protection among participants is evident within the data. This appears to emerge as a result of divested powers giving RCs and AMHPs the power and therefore responsibility for CTO decision-making, and a lack of alternative resource. Working in a culture in which blame is apportioned in the event of adverse incidents as was evident in the case of Christopher Clunis (discussed in chapter 2 above) and the climate of few resources, professionals chose compulsion as a means of appearing to have intervened to provide patient and public protections, but in doing so are armouring themselves against the potential for repercussions in the event of adverse incidents. Therefore, when considering CTOs, RCs and AMHPs should move beyond a defensive approach through adopting a balance-sheet exercise of weighing benefits and burdens. This will help establish the proportionality of intervention, encouraging a clear focus on the patient's needs as opposed to the needs of professionals. This approach of balancing the benefits and burdens of intervention (akin to a best interests decision) has been adopted by the Court of Protection in recent cases[52] concerned with the treatment of patients subject to the MHA. Following this steer from the Court of Protection will also have the benefit of demonstrating defensible decision-making should adverse incidents occur. This approach therefore has the double effect of acting in the best interests of the patient and offering professional protection that is not achieved through disproportionate intervention into the lives of those with mental disorder.

Fourth, and related to the assessment of risk discussed above, where RCs and AMHPs consider community compulsion to be necessary, the order and its

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[52] *Betsi Cadwaladr University Local Health Board and Miss W* [2016] EWCOP 13; *Cheshire and Wirral Partnership NHS Foundation Trust v. Z [*2016] EWCOP 50; *Nottinghamshire Healthcare NHS Trust v. RC* [2014] EWCOP 1317.

accompanying conditions should be aimed at avoiding identified risk to the patient and others. Conditions should therefore be set with a clear goal in mind - for example, conforming to SMART[53] goals. This will provide a clear explanation of what a CTO seeks to achieve, allow success to be measured and indicate an end to use of compulsion. The goal should include consideration of the support a patient may need to help them achieve their goal(s) and services should meet compulsion with reciprocation to support patients. To assess the success of CTOs in achieving set goals, regular reviews with patients should take place to identify progress, and to enable the timely ending of CTOs. Such a process should engender engagement, improve mental well-being and encourage the patient to move to a position of autonomy.

Finally, before concluding these recommendations for practice aimed at the participant population; RCs and AMHPs, it is worth noting that many of these recommendations may be of benefit to those involved with patient care beyond the making and extending of CTOs. It has already been established that other stakeholders – for example, care co-ordinators and service providers, have a role in the maintenance of CTOs, as such recommendations concerned with social and patient perspectives, risk assessment and management, and CTO conditions are applicable to other groups. Adoption of these recommendations may support patient participation and a move away from coercive care to self-led recovery and patient autonomy.

Recommendations for policy and legislation

The above practice recommendations are based on actions professionals may take without policy change. However, these changes alone are unlikely to significantly alter the underlying justifications for intervention. Participants’ focus on risk and professional protection are perhaps best managed by changes to policy and legislation. This section

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[53] Specific, Measurable, Attainable, Realistic and Timely.

will therefore suggest recommendations for policy and legislative change aimed at alleviating risk-averse practice and engendering greater patient autonomy.

First, the professional practice of dividing the RC function between in-patient and community clinicians serves to instigate and maintain CTOs with resources and professional protection in mind, and results in problems with recall and revocation. The practice of one RC maintaining responsibility for patients irrespective of their in-patient or community status would go some way to ensuring clear accountability, continuity of care and ease of access to hospital where it is required.

Second, the introduction of legislative change to ensure professionals place greater emphasis on capacity, best interests and autonomy would redress the propensity of professionals to focus on mental disorder and associated risk, and professional protection. There are a number of findings within this research that led me to conclude that we can learn much from mental capacity legislation (MCA) and judgments by the Court of Protection. The inequality between those experiencing physical and mental ill health was highlighted in Chapter 1 above, and these findings illuminate the discriminatory nature of these differences. For example, the MCA only applies to those lacking mental capacity to make decisions, thus those retaining capacity,[54] are enabled to make their own decisions, irrespective of how unwise they may appear. Where capacity is established to be lacking, those in a decision-making role are required to make best interests decisions for the patient, in order to protect them, as opposed to others (s6, MCA). The notion of best interests has been extended by the courts to move beyond best medical interests to include best social and psychological interests,[55] and establishing best interests should be heavily influenced by the person's wishes, feelings, values and beliefs. The courts have made clear that where a person's views can be ascertained with any certainty, they should largely be determinative of their best interests.[56] This may result in best interests decisions that may be regarded as unwise, thus preserving the right to unwise decision-making afforded to those retaining

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[54] Including those who make an advance decision refusing treatment when capacitous to apply at a later date when capacity is lost.

