Using the Emancipatory Values of Social Work as a Guide to the Investigation: What Processes and Principles Represent Good Practice with People on Community Treatment Orders?

Lisa Mary Brophy

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School of Nursing and Social Work
The University of Melbourne
Abstract

This research explores good practice with people on CTOs - via a case study of one area mental health service in Victoria. The emancipatory values of Social Work were used to guide the investigation, thereby ensuring the involvement of consumers and their families or carers. Critical Social Work theory provided an important theoretical base for the research, and both critical theory and pragmatism supported the methodology. A mixed methods approach was undertaken. This included a cluster analysis of 164 people on CTOs. Three clusters emerged from the exploratory cluster analysis. These clusters, labelled ‘connected’, ‘young males’ and ‘chaotic’ are discussed in relation to their particular characteristics. The results from the cluster analysis were used to inform the recruitment of four people on CTOs who were the central focus of case studies that represented the different clusters. Semi-structured group interviews were also undertaken to enhance the triangulation of data collection and analysis. This resulted in 29 semi-structured interviews with multiple informants, including consumers, family/carers, case managers, doctors, Mental Health Review Board members and senior managers. The data analysis was guided by a general inductive approach that was supported by the use of NVivo 7. Five principles, and the processes required to enable them, emerged from the qualitative data: 1) use and develop direct practice skills, 2) take a human rights perspective, 3) focus on goals and desired outcomes, 4) aim for quality of service delivery, and, 5) enhance and enable the role of key stakeholders. These principles are discussed and then applied to the case studies in order to consider their potential relevance to practice within a diverse community of CTO recipients. The application of the principles identified two further findings: 1) that the principles are interdependent, and 2) the relevance of the principles varies depending on the characteristics of the consumer. The two most important findings to emerge from this thesis are that: 1) people on CTOs, their family/carers, and service providers are a diverse community of people who have a range of problems, needs and preferences in relation to either being on a CTO or supporting someone on a CTO; and 2) the implementation of CTOs is influenced by social and structural issues that need to be considered in developing any recognition or understanding about what represents good practice. Recommendations relating to each of the principles are made, along with identification of future research questions. A particular focus is whether application of the principles will enable improvements in practice on a range of measures, including reducing the use of CTOs, and the experience of coercion by consumers.
Declaration

This thesis comprises only my original work towards the PhD except where indicted in the preface. Due acknowledgement has been made in the text to all the other material used. The thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signed:

Date:
Preface

Dr John Reece, and Dr Fiona McDermott are included as authors in the publication of the cluster analysis conducted as part of this research and successfully published in the *International Journal of Law and Psychiatry*. Dr Reece provided invaluable assistance and collaboration in undertaking the cluster analysis but the data collection and analysis remained the responsibility and activity of the author.

Similarly, Dr Fiona McDermott is included as an author on a publication that draws on the force field analysis of the literature in relation to CTOs in *Australasian Psychiatry*. Again, Dr McDermott was invaluable in her supervision of this work but the reading and subsequent preparation of the paper and the use of the application of the analysis was the full responsibility of the author. Signed statements regarding both of these publications, explaining the contributions of all involved, are included in the appendices.

Ms Siobhan Hannan volunteered to read a draft of the thesis and provided practical editorial comments and advice within the limitations of the *Editing of Research Theses by Professional Editors* guidelines.
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To my family I express my love and gratitude for all they have sacrificed and the support they have offered to enable me to do a PhD. My children, Levin and Lawrence, have always been enthusiastic and patient about my endeavour and my husband Assoc Prof John Reece has been unwavering in his confidence in my ability, and consistently offered sound advice and assistance, especially with data analysis.

I would like to dedicate this thesis to my parents, Joan and Maurice, who have given me so much and yet endured so much pain in the last few years.
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List of abbreviations
Approved Social Worker (ASW)
Continuing Care Team (CCT)
Community Care Unit (CCU)
Community Treatment Order (CTO)
European Convention on Human Rights (ECHR)
Involuntary Treatment Order (ITO)
General Practitioner (GP)
Mental Health Client Management Interface (CMI)
Mental Health Review Board (MHRB)
Mobile Support and Treatment Team (MSTT)
North West Area Mental Health Service (NWAMHS)
Outpatient Commitment (OPC)
Psychiatric Disability Support Services (PDSS)
Introduction (Preamble)

Rosenhan (1973), in his classic study of the experience of being a pseudopatient in a psychiatric hospital, wrote about his subjective experience as follows:

Neither anecdotal nor “hard” data can convey the overwhelming sense of powerlessness which invades the individual as he is continually exposed to the depersonalisation of the psychiatric hospital.... I and the other pseudo patients in the psychiatric setting had distinctively negative reactions. We do not pretend to describe the subjective experiences of true patients. Theirs may be different from ours, particularly with the passage of time and the necessary process of adaptation to one’s environment. But we can and do speak to the relatively more objective indicators of treatment within the hospital. It would be a mistake and a very unfortunate one to consider that what happened to us derived from malice or stupidity on the part of the staff. Quite the contrary, our overwhelming impression of them was of people who really cared, who were committed, and who were uncommonly intelligent. Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they too, found themselves than to personal callousness. (p.250)

Rosenhan (1973) wrote about this experience more than 30 years ago but psychiatric treatment remains controversial. Involuntary psychiatric treatment has been the most consistently debated issue in mental health law for the last 30 years (Ridgley, Borum, & Petrila, 2001 p.5), and in recent times the controversy has shifted, at least in Australia, the UK and the USA, from concerns regarding inpatient admission to the issue of involuntary treatment in the community (Dawson, 2005)

For the last 25 of those 30 years I have followed this controversy as a social worker in the mental health field. My social work career began just as new legislation was being introduced in Victoria in 1986. I became interested in the impact of the Mental Health Review Board (MHRB) and this was the focus of my Masters research (Brophy, 1995). My experience in Forensic Psychiatry Services gave me an insight into coercion and what represents a less restrictive environment for psychiatric treatment
and care. I was initially perplexed when the prisoners I worked with sometimes preferred the tough, uncomfortable life in the mainstream prison over the care and treatment provided in the involuntary forensic psychiatry units. Perhaps it was at this time that I became more critically aware of the power, authority and social control elements of psychiatric services.

My interest in Community Treatments Orders (CTOs) was ignited when I moved into staff training and development roles in the 1990s. In Victoria, Australia, involuntary psychiatric treatment in the community is enabled by CTOs. These orders require consumers to adhere to treatment in the community or otherwise risk being admitted involuntarily to hospital. In the mid 1990s the use of CTOs dramatically increased as sweeping reforms led to the closure of large institutions and increased reliance on care and treatment in the community (Gerrand, 2005). In response, I was involved in providing staff training and development opportunities focused on building skills in working with people on CTOs. However, this training was rather inadequate. It grew to represent only a few one day events that have not been a consistent feature of ongoing initiatives. I was subsequently invited to be involved in the implementation of major amendments to the Mental Health Act 1986 (the Act) in 2003, in particular the introduction of treatment plans. At that time I was confronted by the limitations of legislation in attempting to require good practice or higher standards of care. This PhD research was then in its early stages and my interest in the implications of CTOs for consumers, carers and service providers and what represents good practice, was reinforced. Throughout this time I was also involved in the committee of management of The Mental Health Legal Service in Victoria and consistently maintained that, although it was difficult at times, it was possible to work within the mental health system and also maintain a critical, rights focused perspective – what has been described as ‘and/both’.

My main contention, in this study is that there is considerable value in exploring the ‘lived experience’ of people on CTOs – in the same way that exploring the ‘lived
experience’ of people in institutions proved to be so influential in enabling new developments in social policy and treatment.

In researching this topic I was initially interested in broad questions about the experience of being an involuntary patient in the community, and also the experience of the family/carers and service providers involved. I wondered whether it was possible that some of those feelings of depersonalisation in Rosenhan’s study would be found again amongst people on CTOs. It may be that I would find that the consumers on CTOs in the waiting rooms of community based services had apparently adapted over time to the experience of having other people tell them that they must submit to treatment. Perhaps, even when implementing the coercion that a CTO enables, service providers would be perceived as the intelligent, caring people that had impressed Rosenhan. This is consistent with Young’s (1990) contention that oppression is occurring in everyday life and often its agents are caring people acting out the expectations of state based health and welfare provision. The ‘failures’ Rosenhan (1973) referred to included a high tolerance for poor practice, lack of proper assessment and treatment and a tendency to resort to labelling, stigmatisation and coercion in a difficult and restraining service environment. There has been hope that the process of deinstitutionalisation and the shift to care in the community provides a new environment for action that is less likely to result in these ‘failures’. However, Sapouna (2006) suggests that there is evidence, at least in the Irish experience, of ‘a continuation of institutional patterns of thinking and practicing’ (p.85) in the post-institutional mental health service sector and Gerrand (2005) has raised similar concerns about Victorian psychiatric services in the post mid 1990s reforms.

Hence, my interest as a social worker in the mental health field in this topic. Social work in Australia stands outside, but works alongside, the disciplines most formally linked with the power and authority related to the questions surrounding CTOs, traditionally those of psychiatry and law. However, this research aims to bring a perspective that embraces the knowledge base and emancipatory values of social work (Ife, 2001). Social work is guided by valuing social justice, empowerment and a broad
conceptualisation of human rights. The research aims to have these values, reflected in both what questions are being asked and in the process of conducting the research (Goldstein, 2001; Ife, 2001). As stated by Ife (2001):

The ethically grounded social worker is alert and responsive to questions of moral choice, social justice, prevailing moral codes of conduct, and, not the least, personal accountability, whether she is doing research, applying theory, planning, or engaging in practice - any professional activity for that matter, that impinges on the life and well being of others. (p.246)

Social work, as a profession, is often best placed to consider practice, not only in relation to what has become standard agency procedure, but also in its legal, policy and ethical context. Furthermore, without preparedness to question and advocate from a client centred perspective, social workers in mental health run the risk of being increasingly unable to work within the spirit and mission of the profession (Ramon, 2006).

During my candidature I have, first hand, been able to identify CTOs as an international human rights issue. When I arrived in London in 2001, just before my first international conference, there was to be a protest in the streets, organised by Mad Pride, against the potential introduction of CTOs in England and Wales. This came as a surprise because CTOs had become so familiar and accepted in Victoria. Thus an international perspective has been helpful and I have since become part of an international network of social work colleagues who have been able to share varied experiences and perspectives on CTOs (Campbell, Brophy, Healy, & O'Brien, 2006). I have also been involved in the review of the Mental Health Act 1986 (State Government of Victoria, 1986) and assisted in formulating questions for the rest of the Victorian community about how the legislation could be improved. Victoria has considerable experience in implementing CTOs and is currently in the position of needing to respond to concerns that have been generated both locally and in international reviews (Dawson, 2005; Kisely, Campbell, & Preston, 2005).
The justification for this study, and the worldview informing it, is initially located in theories and values relevant to social science and social work and this is discussed in detail in Chapter Two. However, it is assumed that all professionals, including medical, nursing and allied health staff, who work in mental health services, are contributing to the potential failures within the current mental health system. This study presumes, as Rosenhan (1973) did, that the majority of these service providers do not necessarily want to work in a way that rejects emancipatory values, such as social justice and citizenship. Indeed the literature reviews in Chapters One and Two establish that there are a range of professions represented in investigating CTOs and many of the same researchers have expressed the view that there needs to be a greater understanding of the impact of CTOs on consumers, service providers and family/carers and improvements in practice guidelines as a result of this understanding (Churchill, Owen, Singh, & Hotopf, 2007; Dawson, 2005).

The contention that service providers are operating in a system that they also find oppressive and constraining is informed by the discussion in Chapters One and Two that identifies the degree to which social and structural forces have impacted on practice in mental health, in particular the pressure to contain risk, preserve resources and the lack of preparation of mental health staff for the challenge of working with involuntary consumers. Hence, the informants in this study, alongside consumers and carers, included not only social workers but also other service providers. Subsequently it is expected that not only social workers but other service providers will benefit from the guidance about good practice that this thesis provides. This guidance is represented in the findings that are presented in Chapters Four, Five and Six and the processes and principles for good practice identified and ‘tested’ in Chapters Seven and Eight.

Further support for undertaking research focused on good practice in mental health involving professionals, consumers and family/carers is found in the Deakin Human Services Project (1997). This project established two guiding principles after undertaking a project that had representation from the five major mental health disciplines (psychiatry, psychology, nursing, occupational therapy and social work). The
participants developed a consensus about reform of education and training that included a commitment of all parties to two central principles:

1. Mental health professionals need to learn about and value the lived experience of consumers and carers.
2. Mental health professionals should recognise and value the healing potential in the relationships between consumers and service providers and carers and service providers. (Deakin Human Services Project, 1997 p.8)

A key question in this study is what is meant by ‘good’ practice? There are many potential definitions of this concept, and currently, as will be discussed in Chapters One and Two, much of the emphasis of research in this area has been related to particular outcomes, such as reduced hospital admissions or reduction in violence. These generally positivist, empirical studies appear to locate effectiveness as the key element in determining the value of CTOs and then face the problem of determining what represents effectiveness and all the contentious issues that go with those decisions. This study establishes the worth of an investigation that ‘sets aside’ and tolerates not knowing the answer to the question of whether or not CTOs are ‘effective’, and instead enquires into how CTOs are implemented, the processes involved and the experience of the key stakeholders. An assumption held throughout is that a good outcome in relation to CTOs is the implementation of good practice. Investigating practice issues does not lend itself well to quantitative research and suggests the need for a qualitative study and the methodology and research design is presented in Chapter Three. A case study is the primary method of investigation and a cluster analysis forms an important part of understanding more about who is on CTOs in one area mental health service. The cluster analysis findings assist with the selection of four individual case studies. Undertaking a cluster analysis, case studies and also including semi-structured group interviews with key stakeholders forms the basis of a mixed methods approach where considerable triangulation of data collection and analysis occurred.

The challenge with qualitative methods is to organise the data to enable some meaning to be derived from it so that theory can be developed. NVivo 7, a computer
program, provided considerable assistance with an analysis based on a general inductive approach (Thomas, 2004). The aim of this study was to develop theory that informs mental health practitioners regarding their work with people on CTOs and ensure that the lived experience of consumers, carers and service providers informed the development of this theory. In Chapters Seven and Eight, five principles are identified, discussed and tested. Guidelines for good practice have been developed with the assistance of this research design and its underlying theoretical framework. It is anticipated that this will assist service providers to include the aspirations of the emancipatory values of social work into their everyday practice with people on CTOs.
Chapter One: Community Treatment Orders – A Contested International Human Rights Issue.

Introduction

CTOs may be understood to have been an inevitable consequence of the process of deinstitutionalisation, a policy and process that is now increasingly relegated to history (Gerrand, 2005), given that inpatient beds in Victoria remain relatively few in number and, some would claim, difficult to access even for short periods of time. The development and use of CTOs appears to be a response to the view that there are many people who cannot live safely in the community unless they are subject to involuntary treatment. In this light, CTOs provide an opportunity to fulfil the positive human rights of these citizens – to enable a less restrictive option while acting in their best interests and meeting duty of care requirements (Bell, 2003).

Involuntary psychiatric treatment in the community raises considerable concerns regarding ethics and social justice. Social work practitioners in particular, who often hold case management or other direct service responsibilities with people who are subject to these orders, may find themselves faced with considerable disquiet regarding the situation faced by their clients (Campbell, Brophy, et al., 2006; Scheyett, et al., 2009). Most obvious is the potential clash between the emphasis given in our professional principles and values to client self determination with those principles emphasising service and duty of care. However, on deeper reflection, other ethical dilemmas are raised, particularly when it is acknowledged that the presence of CTOs is not only driven by the needs of particular clients, but also influenced by other factors. Social and structural issues appear to be being played out in decisions regarding the existence and implementation of CTOs, as well as who might be more vulnerable than another to be placed on a CTO and stay on one for a long time. This is evidenced in the current debates surrounding the implementation of CTOs in the UK and elsewhere (Churchill et al., 2007; Dawson, 2005; Nagel, 2003; Segal & Burgess, 2006a).
In addition to what has been argued as the relevance of a social work enquiry into this topic, there is also considerable justification for research activity that attempts to explore the impact of CTOs and improve the processes associated with the implementation of these orders. CTOs are likely to continue to feature in developments in mental health legislation and maintain their position in the landscape of psychiatric services (Campbell, Healy, & Brophy, 2006). However, they have also become, and remain, a contested international human rights issue (Campbell, Brophy, et al., 2006; Churchill, et al., 2007; Dawson, 2005). Many of the forces driving the implementation of involuntary community treatment that are described in this chapter (Brophy & McDermott, 2003), are not necessarily in the interests of consumers or service providers, but the product of social and structural forces impacting negatively on psychiatric services. Furthermore, concerns about human rights abuses and lack of evidence regarding effectiveness, cannot be ignored. It is important that the problems and abuses of the previous custodial institutions are not transferred and reinterpreted in the community to become new forms of coercion and control, without the walls (Sapouna, 2006).

The topic of CTOs has considerable scope for enquiry. The very existence of CTOs can be seen as a response to contemporary debates about mental health service delivery and risk management at a time when institutions have been closed and policy makers hope that they can provide ‘a fix’ for consequent problems. It has been suggested that, without more research into their effectiveness, and clearer ethical and practice guidance, there are risks that CTOs may be open to inappropriate use, and operate as a diversion from adequately funded community services (Appelbaum & Redlich, 2006; Kisely, et al., 2005). This chapter provides the background to the use of CTOs in Victoria and internationally. A force field analysis is used to sort through the complex literature on the topic of CTOs. This enables the identification of driving and restraining forces surrounding the development and implementation of CTOs.
CTOs in Victoria

Debate regarding the implementation of CTOs in Victoria, enabled by the *Mental Health Act* 1986, was relatively low key (Carney, 2003), without the controversy that has characterised the debates about the introduction of CTOs in the UK (Campbell, Brophy, et al., 2006; Hall & Ali, 2009; Moncrieff & Smyth, 1999).

CTOs were introduced in Victoria based on assumptions that they would be useful and effective, rather than on evidence from research findings. Carney (2003) describes the inclusion of CTOs in the Victorian *Mental Health Act* 1986 as a ‘afterthought’ (p.24). But this apparently minor section became crucially important in the 1990s when sweeping reforms led to the closure of psychiatric hospitals and a shift to emphasis on community based care, such that now, in Victoria, most involuntary patients are on CTOs (Mental Health Review Board, 2008).

Although examples in other states involve courts or tribunals making the order, in Victoria the orders are made and confirmed by doctors and psychiatrists. The Victorian Mental Health Review Board (MHRB), a multidisciplinary panel consisting of a legal, psychiatric and community member, reviews the validity of the orders. Patients can appeal the order and the hearing will occur as soon as possible, otherwise a standard review date is set. In Victoria this is within eight weeks after admission on the order, and then annually. Legislation in other states varies considerably on the duration of the orders and periods prior to review (Brophy & Healy, 2009; Rolfe, 2001).