[55] *Aintree University Hospitals NHS Foundation Trust (Respondent) v. James (Appellant)* [2013] UKSC 67(2).

[56] *Wye Valley NHS Trust v. Mr B* [2015] EWCOP 60 and *Briggs v. Briggs* [2016] EWCOP 53.

capacity. This is in stark contrast to the MHA, which has no regard for the patient's capacity at the point of compulsion. As such, decisions may be made to enforce treatment in the face of a capacitous refusal. These decisions are not expressly linked to the patient's best interests and interventions may be to protect others. Based on the findings concerned with anticipated risk according to problem populations, current legislation has the effect of allowing professionals to put the cart before the horse.

The inclusion of a capacity threshold within the MHA would prevent intervention in some instances, and as a result would remove professional concern for the implications of having failed to intervene. The extension of advance decisions to apply to mental health treatment given under the MHA would also have the effect of preventing intervention, removing professional power in favour of patient autonomy. Where decisions are taken for those lacking capacity, the same principles to those of the MCA should apply – namely, a broad view of best interests, including best social and psychological interests, as a counterbalance to best medical interests, and where the patient's views can be ascertained with any certainty they should, in the majority of cases, be determinative of best interests. Inevitably, in the sphere of mental health concern will remain for the few instances of suicide and homicide. Here, where patients lack capacity in respect of these risks, measures to intervene should remain.

Finally, and related to the above point, the ability of professionals to make decisions about the imposition of compulsory community treatment should be restricted to what may be regarded as the most concerning cases, in line with parliaments initial intention. To do this, legislation should be altered to include stringent risk criteria to narrow the scope of patients that may be eligible for CTO consideration, thus reducing professional discretion.

Limitations and areas for future research

There are a number of limitations to this study concerned with the sample; both of the participants and the inclusion criteria for the patients discussed by participants. These limitations are discussed first, before considering areas for future research, some of which are informed by the limitations of this study.

First, in respect of the participant sample, the sample size for this study was small, albeit this was methodologically justified on the basis of providing rich and nuanced data from RC and AMHP participants, providing internal diversity. However, it is acknowledged that two participants were interviewed on two separate occasions and no RCs participated in individual interviews (as discussed in chapter 3 above). Differences in the professional status of participants was also evident, whilst AMHP participants represented those in AMHP and lead AMHP roles, RCs were all in consultant posts. These differences bring some limitations to the data. The sample was also limited to AMHPs and RCs, and therefore did not include the views of other stakeholders involved in the maintenance of CTOs – for example, care co-ordinators, service providers, carers and relatives (as discussed in chapter 3 above). Had the study involved others without the procedural powers of making and extending CTOs the conclusions may have been more divers, with a greater focus on enabling as opposed to coercion (Doughty *et al.,* 2013 and Stroud *et al.,* 2015, 2017). However, as the study aimed to understand the greater than anticipated update of CTOs, it was appropriate to limit the sample to those with legal decision-making powers in respect of the making an extending of CTOs. In addition, the sample was limited to participants from three geographical areas. While this showed some variation in working practices - for example, one geographical area favoured use of extended s17 leave of absence before CTO consideration; in contrast, two areas did not adopt this practice - this too was limited. Due to these limitations and geographical variation in CTO use, the findings cannot be generalised.

Second, in respect of the patients discussed by participants, the inclusion criteria was limited to male patients, subject to s3 MHA, who were most commonly diagnosed with psychotic illnesses. As a result, the findings cannot be generalised to the population for whom CTOs may be used. As the statutory criteria for a CTO are broad, many more patients falling outside of this inclusion criteria may become subject to a CTO, consequently the factors behind such decisions and professional intent may differ. This limited inclusion criteria is however justified on the basis of examining the group for whom the Government initially intended CTOs. This limited inclusion criteria also omitted the patient perspective, as such the study may be criticised for not considering how patients view and experience use of professional power by means of CTOs. Acknowledging this omission and the consequent failure to include potentially different perspectives to that of AMHPs and RCs, the limited inclusion criteria allowed examination of the perspectives of those with the professional power to make and maintain CTOs. Having identified these limitations this small-scale qualitative study does however provide rich, detailed data concerned with the exercise of professional power over the psychiatric patient, and it is this data that makes a contribution to practice.