The establishment of specific criteria that determine whether involuntary treatment is able to take place has been an important development in mental health legislation and is the key feature of all mental health legislation in Australia (Brophy & Healy, 2009). It is arguable that, after developing an understanding of the objects and principles of the Act, the most important feature to be understood by all mental health workers is the interpretation and application of these criteria. This is because they determine the important decision-making regarding involuntary treatment both in hospital and in the community. Initially in Victoria the criteria for admission onto a CTO was the same as the involuntary admission criteria for inpatient admission (*Mental Health Act* 1986).
Health Act 1986 (Vic) s. 8). However, in 1995, the Act was amended and specific (although very similar) criteria for admission onto a Community Treatment Order were included (s.14 (1A)). In 2003 the Act was again amended and it reverted back to having a single set of criteria for all people placed on an involuntary treatment order, whether this was to enable inpatient admission or a CTO. The criteria are as follows:

(a) the person appears to be mentally ill; and
(b) the person’s mental illness requires immediate treatment and that treatment can be obtained by making the person subject to an involuntary treatment order; and
(c) because of a person’s mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person’s physical or mental condition or otherwise) or for the protection of members of the public; and
(d) the person has refused treatment or is unable to consent to the necessary treatment for the mental illness; and
(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person’s freedom of decision and action. (Mental Health Act 1986 Section 8(1)).

CTOs can only be made if the person meets the above criteria and is assessed as being able to obtain treatment in the community. The order cannot exceed 12 months and may include a residence condition (Section 14(3)(b)).

A CTO must specify:

(a) the authorised psychiatrist or delegate of the authorised psychiatrist who is to monitor the treatment of the patient; and
(ab) the registered medical practitioner who is to supervise the treatment of the patient; and
(b) where the patient is to receive treatment; and
(c) the intervals at which the registered medical practitioner must submit a written report concerning the treatment of the patient to the monitoring psychiatrist; and
(d) the duration of the CTO which must not exceed 12 months. (Mental Health Act 1986 Section 14(2)).
Section 2A was inserted in 1993 and this section enabled a CTO to specify where a patient must live ‘if this is necessary for the treatment of the patient’s illness’. Although the duration of residence conditions is not specifically determined in the Act, policy guidelines issued by the relevant government department encourages highly restricted use of residence conditions and recommends ‘a residence condition should not routinely apply for 12 months’ (Chief Psychiatrist, 2005 p.13).

The careful wording of the above legislation reflects attempts to be in keeping with the objects of the Act, which are, in summary, to provide for the care, treatment and protection of mentally ill people and to also protect their rights (Mental Health Act 1986, s.4) (State Government of Victoria, 1986).

The most recent amendments also introduced the requirement that all patients subject to involuntary treatment, including those on CTOs, be issued with a Treatment Plan (s.19A) (inserted by no. 18/2003).

Initially, when CTOs were first introduced in Victoria, they were designed to facilitate the ongoing treatment of patients after discharge from hospital. However, the Act was amended in 1990 to enable involuntary admission without the person ever attending an inpatient facility, thereby acting as a direct alternative to inpatient admission (Mental Health Act 1986 (Vic) s.14(1)). Recent amendments appear to have further encouraged involuntary treatment to be community based.

Estimates vary about the number of people on CTOs in Victoria because reliable data is difficult to obtain but, based on MHRB Annual Reports and research findings (Brophy, Reece, & McDermott, 2006), about 3,000 people in Victoria are currently on CTOs. It has been estimated that in 2003 approximately 20% of people who were consumers of community based public mental health services in Victoria were on CTOs, equivalent to roughly one person in every 2,000 (Dawson, 2005, 2008). In an article in The Age, a Melbourne newspaper, on the 24th April 2009, the estimated figure was 5,099 involuntary CTO patients. However, it could be argued that this figure is inflated because it is based on the MHRB Annual Report 2008 and its data on MHRB hearings. This report is unable to provide accurate data on how many people are on CTOs at a
single point in time. This data is not readily available and, as explained above, estimates can only be made on the basis of multiple sources.

These large numbers are in part explained by the strong support for the use of CTOs amongst service providers in Victoria (Dawson, 2005). Quantitative studies using Victorian data by Power (Power, 1998, 1999), Muirhead (2000), and Segal and Burgess (Segal & Burgess, 2006c, 2006d) have demonstrated support for the ‘clinical wisdom’ attached to the use of CTOs. In a qualitative study, Brophy and Ring (2004) investigated the views of service providers and found that they generally held positive views about the operation of the orders in enabling greater opportunity for treatment and service provisions. Even so, participants also expressed concern about the disempowering and stigmatising impact on consumers. Patel (2008), a Victorian based psychiatrist, disagrees with the positive perspective of some of his colleagues and has argued that CTOs have ‘undermined optimal service delivery and supported paternalistic, reductionist clinical practice’ (p.340).

Carney (2003) identifies people on CTOs as continuing to grow as an invisible, marginalised group in the community; thus, the people decanted from institutions have become the subject of social control measures in the community (Rose, 1998). Carney (2003) also questions the legal protections offered by compulsory annual reviews when large numbers of people are discharged just prior to their review hearings. This activity may indicate misuse and complacency, or, at least, a lack of appreciation of the implications of the exercising of these powers. This means that many people may be on CTOs for longer than necessary, potentially many months, and what is stimulating the decision to discharge the person from the CTO is a forthcoming MHRB hearing rather than careful monitoring and thoughtful decision-making.

The operation of CTOs and the legislative scheme supporting them were criticised by the coroner in the findings on the death of Mr Nicholas McNulty (Victorian State Coroner's Office, 1997). Mr McNulty was stabbed by a man who was, at the time, on a CTO. The coroner found the legal requirements for managing CTOs to be unclear and identified deficiencies in the awareness of mental health professionals in
undertaking their legal obligations. The coroner also found that some staff were ill prepared to manage the demands of providing effective care and treatment. Recent law reform acknowledged some of the broader concerns about examples of inappropriate or poor implementation of CTOs. The need for improved consumer\textsuperscript{1} focus in treatment planning has also been identified (Department of Human Services, 2005a).

Statutory treatment plans were introduced in 2004 as a result of amendments to the Victorian \textit{Mental Health Act 1986} (Section 19A) in order to give consumers guidance about their obligations under a CTO and a clear statement of the treatment that they can expect (Department of Human Services, 2005a). This was implemented in order to be in line with other jurisdictions in Australia, and also in response to criticism from consumers and carers in feedback about a lack of clarity regarding treatment planning (TQA Research, 2004). Overall these reforms to the \textit{Mental Health Act 1986} were modest, and did not result in major change. More recently the Act has been targeted for replacement, with the publication of a community consultation paper in 2008 and a proposal that a new bill go before parliament in 2010 (Department of Human Services, 2008b). The community consultation paper refers to the concerns about CTOs, including that they may be overused, too long, and used without evidence for their effectiveness with some people. Specific questions posed in the review about CTOs include whether they require separate grounds for admission to those required for inpatient admission, what duration they should be and what types of treatment they can impose. Other relevant topics raised in the community consultation paper include an extensive discussion on how to improve patient participation in treatment and care, improving external reviews and appeals, and having more effective and efficient complaints mechanisms (Department of Human Services, 2008b). As a member of the expert advisory group for this review, and in a previous role assisting with the state-wide introduction of treatment plans, I have been acutely aware of how difficult it is to use legislation to influence practice. For example, having a statutory requirement for

\textsuperscript{1} The term ‘consumer’ is generally used in Victoria when referring to people who use mental health services and it will be used throughout this thesis although, at times, ‘CTO recipient’ will be used when specifically referring to a person who is a consumer on a CTO.
treatment plans is widely considered to have failed to improve practice. Criticism includes the lack of thought and detail, and the lack of meaningful participation by consumers and carers. The president of the Mental Health Review Board (MHRB) has made the following comments:

I regret to report that overall progress in developing treatment plan skills across service staff has been patchy. With relatively few exceptions, Board members continue to report that most treatment plans presented at Board hearings are brief, repetitive, in template form without individualisation to the circumstances of the particular patient, punitive in tone and provide little information of value to the patient and the family in respect of treatment progress, aims and recovery strategies. (Mental Health Review Board, 2008 p.17)

In the same report the MHRB president also expresses concern about the lack of revision of the Chief Psychiatrists treatment plan guidelines because they remain in draft form (Chief Psychiatrist, 2004). He concludes:

Feedback from members throughout the year has confirmed that many doctors and clinicians working in services still assume that they are preparing and reviewing patients’ treatment plans for the purposes of Board hearings rather than as an adjunct to good clinical practice. Many treatment plans seen by Board members do not comply with legislative requirements and, regrettably, many are prepared in a way which is unlikely to improve relationships between staff and patients. (Mental Health Review Board, 2008 p.17)

The Development of Involuntary Treatment in the Community in Australia and Internationally.

As of 2000, all Australian states and territories now have provision for involuntary community treatment (Brophy & Healy, 2009). However, there are some variations, particularly in the lengths of the orders and the periods between administrative reviews. New Zealand has also embraced CTOs, and researchers there are gradually establishing strong support for the use of CTOs amongst service providers and others (Dawson, 2005; Gibbs, Dawson, & Mullen, 2006). They are also increasingly
used in the USA (Churchill, et al., 2007; Ridgley, et al., 2001). Ridgley, et al., (2001) provide a summary suggesting that thirty-eight states and the District of Columbia had statutes that make specific provisions for involuntary outpatient treatment, and several other states have considered such proposals. However the use of, and support for, CTOs varies in the USA (Geller, 2006; Swartz, Swanson, Kim, & Petrila, 2006). Geller (2006) describes the situation in the USA as follows:

Outpatient commitment (OPC)... has evolved in the United States on a state-by-state basis amidst a storm of controversy. The polarising debate has gone on intensely about OPC for the last two decades. (p.234)

The situation in one state, Florida, has been presented as an example of where CTOs have ‘failed’ because they have been rarely used and do not have the community based support services to enable their implementation (Petrila & Christy, 2008).