Based upon the findings, it is difficult to advocate continued use of CTOs in the current climate for the intended CTO population. However, these research findings raise questions that are yet to be answered. If CTOs are to have utility in supporting those with mental disorder, greater examination of how they are used for this group and a broader range if patients is warranted. Inclusion of the patient perspective to inform professional decision-making would also be of value in examining how concepts of mental disorder, risk, recovery and self-regulation are prioritised by patients and to examine whether other factors concern patients. Examination of discussions between professionals and patients at the point of CTO consideration would offer a greater understanding of how competing perspectives and desires are balanced. A longitudinal study to follow the success of those CTOs would offer an insight into the proportionality, measures of success and likely success of CTO use. In addition, examination of risk assessment and corresponding CTO conditions, and the incidence of emergent risk behaviours would indicate the success of CTOs in averting such risks. This would highlight the necessity and proportionality of imposing conditions. From a human rights perspective, another area of interest would be to establish the views of capacitous patients subject to a CTO and professionals about the introduction of a capacity threshold within mental health legislation, and best interests decision-making (including best medical, social and psychological interests) for those that lack capacity. This would allow an analysis of support for the introduction of a capacity threshold within the MHA, allowing for a sole focus on those unable to make decisions, thus removing professional concern for blame in certain circumstances.

Contribution to knowledge

This thesis reinforces the messages of earlier research, raising questions about the effectiveness of CTOs in achieving their intended aim - that of preventing a deterioration in mental health and, as a result, avoiding readmission to a hospital, thus questioning the ethical basis for their continued use (Churchill *et al.;* 2007, Burns *et al.,* 2013; Lepping and Malik, 2013). However, this finding emerged from an analysis of what professionals seek to achieve by use of CTOs, as opposed to setting out to measure the specific benefit of CTOs in avoiding relapse and readmission to hospital. The thesis also supports existing literature about the dominance of medical discourse, (both diagnosis and the need for treatment), and concern for risk and professional protection among those charged with MHA decision-making. However, additionally this thesis adds to the body of CTO knowledge by extending the literature beyond measures of effectiveness according to Government intention; second, from a theoretical perspective, it raises some questions about the utility of applying the theory of governmentality to professional power in the sphere of mental health.

Following inconclusive research findings about the effectiveness of CTOs in achieving stable mental health and as a result avoiding readmission to hospital, Light (2014) called for research into the reasons for CTO use to enable a better understanding of their effectiveness. This thesis offers an examination of the reasons for CTO use for the intended population and questions the effectiveness of CTOs in achieving these aims. The findings therefore move beyond an examination of whether Government intention has been achieved by showing that CTO decision-making is influenced by factors other than those relevant to the patient and the public. Mental disorder and associated risk behaviours continue to be offered as justification for CTO use, yet preventing risk to professionals dominates decision-making.

From a theoretical perspective, the thesis shows governmentality to have utility in explaining the relationship between sovereign command and discipline in the sphere of CTO decision-making. Statute serves to devolve power and provide techniques of control, aimed at governing the conduct of a problem population - the mentally disordered. However, rather than sovereign command serving to influence the conduct of professionals, which in turn conducts the conduct of patients, other factors interrupt this process. A lack of resources making the management of a problem population challenging leads to control for the purpose of self-protection as opposed to control for correction and self-regulation. Concern for ‘bads’ (risk associated with mental disorder) (Beck, 2003, 2009) remains the justification for intervention, yet self-preservation against repercussion as a result of inaction in a climate of blame (Kemshall, 2002) is what professionals seek to achieve. As a result, use of positive power aimed at bringing about self-regulation is lost, eroding the governmental management of patients.

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1950 The European Convention on Human Rights

1959 The Mental Health Act

1983 The Mental Health Act

1995 Mental Health (Patients in the Community) Act

1998 The Human Rights Act

2005 The Mental Capacity Act

2007 The Mental Health Act

Appendix 1 – Semi-structured interview schedule

Introduction:

Hello and thank you for agreeing to be interviewed.
Let participants know that interviews will be recorded for the purpose of data collection.
Give an outline of the structure of the interview and how the information will be used.
Check they have read/understood the participant information sheet and get the consent form signed.