Involuntary treatment in the community has been introduced in two provinces in Canada with generally positive support from key stakeholders (A. M. O'Brien & Farrell, 2005; O'Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006). Scotland has been ahead of other parts of the United Kingdom but, despite considerable opposition, the rest of the UK is now following and CTOs are currently being implemented in England and Wales via the Mental Health Act 2007 (Campbell, Brophy, et al., 2006; Hall & Ali, 2009; Richardson, 2007; Scottish Executive, 2005). However, they are not a feature of legislation in continental Europe, other than Switzerland (Churchill, et al., 2007; Dawson, 2005; Ramon, 2006).

As might be expected, considering this time frame and the circumstances of different jurisdictions, there is some variation in terminology and process. However, fundamentally all legislation involved enables someone who meets certain involuntary admission criteria to be treated involuntarily in the community, usually with medication in conjunction with other psychosocial interventions.

Legislation across the states in Australia varies in relation to how an order is made, the duration of the order, the periods between review, and access to advocacy and external review (Brophy & Healy, 2009; Department of Human Services, 2008b). For
example, in contrast to Victoria where orders are generally made for 12 months, in Western Australia the order is initially made for three months then reviewed every six months (*Mental Health Act, 1996 (WA)).

**A Force Field Analysis**

Involuntary psychiatric treatment in the community has been a topic of considerable discussion in the literature. One way of conceptualising the current debates around involuntary treatment in the community is to think of it as being pulled and pushed by both driving and restraining forces.

Force Field Analysis (Lewin, 1951) is a technique commonly associated with the fields of change management and policy development. It is based on the assumption that:

...in most problem situations that involve change it is possible to identify two opposing sets of forces. There are driving forces that assist and favour change or action, and the restraining forces that oppose change or action. (Tyson, 1998 p.213)

Force field analysis is a useful tool in explaining why involuntary treatment is currently achieving some ascendancy in the development of mental health law, policy and practice (the driving forces) and why it remains controversial (the restraining forces). A range of complex, national and international processes are at work here, involving politicians, public opinion and policy makers. It is apparent that internationally there has been, for the last few decades, a tendency by governments to increasingly favour more coercive approaches to care and control of people living outside hospitals (Szmukler, 2008). However, there have also been calls for more careful consideration of whether CTOs are necessary and to develop greater understanding of the potentially negative implications of the use of CTOs. The forces driving and restraining the use of CTOs appear to be operating at a number of different levels. This includes: local decision-making, such as that undertaken by treating teams in clinical meetings, professional discourses, the consumer and carer movements, reviews undertaken by
tribunals, and decisions made by the judiciary and governments. Activity at all these levels shapes the way orders are conceived and used. Using a force field analysis, albeit in an unusual way, has been a very useful way to deal with a complex array of relevant literature, and sort through the different opinions and evidence. It has also helped in tracing the impact of developments in the implementation of CTOs as an intervention in psychiatric services. These developments appear to be attempting to balance what I have described as the driving and restraining forces.

It is important to note here that while in its conventional use a force field analysis might be used to enable change (such that restraining forces are seen to be problems that need to be dealt with in order to allow a particular change to occur) what is represented here is a modified use of this technique that does not necessarily support the change but simply seeks to understand what is impacting on it. An earlier version of this literature review, using this approach, was published in a peer reviewed journal (Brophy & McDermott, 2003).

**Driving Forces**

**Deinstitutionalisation**

Deinstitutionalisation is a process that has dominated mental health service and policy reform over the last 40 years, with an emphasis on treating people in the least restrictive environment (Carney, 2002, October; Gerrand, 2005; B. Healy & Brophy, 2001; Muijen, 1996). However, its critics have always suggested that there is a certain, large group of people whose interests have never been served by the process of gaining freedom from the artificial and potentially damaging environment of the institution. This is the group who, according to some, have been left ‘rotting with their rights on’ (Appelbaum & Gutheil, 1979; Fuller Torrey & Chamberlin, 1999). In support of the role of CTOs in deinstitutionalisation, Power (1999) suggests that:

They (CTOs) have clear advantages for some patients who might otherwise be subjected to the deprivations of serious mental illness and deprived of the
benefit of vital treatment and care in the least restrictive setting, their own homes. (p.13)

Shorter inpatient stays

Whilst not strongly established in the literature as one of the factors behind the development of involuntary treatment in the community, an increasingly common feature of the modern inpatient unit is that of an emphasis on relatively short inpatient admissions. The average admission in Victoria is likely to be around 21.9 days, compared to the national average of 50.3 days (Commonwealth Government of Australia, 2008). However, even this average figure is misleading as it takes in some longer term units such as extended care. An acute adult inpatient unit is likely to have an average inpatient admission of 14 days or less. Therefore, an acute inpatient unit in Victoria is generally described as a place for short term and intensive treatment. There is considerable pressure on availability of bed vacancies and this leads to ‘gate keeping’. Treating inpatient beds as a relatively precious resource results in service providers attempting to, as far as possible, maintain the community as the primary site for treatment (Sawyer, 2008). These factors may be contributing to the perception that involuntary treatment in the community is a valuable option in attempting to manage the resources available in the psychiatric service system. It is also representative of an ongoing distrust of institutionalised care and preference for community based treatment. This preference is likely to be driven, in the current health and welfare environment, by economic imperatives as much as ideology or ideas about good practice (Carney, 2002). The drive for effectiveness and efficiency can be understood as part of late modernity, the rise of neo-liberalism and the subsequent pressure to be accountable through being cost effective (Webb, 2006). This requires carefully defining the boundaries of intervention through being increasingly narrow and reductive, thereby regulating and ‘micro – managing’ who gets access to increasingly scarce, and expensive, resources such as inpatient beds (Webb, 2006 p.6).
The nature of severe mental illness

As suggested above, many people with serious mental illnesses who, as a result of deinstitutionalisation, are more likely to receive care and treatment in the community, may not benefit from community based care due to their lack of willingness or capacity to engage with services voluntarily. One way of explaining this phenomenon has been offered by Munetz and Frese (2001), who suggest that lack of insight and non-compliance are features of mental illness in that:

There is growing evidence that a lack of awareness of illness in people with schizophrenia, what is commonly called lack of insight, has a biological base similar to anosognosia seen in poststroke patients ....While it is clear there are some people, perhaps a majority, who regain capacity as they respond to treatment, there is a sub-group of unknown size that fails to regain decision-making capacity. (p.38)

These authors use research evidence that demonstrates a link between neuropsychological dysfunction and lack of insight in schizophrenia. They propose that this biological basis underlying lack of insight supports the proposition that a range of involuntary community treatment options needs to be available to ensure the responsiveness of community based treatment to those potentially most vulnerable to exploitation and violence, and who are at risk of not experiencing recovery due to lack of proper treatment.

The ‘risk society’

Internationally, states have been concerned about the risks posed by people with mental health problems; for example, as a result of cases of homicide in the UK (Muijen, 1996) and USA (Behnke, 1999). Developments in these countries are most
clearly related to serious incidents of violence apparently perpetrated by people with untreated mental illness living in the community (for example, ‘Kendra’s Law’ in New York\(^2\)). Risk management is recognised as an important contemporary phenomenon in Western countries, which has far reaching effects on many aspects of social, political and economic life. It is hardly surprising, therefore, that:

The very nature and structure of the mental health system is thus increasingly shaped by risk and the imperative to manage it (Rose, 1998 p.184).

Perhaps as a response to traditional representations of people with mental illness in the modern media, fears are often exaggerated. Even though:

The risk (of homicide) is very low, especially to non-relatives. Far from the tip, reported incidents seem to be the whole iceberg... (Muijen, 1996 p.152).

Theorists argue that the perception of living in a ‘risk society’ results in life being saturated by concerns about risk that then influence decision-making and people’s state of mind through inducing, often unnecessary, doubt, fear, anxiety and lack of trust (Webb, 2006 p.20). The important topic of risk and its relevance to social work and the development of CTOs will be further explored in Chapter Two.

**Accountability**

Mental health staff of all disciplines have been subjected to a continual bombardment of policies and guidelines over the past five years, mostly intending to prioritise people with the most severe mental health problems (Muijen, 1996, 152).

The imperative to ensure adequate follow-up of people with psychiatric problems in a service environment characterised by considerable resource tensions

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\(^2\) Kendra New York State OPC legislation is commonly referred to ‘Kendra’s law’ because it can be seen to have resulted from the death of Kendra Webdale who was pushed in front of a train by a man who had not been taking the medication prescribed for his mental illness.
creates significant problems for service providers. As suggested by Muijen (1996) and Sawyer (2008) this increases the ‘gatekeeping’ activities undertaken by psychiatric services. This involves diverting people from hospital as far as possible and also directing public sector agencies to care for the most seriously mentally ill, even though these consumers may be reluctant and/or have multiple problems including homelessness and drug abuse (Sawyer, 2008). Swartz, Swanson, et al., (1999), on the basis of their evaluative research, suggest that:

Outpatient Commitment (OPC) works when it represents a reciprocal commitment by community programmes to provide sustained and intensive treatment to patients under court orders. In fact, these findings suggest that OPC may exert most of its effect on providers. (p.1975)

Thus, in Brophy and Ring’s (2004) study, consumers described CTOs as assisting in ensuring that help would be available in a crisis. They also shared perceptions that when on a CTO it would be easier to get back into hospital, if required, with less ‘red tape’ (Brophy & Ring, 2004 p.185).

**Clinical wisdom**

In Victoria, CTOs have become an everyday aspect of community mental health treatment. They have been used to prevent admission to hospital and enable shorter admissions. There are thousands of people subject to involuntary treatment in the community in Victoria and some of these people have been on CTOs for many years (Mental Health Review Board, 2008). Muirhead (2000) currently practices as a psychiatrist in Victoria and has researched the effectiveness of CTOs on the basis of a number of factors and he concludes that:

Mental health staff, both community and hospital based, have become accustomed to and experienced in their use. In the author’s experience the resistance to the use of CTOs previously reported ... is no longer characteristic of
community mental health staff members. More recently there has been a call by community based psychiatrists for greater integration of CTOs into patient management plans and greater involvement of community based clinicians in decision-making and consultation regarding the appropriateness of CTOs ...(there is) an apparent trend of increasing use of CTOs in Victoria. (p.8)

Muirhead (2000) supports the clinical wisdom attached to the use of CTOs in Victoria with research evidence. In his mirror image study, he found:

Further evidence to support the effectiveness of CTOs as a means of enhancing outcome for certain sufferers of schizophrenia. Significant improvement during the year of treatment on a CTO was found on measures of number of hospital admissions, length of inpatient stay, episodes of aggression and quality of relationships with family. (p.67)

Legislative reform

As suggested in an article in The Guardian newspaper in the UK, the introduction of involuntary treatment in the community, beyond what was already possible because of guardianship or extended leave from hospital, appears to be attractive to legislators. In summary, ‘The mental health bill may be a crowd pleaser...’(Moller, 2002). This appears to be because involuntary treatment in the community can be used as the ‘carrot’ to appease people concerned about tragic incidents involving people with apparently untreated mental illnesses. This argument is made despite the lack of strong evidence to establish the effectiveness of legislation to prevent such tragedies. One way of understanding why there is an apparent wave of introduction or strengthening of options for involuntary treatment in the community is a ‘domino effect’ both within nations and internationally, in a complex situation where other solutions or symbols of action may be costly or poorly understood by the general community. It seems that before the evidence of effectiveness has been fully established and even while contradictory evidence exists, OPC or CTOs continue to be introduced in countries and states across the world.
Restraining Forces

Despite the considerable support for the development and implementation of involuntary community treatment, it is not without its critics, particularly in the UK where there has been considerable debate and demonstrations of broad based opposition involving many key stakeholders. There are various sources of support for this opposition and these are discussed below.

Contested evidence regarding effectiveness

As will be discussed in greater detail later in this chapter, many of the studies that have tried to establish the effectiveness of CTOs have been contested on methodological grounds because of the lack of control groups and small sample sizes; on the other hand, large, controlled studies have not tended to support the effectiveness of involuntary community treatment (Churchill, et al., 2007; Kisely & Campbell, 2007; Kisely, et al., 2005). The Bazelon Centre for Mental Health Law (2000), in a review of the research evidence, found that there was no statistically significant effect for OPC in terms of rehospitalisation rates. An epidemiological study in Western Australia found that:

CTOs may not be an effective alternative to assertive community treatment programmes (Preston, Kisely, & Xiao, 2002 p.1248).

However, Dawson (2008) argues that there is very good evidence of the value of CTO regimes in Australasia. He contends that CTO regimes have been successful in Victoria, NSW and New Zealand because they are ‘well embedded and adequately resourced’ (Dawson, 2008 p.150).

An important consideration (and driving force) is whether CTOs actually prevent the occurrence of serious incidents. Again there does seem to be some suggestions to the contrary. Appelbaum (2001) suggests that the prevention of violence is ‘one of the
weaker justifications for outpatient commitment laws (p.347). For example, as previously mentioned, a random murder occurred in Victoria and it was not prevented by a CTO. The subsequent coronial enquiry suggested that the key factors contributing to this tragedy related to substance abuse, lack of continuity of care and accountability and inadequate crisis response, and that, although the perpetrator was on a CTO, it had never been ‘reasonably foreseeable that he could commit a homicide’ (Victorian State Coroner’s Office, 1997). Another coronial case was of a young man with schizoaffective disorder who was on a CTO. (A. O’Brien, Ibrahim, & Davis, 2007). When his relatives went overseas this young man stabbed himself in the chest and died from his injuries. Both these incidents challenge the hope that CTOs can prevent such adverse events.

In a comprehensive, long term study on this topic - again in Victoria, Australia-Power (1998), at one level, found considerable support for CTOs in well targeted situations, but he also acknowledged that CTOs may, when poorly targeted, act as a further deterrent to treatment compliance. For instance they tend to be difficult to administer with homeless or itinerant people, often the very people who might be considered most at risk. A review of the studies on effectiveness will be further discussed later in this chapter.

**Ethical concerns**

CTOs have the potential to have a profound effect on the recipient’s well being, not only in terms of treatment compliance, but also in relation to other issues such as empowerment and sense of self-efficacy (Mancini, 2007). It is suggested, therefore, that it is important to reflect on whether CTOs are more concerned about ‘what works’ - rather than ‘what is inherently good for the client’. In other words, how do mental health professionals maintain moral integrity in the face of the temptation created by the ability to coerce (Goldstein, 2001)? Considering the often terrible consequences for mental health professionals if their clients are involved in any serious incident of violence or in committing suicide (Muijen, 1996), it is hardly surprising that there may
be a tendency towards conservative decision-making around issues such as patient autonomy and alternative or innovative treatments. Decisions based on ‘false positives’ may be a perverse outcome of such professional choices. As a result of any ‘false positives’, people are being placed on CTOs, and some of these for many months or even years, who may never have harmed themselves or anyone else during that time and may have also found their own way to treatment rather than requiring long term coercion (Allen & Smith, 2001; Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006). For example, people may need to relapse more than once to begin to acknowledge their need for treatment or they may respond to efforts to engage them through other methods, such as financial incentives or the influence of their informal support network (Moynihan, 1996). There is also the possibility that in the context of the relatively easy availability of coercive methods, other techniques to encourage engagement are neglected and the chances of receiving innovative, more client focused treatment is thus reduced (Wales & Hiday, 2006). What partly contributes to competing ideas about the ethics of the use of CTOs is the lack of a shared theory of individual autonomy between professionals and across states:

Laws governing OPC must be based on a theory of individual autonomy....Civil rights attorneys have traditionally tended to favour accepting what a patient says at a given point in time as an expression of that patient’s autonomy and have advocated accordingly. Mental health practitioners on the other hand, have tended to follow an individual's wishes as expressed over time and after due consideration. (Behnke, 1999, p.4)

Dawson (2008) discusses human rights in this area and contends that, how they are understood, and the degree to which they are entrenched in constitutional law, has an impact on how CTOs are approached in different parts of the world,- and the degree to which they are seen as ethical. Whilst in the USA there is vigilance in the protection of individual rights in mental health law, increasingly in Australia the long term view, which is more likely to take into account wider social and public factors, has a significant influence on decision-making. For example the MHRB of Victoria rarely makes a decision
based on current presentation, but will take into account the person’s history, especially one that involves violence and non-compliance (Jaworowski & Guneva, 1999). While this may seem to be a considered approach to decision-making, it appears to clash with the Board’s lack of ability to comment directly on treatment issues, even standards. Therefore, the Board is locked into only being able to discharge or uphold the decision, and extremely limited in its capacity to expect that other methods to engage the consumer or develop insight will be implemented. This may be inadvertently reinforcing coercion as the only option to consider when consumers have a history of relapse, reluctance and non-compliance with treatment.

**Availability of effective treatment and resources**

It has been argued that one of the disadvantages of CTOs is the emphasis placed on medical treatment, particularly medication, and, at least in Australia, higher usage of depot medication (i.e., weekly, fortnightly or monthly injections). Schwartz, Swanson, et al., (1999) suggest that OPC, or CTOs, will only be effective if associated with intensive treatment, which they define as an average of seven contacts per month over a sustained period. Furthermore, education and training for mental health clinicians in working with involuntary clients in the community tends to be limited even though, increasingly, mental health clinicians are required to make decisions regarding whether a CTO should be revoked and generally try to build relationships with involuntary clients. Another problem is the lack of advocacy and legal services, especially in rural communities (Carney, Beaupert, Perry, & Tait, 2008; Department of Human Services, 2008b).

Dawson (2008) has made positive comments about the structure and availability of mental health services in Victoria when compared internationally. However, mental health service providers have commonly expressed frustration that their services are not able to provide an adequate standard of care because of economic constraints, and that is a significant cause of stress amongst both nursing and allied health staff in case
management roles (King, Lloyd, & Holewa, 2008). People on CTOs may be included amongst those not receiving an adequate standard of treatment and care. The lack of an adequate standard of care has a number of possible explanations. This includes a perception that the medical, disease framework that dominates mental health service provision is generally inadequate to meet the complex needs of people with serious mental illness (Bland & Renouf, 2006). Medication is often relied on as the primary, and sometimes only, treatment in some cases, even though medications can be unpleasant, especially in depot form, and have a range of side effects. For these reasons and others, compliance with medication amongst people with schizophrenia is notoriously poor (Corrigan, Liberman, & Engel, 1990). Also, treatment with medication only is problematic when the effectiveness of medication for some groups of consumers may actually be in doubt (Cohen, 2003; Moncrieff & Smyth, 1999). The emphasis on medication may be explained by considering it as a relatively cheap and quick treatment that can be forcibly administered if necessary, with strong support about its effectiveness from the lead professionals in psychiatric care. However, there is some concern about whether people should be coerced into treatment that is often the product of private pharmaceutical companies, has significant risks, and is often unattractive to the consumers (Cohen, 2003). Wales and Hiday (2006) express concern that involuntary treatment options are a cheaper alternative to more intensive, creative care and treatment options such as assertive outreach and consumer led services. There is also the possibility that, fundamentally, alternative treatment options simply do not exist, or have not been able to establish themselves, possibly due to a combination of the emphasis on medication, fiscal constraints and lack of innovation. Alternatives that have been suggested include ‘the use of consumer-run guardianship program and a capacity review panel’ (Munetz & Frese, 2001 p.35), advance directives (C. Henderson, Swanson, Szmukler, Thornicroft, & Zinkler, 2008; Papageorgiou, King, Janmohamed, Davidson, & Dawson, 2002) or complete overhauling of incapacity legislation (Dawson & Szmukler, 2006). A study in the USA found that the availability of housing was a better form of leverage into treatment than OPC (Monahan, et al., 2005). Advance directives
are favoured by many consumers because they enable people to provide a statement in advance regarding their preferences for treatment and care when their capacity and judgement has been compromised by a relapse of serious psychiatric illness (C. Henderson, et al., 2008). McSherry (2008) suggests that, although the new United Nations Convention on the Rights of Persons with Disabilities, especially Section 17 which seeks to protect the physical and mental integrity of every person with a disability, is unlikely to completely overturn involuntary treatment, it does enable the potential for greater restriction on ‘unbeneficial and overly intrusive treatment’ (p.122).