I am curious about:

- how you come to consider CTOs,
- how the process works, and
- how you feel about this part of your role.

How common are CTOs in your area of work?
Is it a routine part of your work?
Do you enjoy that element of your work? (may have been answered above)
Do you feel equipped to do CTOs as part of your work (you receive statutory training which covers CTOs, but does it equip you to consider CTOs in practice)?
Do you have particular views about the introduction of CTOs?

Case specific questions:

Thinking about the case you have selected:

How did consideration of a CTO come about? (AMHP and RC may have different accounts)
Could you tell me about the persons characteristics? (if not covered in previous question)
How did you become involved?
What did you do?
What were the issues for you in this case? (AMHP and RC)
Was this a typical case or do they vary?
In hindsight, would you do anything differently?

Ending:

Is there anything that you haven't said that would help me understand the CTO process?
Do you have any questions for me?
Thank you for your time and for helping me.
Would you be willing to participate in an individual interview that would focus on your professional role in the CTO process?

Appendix 2 – Information sheet for participants

Participant information sheet

Community Treatment Order Research

Dear participant,

This sheet aims to introduce you to and give you information about the research.

What is the research about?

This research is concerned with professional decision-making in the context of CTOs. This study aims to explore the factors that influence professional decision-making to better understand why, and to what end, the CTO is used.

Why have I been approached?

I am seeking participation from RCs and AMHPs who have considered use of a CTO for a male patient subject to section 3 of the MHA. I would be interested to speak to you irrespective of the outcome as the factors that inform your decision-making are important to help our understanding of the way in which we view and manage mental disorder.

What am I being asked to do?

You are being asked to participate in an interview with Debbie Martin as part of a pair (comprising an RC and an AMHP), having considered the use of a CTO for a male patient subject to section 3 of the MHA. Interviews will last for no more than one and a half hours. You will be asked to give some factual information about the patient - for example, the patient's age, diagnosis, and any factors that led you to consider a CTO. You will not be asked to give the name or address of the patient, and none of the information in the study will allow identification of individual patients. Your name and place of work will equally be kept confidential, and will not be included in the study or any associated publication. Following the paired interview, you may be asked to participate in an individual interview. This is to allow exploration of any differing professional views. However, your consent will be sought for this, and there is no obligation to participate in an individual interview.

How will this information be used?

The interviews will be recorded and transcribed. Once the interviews are transcribed, personal details will be removed from the transcripts and the data will be stored securely.

The findings will be included in the research project (PhD thesis) and may be used in associated publications.

What are the limits to confidentiality?

As a registered social worker with the Health and Care Professions Council, the researcher is bound to share information where it is considered necessary to 'safeguard service users and carers and others' (HCPC, 2012, p. 2). This may include identification of incidents of dishonesty, danger to the service user or illegality.

Do I have to participate in the interviews?

No, participation is on a voluntary basis. If you are willing to participate in the interviews, please contact me on the email address below and we can agree a mutually convenient time to meet.

Further information and support:

If you have any ongoing concerns or questions about CTOs, please raise these with your professional supervisor. If you have any further questions about the research project please email Debbie Martin at d.martin2@bath.ac.uk

Thank you for reading this information sheet. I appreciate your help.

Debbie Martin
PhD Candidate, University of Bath, 3 East 4.34, Department of Social and Policy Sciences,
Claverton Down, Bath, BA2 7AY

Ethical approval for this study has been gained from:

The University of Bath, [A] Mental Health Trust, and relevant Local Authorities.

Those supporting Debbie in her research are:

Professor Ian Butler who can be contacted by email at I.Butler@bath.ac.uk, and

Dr Jeremy Dixon who can be contacted by email at J.Dixon2@bath.ac.uk

7 January 2015

Appendix 3 – Participant consent form

Community Treatment Order Research

Participant consent form

Participant name:

Participant consent	**Please initial below**
1. I confirm that I have read and understood the participant information sheet for the above study and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. In the event of withdrawing from the study, I will clarify below whether any of the information already provided may or may not be used (see below).	
3. I understand that patient and participant information will be kept confidential and that no individuals will be identifiable within the study findings.	
4. I agree that contact information, contextual information, and recordings and transcripts from interview(s) will be treated as confidential and kept securely.	
5. I agree to take part in the study.	