Increased stigma

In the UK one of the most commonly reported concerns about the introduction of involuntary treatment in the community is that it will drive people away from seeking treatment out of fear of compulsory treatment (British Broadcasting Corporation, 2002). Compulsory treatment is thus seen as a threat to the autonomy of people with serious mental illness, and also as potentially further stigmatizing an already marginalised group. Ring, Brophy and Gimlinger (2001) found that service providers were concerned that disempowerment amongst their clients was associated with limitations in the development of insight. What they appeared to be describing was the negative impact of coercion on self-efficacy. They then made a link to lack of self-efficacy and interference with recovery (Mancini, 2007), which may include, or even be dependent upon, the development of insight (Lincoln, Lullmann, & Rief, 2007).

Minkowitz (2006) expresses concerns about the impact of compulsion on recovery and anticipates that compulsion is likely to interfere with recovery. Codyre (2006), in a subsequent commentary, acknowledges that very little research appears to have been undertaken that attempts to ‘quantify harms from compulsion as an intervention’ (p.47).

Dawson and Szmukler (2006) have suggested that there should be a single statutory process governing all forms of non-adherence in both general and psychiatric
medical conditions, thereby reducing discrimination in the law. They argue that mental health laws are in themselves discriminatory because they single out people with mental health problems, even though there are a range of psychosocial problems or illnesses that could potentially lead to loss of capacity or risk to self and others, such as neurological conditions or drug dependence.

**Human rights and civil liberties objections**

Some consumer groups, such as Madpride, a consumer survivor group, in the UK, are strongly opposed to CTOs. After the publication of the UK government’s white paper (Department of Health, 2001), the consumer based opposition was extended to the Mental Health Alliance, who, in September, 2002, organised a public rally in London opposing the introduction of CTOs in England and Wales. Brophy and Ring’s (2004) work with consumers indicated considerable concern regarding the disempowering effect of being on a CTO, described as equivalent to being ‘in jail without any walls’ (p.165) by one consumer in their study. Consumers interviewed also complained about a lack of access to alternative treatments (including counselling), treatment choices and a general lack of dialogue about rights. This lack of dialogue about rights was also found in a Victorian Auditor General report (2002) and in Victorian government survey data (TQA Research, 2004). Human rights issues have become increasingly important in the implementation of CTOs in Victoria where legislation and practice is being influenced by local and international human rights law. The Victorian Charter of Human Rights and Responsibilities Act, 2006 (the Charter) and the United Nations Convention on the Rights of People with Disabilities are two important influences on proposed changes to legislation in Victoria (Department of Human Services, 2008b). Already, the MHRB has been found to be in breach of the Charter when it did not undertake a review of a

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3 Mental Health Alliance “Rights Not Compulsion: March and Rally” 14/9/2002, London UK.
person’s CTO within the time period set by the legislation. This was seen to be a breach of this person’s right to a fair hearing (Cain, Dixson, Davidson, & Dewey, 2009).

**The Unintended Consequences of CTOs**

The above suggests that CTOs are the result of a range of driving forces. They are not simply a response to the particular needs of a specific group of consumers of mental health services. Similarly, it can recognised that CTOs have unintended consequences. They are a response to, and causing, some broader systemic change in the way mental health services are delivered. For example, CTOs may be ‘deskilling’ in that they have become, in some cases, a substitute for highly skilled and resource intensive interventions. Similarly concerns have been expressed that CTOs result in an increased medicalisation of psychiatric care because the legislation is strongly focused on medical intervention. In Victoria, case managers, despite their important role in mental health service delivery, are rarely mentioned in the Mental Health Act 1986, and they have a minimal role in the administration and formal decision-making about CTOs (Brophy, Campbell, & Healy, 2003). There are also frustrations for medical staff who Jaworoski and Gunevra (1999) describe as having had the clinical aspects of their role with people on CTOs often overshadowed by administrative issues.

Another consequence, that does not seem strongly established in the literature specific to CTOs, although there is enough evidence to anticipate it, is that some groups are more likely to be placed on a CTO - even in the absence of an evidence base for doing so. When these groups appear to be young men from ethnic or indigenous backgrounds then perhaps it indicates how much decision-making is being guided by issues of risk management (Nagel, 2002; Hatfield et al, 2001; Dawson & Romans, 2001). This raises issues about the possibility of CTOs increasing the social control function of mental health service providers rather than doing what Power (1999) suggests is most effective, that is persuading those who are most likely to be persuaded into treatment and care by the powers of the CTO.
Evidence regarding the effectiveness of CTOs

As a result of inconsistent and contested research findings, evidence regarding the effectiveness of CTOs is represented in both what is driving CTOs and in the restraining forces. Despite being at the forefront in terms of experience, there has been, relative to efforts in the United States and New Zealand, very little investigation into the effectiveness of CTOs in Australia, and the results vary in the studies that have been done (Hough & O'Brien, 2005; Kisely, et al., 2005; Muirhead, Harvey, & Ingram, 2006; Power, 1998; Preston, et al., 2002; Segal & Burgess, 2006d).

A Cochrane review was unable to find enough evidence to suggest that CTOs may not be an effective alternative to standard care (Kisely, et al., 2005). The findings of many of the studies investigating the effectiveness of CTOs are very well summarised in an international review by Churchill, et al. (2007). Churchill, et al. (2007) identified 28 reports of CTO outcome studies and identified readmission to hospital as the most common indicator used to measure the effectiveness of CTOs. Others included:

Length of length of stay, remaining in contact with services, service intensity and compliance with treatment. Patient level outcomes with data (of any quality) from at least one study included social functioning, violence/threatening behaviour, arrest, employment, accommodation status, mental state and psychopathology, quality of life, criminal victimization, number of needs for care, carer satisfaction, perceived coercion, and adverse events. No evidence was available on other important patient outcomes, including self esteem, patient satisfaction, and general psychosocial outcomes (Churchill, et al., 2007 p.178).

This review concluded that the international findings regarding the evidence to support the effectiveness of CTOs were contradictory and inconclusive. This is despite recent efforts by Segal and Burgess (2006a, 2006d) to confirm positive outcomes for people on CTOs, especially in relation to mortality rates.

Therefore, some of the unanswered questions about CTOs appear to be around the issue of how the practice wisdom about the value of CTOs in well-targeted situations can be measured and established (Muirhead, et al., 2006).
Researchers (Muirhead, et al., 2006; Power, 1998; Segal & Burgess, 2006b) have evidence to support the value of CTOs on a range of measures, but most particularly readmission rates and other indicators of service usage. However, both in Australia and overseas (Kisely, et al., 2005; Preston, et al., 2002; Steadman, et al., 2001; Swartz, et al., 1999), results question the effectiveness of CTOs and argue that studies that have been conducted using control groups have tended not to support the effectiveness of CTOs over assertive community treatment programmes.

Whilst Muirhead, et al. (2006) and Power’s (1998) studies both provide support for the effectiveness of CTOs in reducing readmission rates, Preston’s (2002) study in Western Australia, found no evidence to support the use of CTOs and questioned whether they were more effective than assertive outreach. Furthermore, even though Power’s (1998) results appeared to contribute to support for CTOs, he makes a number of cautionary comments in his conclusions, particularly regarding problems associated with targeting CTOs towards the groups of consumers most likely to benefit and the need to recognise that with some groups of consumers a CTO may ‘backfire’ and actually discourage any potential for engagement and compliance in the future.

**Key stakeholder perspectives**

Studies are contributing to developing an understanding of the ‘lived experience’ of the consumers, carers and service providers involved in the implementation of CTOs. There is considerable support in the literature for qualitative studies that value multiple and co-occurring perspectives (Freckelton, 2003a; Freckelton & Lesser, 2003). There is currently a growing body of international literature and other sources reporting on qualitative data. Rachel Churchill and her co authors (Churchill, et al., 2007) have thoroughly collated numerous qualitative studies, including material from Australia, UK, New Zealand, the United States and Canada. There is also data from Atkinson, et al.’s study in Scotland (Atkinson, Garner, Gilmour, & Dyer, 2002), and Canvin, et al.’s London study (Canvin, Bartlett, & Pinfold, 2002). Two studies in Melbourne have involved the author (Brophy & Ring, 2004; Ring, et al., 2001). There is unpublished qualitative data
from Western Australia (Davidson & Rolfe, 2003) and O’Reilly, et al. (2006) have also published a study on the situation in Saskatchewan, Canada.

As described above, despite the many efforts of local and international researchers, quantitative evidence remains highly contested regarding the effectiveness of CTOs. Similarly there is also concern about qualitative data especially whether – in making comparisons across jurisdictions – the same thing is being compared and discussed. As noted by Dawson (2005), there are significant differences in both legislation and levels of implementation in different states. Even so, the consistency introduced below in relation to qualitative findings does suggest considerable similarities in lived experience when it comes to CTOs and similar orders across different jurisdictions. Generally key stakeholders in CTO research have included consumers, families and/or carers and service providers (mainly psychiatrists).

**Key themes in key stakeholder research findings**

Key stakeholders perspectives on CTOs have been invited in various qualitative studies reported on in the literature. What they observe about CTOs seems to gather under the themes that are presented and discussed below.

**Comparative liberty**

A consistent common theme about the value and purpose of CTOs from a key stakeholder perspective is the view that CTOs provide ‘comparative liberty’. This theme is used to describe how for many people it is better to be on a CTO than be in hospital, jail or subject to other sorts of coercion (Dawson, 2005; McDonnell & Bartholomew, 1997).

**Complaints about medication**

The issue of people not feeling heard about medication preferences and side effects has been raised in the New Zealand (Gibbs, Dawson, Ansley, & Mullen, 2005),
Canada (O'Reilly, et al., 2006), USA (Swartz, et al., 2003; Wales & Hiday, 2006), Western Australia (Davidson & Rolfe, 2003), as well as in Victorian studies (Brophy & Ring, 2004).

**Bittersweet**

Canvin, Bartlett, et al. (2002) describe how people can simultaneously resist and accept orders. This is consistent with findings in New Zealand (Gibbs, et al., 2005).

**Quality of Care**

What is apparent from consumers or service users about being on CTOs is that they are primarily engaged in active evaluation of their care. They tend to discuss the experience of being on a CTO, or other similar orders, in relation to the standard of care they are receiving rather than emphasising their own beliefs about the rightness or wrongness of the order itself (Canvin, et al., 2002; Corrigan, et al., 1990).

**Safety and security**

The emphasis on safety and security is one of the key themes found in Churchill, et al.’s summary (2007). This seems to be consistent with the focus of CTOs being on clinical need that extends beyond critical risk factors such as violence or homelessness. Ring, Brophy and Gimlinger (2001) reported on comments that coincide with those in Dawson, et al.’s (2003) study, namely that being on a CTO could be compared to having an insurance policy, particularly in relation to ensuring that services were not hard to access or were withdrawn. Therefore consumers might appreciate that services are obliged to provide them with care, and family/carers are relieved that they are receiving assistance in caring for their loved one (Mullen, Dawson, & Gibbs, 2006).

**Mutual obligation**

There are numerous findings related to CTOs being understood as an expression of the commitment of the service as much as of the patients or consumers (Brophy & Ring, 2004; Geller, 2006; Gibbs, et al., 2006; Swartz, et al., 2006). Therefore, no matter
how difficult the task may appear to be, a CTO requires the service provider to attempt to provide treatment and care in the community.

**Impact on therapeutic relationships**

In Western Australia, the Chief Psychiatrist’s unpublished research (Davidson & Rolfe, 2003) offered a strong suggestion of CTOs having a negative impact on therapeutic relationships, but other studies have found less negative effects. In New Zealand it was suggested that CTOs offered, at least in the long term, the possibility of enhancing the relationship - through enabling engagement and providing a structure or framework for difficult conversations to occur (Gibbs, et al., 2006). Even so, service providers do express concerns about the potential negative short term impacts, including the risk of being ‘the bad cop’.

**Disempowerment**

Service providers consistently express awareness that many CTO recipients experience disempowerment due to the coercive and restrictive effect of CTOs (Brophy & Ring, 2004; Davidson & Rolfe, 2003; Gibbs, et al., 2006; McDonnell & Bartholomew, 1997).

**Impact on recovery**

Most key stakeholders held general concerns about CTOs having minimal impact on the psychosocial dimensions of treatment and recovery (Ozgul & Brunero, 1997). Concern has also been expressed about CTOs actually interfering with a person’s opportunity to recover because of loss of self-efficacy and the enforced powerlessness and victimisation that results from being placed on a CTO (Minkowitz, 2006).

**Increased use of coercion**

There is also concern that CTOs may encourage inappropriate levels of coercion because of the powers available (Minkowitz, 2006; Wales & Hiday, 2006). These powers
are seen by some consumer advocates as part of an abusive service system based on inequality and discrimination (Minkowitz, 2006).

**Lack of reciprocity**

Another problem observed in key stakeholder interviews is that people on CTOs may not be experiencing reciprocity. Reciprocity would require people on CTOs to receive a level of service, or treatment and care, commensurate with the loss of liberty they experience (Bartlett & Sandland, 2007). Atkinson, Garner, et al. (2002) explore this in relation to supervised discharge orders in Scotland. They discuss the difficulty in unpacking the degree to which this is about resources or reluctance. They have difficulty in determining whether, perhaps, people on CTOs would not access services no matter how attractive they became because of the fundamental impact of their lack of insight and refusal to receive treatment voluntarily.

**The unpersuadable**

Dawson (2005), in reviewing the findings of Power (1998) in Victoria, suggests there is enough evidence to find that there are groups of people who appear to be unlikely to benefit from a CTO, people described as ‘the unpersuadable’, those who find CTOs so abhorrent they will do everything they can to escape them, such as by moving interstate. These are people also unlikely to be captured by research and there are no current research findings that provide evidence about what happens to them.

**The length of CTOs**

The length of CTOs is an important issue in debates in different jurisdictions and is often reported in qualitative research findings. Three months is seen as too short in Saskatchewan, Canada (at least by carers) (O'Reilly, et al., 2006) and one year seen to be too long in Victoria (for consumers and others) (Dawson, 2005; McDonnell & Bartholomew, 1997).
Poor awareness about rights

There is a consistent theme in the literature about key stakeholders, including consumers, carers and service providers, having a poor awareness about their rights, responsibilities and the legislation (Atkinson, et al., 2002; Brophy & Ring, 2004; O'Reilly, et al., 2006; Rolfe, Sheehan, & Davidson, 2008).

Volunteers for compulsion

The final common theme is that of ‘volunteers for compulsion’. This rather unexpected theme describes people who request the CTO to be continued in order to feel safe, have a boundary and/or avoid the potential to be overlooked or abandoned by service providers (Dawson, 2005).

Key Stakeholder perspectives in Victoria

Key stakeholder perspectives about involuntary treatment and care in psychiatry in Victoria tends to reveal both similar and divergent themes (Brophy & Ring, 2005; McDonnell & Bartholomew, 1997; Skegg, 2002).

Dawson (2005), in reporting on his international investigation and comparison of the implementation of CTOs, described the principal doubts about CTOs in Victoria as including: concerns about the overuse of CTOs, the length of the orders, and quality of treatment.

There is general agreement that, at times, involuntary treatment in the community is required. Being heard and respected and receiving good quality treatment in the context of genuinely helpful relationships is commonly agreed upon as important, although all three groups in various studies were able to identify deficiencies (Brophy & Ring, 2005; Skegg, 2002; McDonnell & Bartholomew, 1997). The consumers interviewed by McDonnell and Bartholomew (1997) expressed disappointment and frustration around not being listened to and not understanding the way decisions were being made about them, leading to experiences of powerlessness; for example ‘there is not much I
can do to get out of psychiatric services (p.32)’. Skegg (2002) interviewed carers for her study exploring the impact of involuntary treatment in mental health on carers. Her findings suggested that many carers were ambivalent about involuntary treatment especially when they perceived the quality of treatment to be poor. Carers were relying on the skills and experience of staff, and often had difficulties accessing services even in times of crisis, despite the existence of a CTO. As with both the consumers and service providers in Brophy and Ring’s (2004) study, they tended not to know the details of the involuntary admission criteria.

There appears to be general frustration regarding lack of skills and resources. The results of recent surveys in Victoria suggest that carers and consumers often have a poor understanding of the legislation impacting on them, even if on a CTO (TQA Research, 2004). Brophy and Ring (2004) also found this amongst service providers. Consumers tended to be less positive about the benefits of CTOs, especially considering the emphasis on medication and the potential to be on CTOs for over one year (McDonnell & Bartholomew, 1997). Jaworowski and Guneva (2000) also identified uncertainty about the optimal duration of CTOs amongst clinicians. Carers tended to be less optimistic about the quality of treatment and care available for involuntary patients (Skegg, 2002).

Conclusion

CTOs are likely to continue to feature in developments in mental health legislation and maintain their position in the landscape of psychiatric services. However, they have also become, and remain, a contested international human rights issue (Churchill, et al., 2007). Many of the driving forces identified above are not necessarily in the interests of consumers or service providers, but rather the product of broader social and structural issues impacting negatively on psychiatric services. Furthermore, as suggested earlier, the restraining forces cannot be ignored, lest we do not heed the wisdom of hindsight, whereby the problems and abuses associated with institutionalisation are transferred into a new era. It remains unclear who are most likely
to be placed on CTOs and whether this equates with who is most likely to benefit and why. In Australia the federal system enables considerable variation among states regarding the development of mental health law (despite commonwealth model legislation) and a particularly important variable is the length of CTOs. Therefore the Victorian community consultation paper has raised questions regarding the optimal duration of a CTO and how often administrative reviews of a CTOs should occur (Department of Human Services, 2008b). There are also questions raised by the unintended consequences of CTOs, in particular, whether clinicians are devolving responsibility for decision-making and clinically-indicated risk taking to the MHRB. If this is so, it may be influenced by at least two factors. First the issue of how increasingly important it has become to preserve resources, particularly inpatient beds, and whether clinicians may be most likely to see failure in their practice via readmission rates. Second is the ‘culture of blame’. Muijen (1996) makes the following comment about the increased number of inquiries:

The perceived message - that services are guilty unless proven innocent - is damaging even if it is unintended. (p.153)

The implementation of CTOs in Victoria remains, in many ways, poorly understood. While CTOs are supported by many clinicians and some research, there has been considerable criticism by consumers and MHRB members that suggests poor practice by treating teams. Furthermore, the existence of CTOs may be seen to be a response to a contemporary tussle in mental health service delivery, suggesting that they are not necessarily a strongly evidenced-based intervention, even though much hope is held that they can ‘fix’ some longstanding problems attached to deinstitutionalisation. CTOs hold great potential for inappropriate use especially without proper investigation to establish when, why, how and if ever they should be used and what impact they are having on CTO recipients and their carers.