Name of participant:	**Signature**	**Date**
Name of researcher taking consent:	**Signature**	**Date**

In the event of withdrawing from the study:	**Please initial below (one box only)**
1. I am withdrawing from the study, but give my permission for the information already provided to be included in the research findings.	

2. I am withdrawing from the study, and I am withdrawing my permission for any of the information already provided to be included in the research findings.

Appendix 4 – Participant list

Pseudonym	*Professional training*	*Individual or paired interview*	*Duration of interview*
Norman	RC	Paired with Flora	1 hr 8 minutes
Flora	AMHP	Paired with Norman and individual	58 minutes
Desmond	AMHP	Paired with Reg	1 hr 11 minutes
Reg	RC	Paired with Desmond	
Mike	AMHP	Paired with Charity	
Charity	RC	Paired with Jim and then with Mike	28 minutes 38 minutes
Mary	AMHP	Paired with Tony	48 minutes
Tony	RC	Paired with Mary	
Hope	AMHP	Individual	40 minutes
Alice	AMHP	Individual	24 minutes
Jim	AMHP	Paired with Charity	
Charlie	AMHP	Paired with Hugo	54 minutes
Hugo	RC	Paired with Charlie	
Ben	RC	Paired with Sam	1 hr 40 minutes
Sam	AMHP	Paired with Ben	
Siri	RC	Paired with Joe	47 minutes
Joe	AMHP	Paired with Siri	
James	AMHP	Individual	45 minutes

Appendix 5 – University of Bath ethical approval

ETHICS APPROVAL FORM 2013-14

This document comprises pages 1 and 2 both of which must be competed in full.

You must then attach:

- page 3 - a summary of the research proposal (including full referencing, if cited)
- page 4 - a series of headings from the Ethics Checklist below that have been ticked as noted, each heading being followed by a brief paragraph on how any issues have been addressed.

You should use A4 paper, 12pt type and normal margins.

If you are conducting research on a placement or in association with another body where ethical approval has to be granted through a professional body, for example the NHS, or another University department, it is sufficient to append only the first two pages to the front of the ethical approval granted by the other body.

In all other cases, ALL research must meet the Department's Ethics Committee requirements. To do this, consult your Department's guidance.

You should pass a draft copy of your completed ethics form to your lead supervisor for discussion before submitting a final copy to him/her. Once the form is ready and signed by you both, you should pass the form to the Department's Ethics Officer for his approval. The Ethics Officer for SPS is Dr Joe Devine and you may email him the form direct or pass him a signed hard copy. Once his approval has been obtained, you should submit the form to the PGR administrator for your file (either the signed hard copy or electronically with an email trail with each level of approval recorded).

Note
1. You should not begin work on your research until this approval is obtained
2. You are required to submit the signed off ethics approval form along with the other documentation required for the transfer to (or confirmation of) PhD status.

Ethics Checklist

ETHICS APPROVAL FORM 2013-14

Issue	***Noted***	***Not applicable***
A justification for the research	√	
Avoidance of deception, presentation of purpose of study	√	
Arrangements for debriefing, including access to support	√	
Obtaining consent, including right to withdraw	√	
Avoidance of distress or threats to self-esteem	√	
Privacy and confidentiality	√	
Special circumstances (eg respondents who cannot give consent, children under 16, unusual issues around privacy)		*NA*
Additional general ethical issues	√	

STUDENT TO COMPLETE

Student name (please print): Debbie Martin

Email: d.martin2@bath.ac.uk Tel: ………………………………………

Programme: MPhil/PhD/Probationer PhD, Department of Social & Policy Sciences

ETHICS APPROVAL FORM 2013-14

I hereby confirm that this document represents an accurate record of my proposed research.

Student's signature: ………………………………………… Date: 10th March 2014

STAFF MEMBERS TO COMPLETE

You must show your supervisor your completed ethics form and obtain their agreement (evidenced through their signature below) that your proposal is of an appropriate academic standard to be forwarded to the Departmental Ethics Committee. Once your supervisor has signed off the ethics form, it should be passed to the Ethics Officer for his approval.

Supervisor

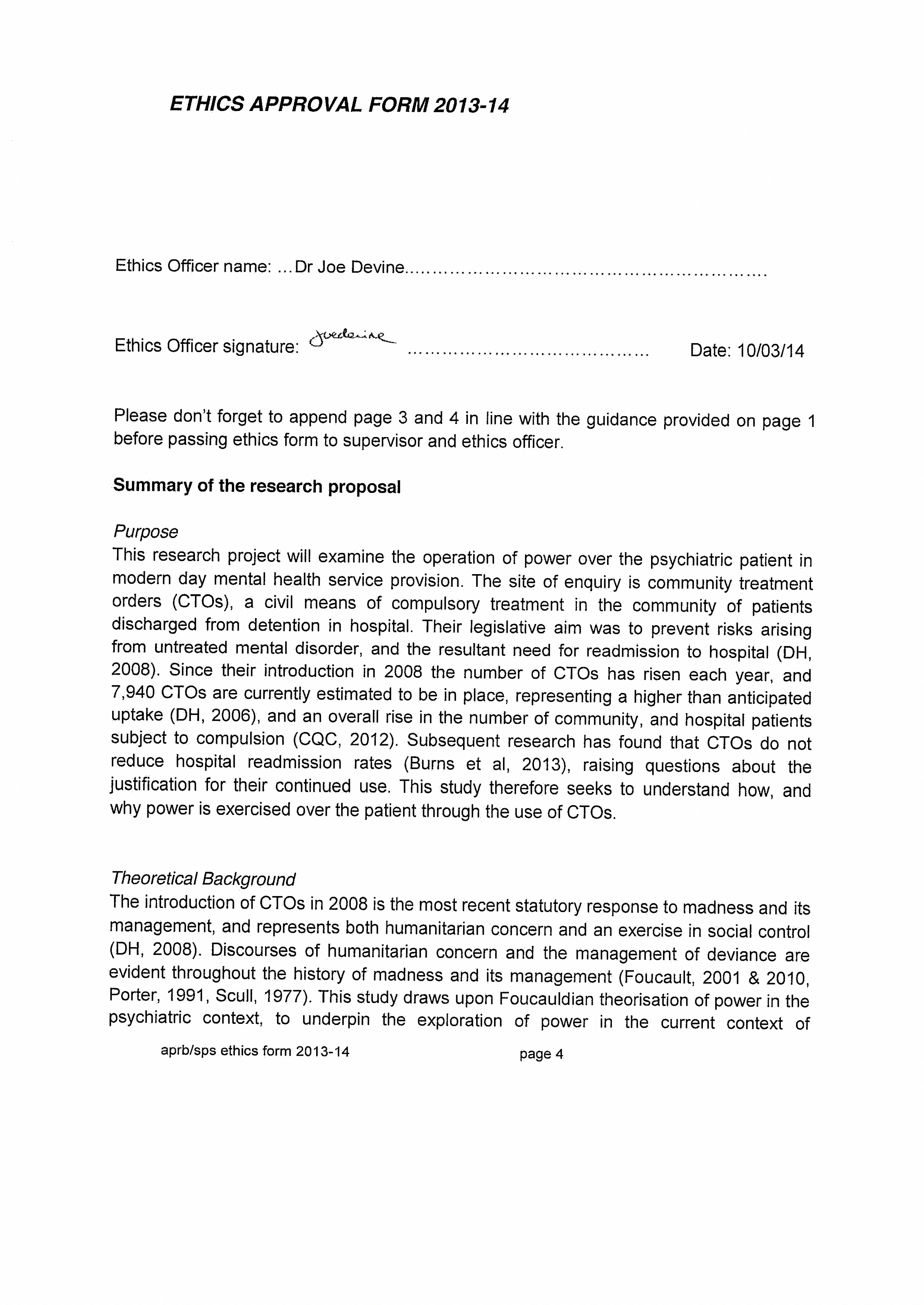
I hereby confirm that this proposal is of an appropriate academic standard to be forwarded to the Departmental Ethics Committee.

Supervisor name: Professor Ian Butler

Supervisor signature: Date: 10th March 2014

Ethics Officer

I hereby confirm that this proposal is of an appropriate academic standard and is approved by the Departmental Ethics Committee.



ETHICS APPROVAL FORM 2013-14

Ethics Officer name: ...Dr Joe Devine...

Ethics Officer signature: .... Date: 10/03/14

Please don't forget to append page 3 and 4 in line with the guidance provided on page 1 before passing ethics form to supervisor and ethics officer.

Summary of the research proposal

Purpose

This research project will examine the operation of power over the psychiatric patient in modern day mental health service provision. The site of enquiry is community treatment orders (CTOs), a civil means of compulsory treatment in the community of patients discharged from detention in hospital. Their legislative aim was to prevent risks arising from untreated mental disorder, and the resultant need for readmission to hospital (DH, 2008). Since their introduction in 2008 the number of CTOs has risen each year, and 7,940 CTOs are currently estimated to be in place, representing a higher than anticipated uptake (DH, 2006), and an overall rise in the number of community, and hospital patients subject to compulsion (CQC, 2012). Subsequent research has found that CTOs do not reduce hospital readmission rates (Burns et al, 2013), raising questions about the justification for their continued use. This study therefore seeks to understand how, and why power is exercised over the patient through the use of CTOs.

Theoretical Background

The introduction of CTOs in 2008 is the most recent statutory response to madness and its management, and represents both humanitarian concern and an exercise in social control (DH, 2008). Discourses of humanitarian concern and the management of deviance are evident throughout the history of madness and its management (Foucault, 2001 & 2010, Porter, 1991, Scull, 1977). This study draws upon Foucauldian theorisation of power in the psychiatric context, to underpin the exploration of power in the current context of community compulsion.

For most of the pre-modern age, those deemed ‘mad’ (using the word ahistorically) were accommodated within the wider community. The shift from care in the community to institutionalised care occurred during the seventeenth and eighteenth centuries, a period referred to by Foucault as the ‘great confinement’. Foucault argued that society needed out people, ‘because their exclusion promotes everyone else’s feelings of inclusion and solidarity’ (Cashmore and Mullan 1983:196). However, Porter argues against Foucault’s notion of the great confinement, stating that it came late to England, and signalled commercial and professional enterprise, rather than a societal need to control, and that confinement was the result of ‘complex bargaining between families, communities, local officials, magistrates and the superintendents themselves’ (2002, p99). The enlisting of help from medical and clergymen has therefore been argued to be the result of the affluent classes seeking to relieve their burden (Parry-Jones, 1972) resulting in the growth of private madhouses (Scull, 1979) as opposed to a societal need to control deviance.

By the eighteenth century a distinction between madness and other deviants had occurred. Madness was perceived as factual, a disease to be administered by the ‘mad-doctors’ (Scull, 1979, p 14). Foucault referred to this period as the modern experience of madness, and viewed it as a new mode of societal control. He argued that the ascribing of madness was an operation of state power, distinguishing the elite from outcasts, reinforcing society’s need for outcasts (Foucault, 2001). Shifts in the emphasis between humanitarian concern and social control have continued during the twentieth century. This thesis is intended to explore where the balance currently lies and answer the question; Community Treatment orders: what do they tell us about the exercise of power over the psychiatric patient in modern day mental health service provision?

Research Design

The research will involve semi-structured qualitative interviews with mental health professionals (responsible clinicians (RCs), and approved mental health professionals (AMHPs)). These professionals, referred to as decision-makers, will be asked to volunteer to discuss their consideration of CTOs. Purposive sampling will be used to select participants to ensure a relevant range of patients being considered for a CTO. The relevant range will seek to include patients across a range of ages and diagnosis, both male and female, and those subject to civil and criminal sections of the Mental Health Act 1983. Inclusion of discussion about a range of patients is intended to ensure an illustration of the breadth of factors that influence decision-makers. A small number of interviews will be undertaken, and transcribed (using conversational analysis), and further participants will then be selected to ensure a relevant range. The aim is to conduct 15 interviews in total, comprising views of 30 decision-makers.

Ethics Checklist

A justification for the research:

CTO are a new means of compulsory community treatment introduced by the Mental Health Act 2007. Their legislative aim was to prevent risks arising from untreated mental disorder, by enforcing treatment compliance, and in doing so prevent the need for readmission to hospital for treatment. In a study by Manning et al, adherence to medication and protecting individuals from the consequences of relapse were more influential in decisions to impose community compulsion than ethical considerations (2011). However, subsequent research conducted by Burns et al reported that CTOs do 'not reduce the rate of readmission of psychiatric patients' (2013, 1). This finding led Burns et al to question the justification for continued curtailment of patients' liberty (2013). In the absence of a robust evidence base for CTOs their use continues, in increasing numbers. The study will examine the exercise of this power over the psychiatric patient, to better understand the influences behind the use of CTOs, and what their use is intended to achieve.

Avoidance of deception, presentation of purpose of study:

Information about the study will be provided in writing (participant information sheet) and in person at the time of the interview. In addition, a detailed consent form will make clear the voluntary nature of participant involvement, the right of the respondent to withdraw, and the limits of the confidentiality offered.

Arrangements for debriefing, including access to support:

Sufficient time will be allowed for interview to enable collection of data, and to allow for informal discussion about the process following interview. This will allow for discussion about any issues that arose during interview, and a further opportunity for participants to ask questions. Should participants need additional support following interview as a result of any practice issues that arose during interview, they will be encourage to seek support within their supervisory arrangements.

Obtaining consent, including right to withdraw:
Participants will be given information verbally and in writing, and will be given the opportunity to ask questions. They will be informed that participation is voluntary, and that they are free to withdraw at any time. In the event of withdrawal from the study, I will clarify whether consent is also being withdrawn for use of any data already collated; where this is the case date from that participant will not be included in the study.

Avoidance of distress or threats to self-esteem:
It is not anticipated that involvement in interviews will cause any distress or threats to self-esteem. Interviews are intended to illicit information in relation to practice, and how this is informed. Participants will be advised that there are no incorrect answers, and that their practice is not being scrutinised with the intention of identifying error.

Privacy and confidentiality:
The privacy and confidentiality of participants, and those discussed will be maintained, other than in exceptional circumstances, see below.
Participants: Consent to store data; including electronic and personal data (name, professional role, place of employment and contact details) will be gained.
Patients discussed: Participants will not be asked to disclose the names of those they are discussing. Whilst some factual information will be sought about the patient (for example, their age, gender, diagnosis) this information will only be used to ensure selection of participants to represent a relevant range of those considered for a CTO. Links between factual information and professional decision-making will be made in the study but patient anonymity will be maintained.
As a registered social worker, I am bound by the HCPC standards of proficiency. As such there are limits to the maintenance of confidentiality. Information will be shared where it is considered necessary to 'safeguard service users and carers and others' HPCP, 2012:7.2).

Special circumstances (eg respondents who cannot give consent, children under 16, unusual issues around privacy):
NA

Additional general ethical issues:
Having contacted the research and development department for the relevant Mental Health Trust (MHT), I have been informed that NHS approval will not be necessary. However, ethical approval will be necessary from the MHT before interviews can commence. In order to obtain their approval the following will be required:

- University of Bath ethical approval,
- Relevant documents (research CV, participant information sheet, consent form, interview tool),
- Clinical representation from a member of staff from the MHT, and
- Attendance at the NHS, National Institute for Health Research, Good Clinical Practice training (attended on 18/2/14).

MHT ethical approval will be sought following transfer. This is to enable feedback from the transfer to inform design of the interview tool required for MHT ethical approval. Interviews will not commence until full MHT, and local authority approval (LA) is gained.

I have been advised by the LA that University of Bath, and MHT ethical approval will be sufficient for their purposes of enabling me to interview their employees. Written confirmation of this will be sought before interviews are commenced.

Appendix 6 – Mental Health Trust ethical approval

Department of
Social & Policy Sciences

UNIVERSITY OF
BATH

Bath BA2 7AY · United Kingdom

Telephone +44 (0)1225 388388
Facsimile +44 (0)1225 386381

Dear examiners,

R.E. Deborah Martin ethical approval

I am writing in order to certify that Deborah Martin was granted ethical approval to complete her research in an English mental health trust. This is so the Trust in question can remain anonymous.

I have viewed the approval letter received by Mrs. Martin from the Research and Development Manager of that Trust. This was dated 10th February 2015. The letter states that her study was approved on 10th February 2015 and that approval was granted until 31st December 2017. The letter also states, “As you are recruiting staff to participate in this research, the study falls outside of the scope which requires review by the National Research Ethics Committee, and therefore does not require an NHS ethical opinion”.

Yours sincerely

J. E. Dixon

Dr Jeremy Dixon
Lecturer in Social Work / Head of Group
Department