This chapter has provided an overview of the current debates and issues raised by CTOs and it has identified some of the questions that remain unanswered. In the next
chapter the relevance of social work values, skills and knowledge will be explored in the context of these unanswered questions, focusing on those that are most relevant to social workers and those that a social worker is best placed to address.
Chapter Two: Why are CTOs of interest to Social Work?

Introduction

This chapter will explore the issues and dilemmas characterising the early stages of this research, once a preliminary review of the literature had been conducted. An early challenge was to develop a research question that reflected the value of a fundamentally social work based enquiry into CTOs. This chapter will explore how critical theory (K. Healy, 2005) provided a theoretical lens for further developing the research question. Critical theory encouraged an exploration of how the power and authority that CTOs represent can be justified. This also enabled a further exploration of the importance of risk, as a social phenomenon, in formulating understandings about the purpose of CTOs. The difficulties in coming to a question are discussed in this chapter, particularly in the context of so many questions about CTOs remaining unanswered. The question chosen focuses on good practice with people on CTOs and seeks to identify processes and principles that would help not only social workers but other service providers working with people on CTOs using an emancipatory value base as a guide to the investigation. But the question then poses its own dilemmas about how good practice is defined, and by whom, and whether a focus on process is ethical and useful when outcome and effectiveness studies are so inconclusive. This matter is somewhat resolved by the recognition that CTOs are definitely ‘here to stay’. In that context, people on CTOs in Victoria, and other key stakeholders, offer us an opportunity to share their lived experience and practice wisdom in building a body of knowledge that assists in understanding: ‘What processes and principles represent good practice with people on CTOs?’
Social work’s interest in, and practice with, involuntary clients

Furlong (1991) contends that, despite a prevailing view that social workers have poorly engaged with the issues of power and authority in their practice, there is evidence that social workers have:

At the very least...produced more in the way of “how to” and commentary type material than any other professional group in relation to power and authority issues. (p.28)

The literature Furlong (1991) used to support this claim proved relevant to engaging with families on involuntary court orders even though much of it was from the field of corrections. Some of this literature dates back to the 1950s (Studt, 1959 cited Furlong 1991) but there is considerable consistency with themes discussed in more contemporary literature (Baldry & Sotiri, 2009). For example, Furlong (1991) summarises Studt (1959) as follows:

There are always dimensions to the worker/client relationship of a supportive/caring description concurrent with the control dimension. Studt concludes that there are authority issues in all client/worker relations extending across all field of service demarcations. (p.29)

Baldry and Sotiri (2009) recommend that:

Honesty, following through and genuine empathy are perhaps the most important characteristics that social workers involved in prisoner client work can bring (p.366).

And this is in the context of:

Recognising the position of power and authority occupied by the social work professionals and whenever possible attempting to minimise the impact of this power imbalance (Baldry and Sotiri, 2009 p.366).

The discussion on authority undertaken by Furlong (1991) enables a formulation about how social workers might come to understand the role of authority in practice.
and appreciate how the appropriate use of authority (rather than control) may actually be helpful in engaging with clients and be consistent with the central goal of empowerment in casework. Authority represents skill and expertise and can be used to help motivate and enable change. Authority also represents a transaction between the worker and consumer, such that the worker’s authority depends on the preparedness of the consumer to recognise its existence and respond.

These ideas are important when returning to CTOs. It suggests that the worker-client relationship has the potential for greater sophistication than simply one of attempting to coerce and control the person on a CTO. There is the potential for concepts such as empowerment and self determination to be particularly relevant as the practitioner attempts to enhance the participation of the consumer in a change orientated process.

Drawing a distinction between ‘voluntary’ and ‘involuntary’ consumers of social work services may be misleading. What is more helpful is to recognise that consumers are on a continuum. On this continuum there may be people who are subject to more subtle or informal sources of influence or even coercion in regards to being required to make a connection or seek help from a health or welfare service, thus making a voluntary/involuntary distinction less polarised. De Jong and Insoo-Berg (2001) suggest that:

Mandated clients were involuntary clients who had been ordered into services by the court and were distinguished from clients informally pressured into services by, for instance, a school, a parent or a spouse. The challenges for practitioners at engagement are similar for both categories. (p.362)

Furlong (1991) also reports on findings that there are some consumers who, while on the face of it are involuntary, are actually seeking the help of public welfare, or ‘at least come to value this involvement even if they did not initiate it’ (p. 35).

De Jong and Insoo-berg (2001) provide examples of this when taking a solution focused approach to working with consumers mandated by the courts. This approach uses strategies that:
Simultaneously attempt to maximise client’s sense of choice and control while, at the same time, being clear about any non negotiable matters such as those mandated by the court. (p.362)

Having such clarity about the ‘non negotiable’ connects with Thompson’s (2000) proposal that social workers taking an emancipatory approach should also be ‘authentic’ (p.121).

Therefore it is not inevitable that casework practice with involuntary clients will be characterised by hostility and resistance and require persistent use of negotiation and efforts to control and coerce. In Baldry and Sotiri’s (2009) experience, some prisoners do attempt to manipulate the service system or be dishonest in their dealings with social workers. However, a case work relationship based on an understanding of not only the individual client but also the social and structural forces influencing their behaviour, including co- construction of the behaviour (as a result of the interaction between agency policy or expectations), the approach taken by the service providers and the needs or experience of the consumer, can assist the social worker to anticipate, tolerate and reflect on this behaviour.

Overall the above suggests that working with involuntary clients is not outside the overall mission of casework in social work, and can be consistent with working towards empowerment and social justice (Adams, Dominelli, & Payne, 2002). Furlong (1991) suggests that there is ‘accumulated wisdom’ that ‘both care and control dimensions are present and need to be addressed in public welfare and public welfare related practice’ (p.36). He goes on to discuss how combining these dimensions can be very helpful to people who previously could not access services for various reasons without legal leverage and that such leverage can be ‘face saving’ for the consumer and facilitate engagement. Thus:

Clients who feel defeated, disempowered and generally hopeless may quite particularly need a “nudge” towards beginning a process the aim of which is to (re) envisage a sense of hope and competence (Furlong, 1991 p.38).
Whilst the above discussion has particularly focused on public welfare practice, particularly child welfare and corrections, what of mental health? Szmukler (2008) sums up the situation as follows:

There is probably no more unpleasant task for a clinician working in mental health than imposing treatment on an unwilling patient; and probably no experience for the patient that is more humiliating. Yet this area of practice has received scant attention. For instance, how many clinicians have trained in approaches aimed at reducing the distress surrounding involuntary treatment? There are no clinical guidelines. (p.229)

Despite this gloomy comment there have been efforts by some social work researchers and practitioners to explore the experience and practice of statutory mental health social work, in particular the role of Approved Social Workers (ASWs) in the UK (Manktelow, et al., 2002). Social workers in the USA have also been surveyed in relation to their attitudes towards directive interventions with people with serious mental illnesses (Scheyett, et al., 2009).

In a study of ASWs it was found that consumers and carers appreciated ASWs being clear about their role and what authority and expectations they had. Problems about the tension between protecting the rights of consumers and moving beyond a totally functionalist interpretation of the role towards one that acknowledges the therapeutic potential of working with people in crisis was also acknowledged (Campbell, et al., 2001). Henderson (2001) discusses how, as an ASW, she has been aware of the ongoing relevance of the social work code of ethics in her practice, because, although the law provides a framework for statutory mental health work, guidance is required in interpreting and implementing the legislation. This is described as law being ‘alongside practice’, such that the process (in this case of the assessment) of the implementation of the law requires consideration, as well as the outcome, especially when the process may have as much significance to the person being assessed as the eventual outcome (J. Henderson, 2001 p.193). While ASWs did receive specialist training and supervision during the period of the study it was suggested that often this was inadequate to meet
the challenges of combining social work values, and a potentially therapeutic approach, whilst also appropriately exercising the required power and authority (Campbell, et al., 2001).

In Victoria, there has been no research that specifically considers social workers and their role in relation to work with involuntary clients in the mental health field. However, a local study explored the work of mental health social workers and identified the central features of expertise in social work practice in mental health as “belief, optimism and caring” (Ryan, Dowden, Healy, & Renouf, 2005; Ryan, Merighi, Healy, & Renouf, 2004 p.423). These findings provide support to the importance of interpersonal skills and personal qualities being important to the roles that mental health social workers undertake, therefore going beyond narrow, instrumental conceptualisations of practice. This is especially important in relation to case management, the role mental health social workers are most likely to undertake. It is in the role of case manager that they have involvement with people on CTOs. Some case managers and other service providers have been critical of CTOs because of the potential threat they represent to the therapeutic alliance between clinician and consumer (Brophy, et al., 2003; Patel, 2008). A therapeutic relationship has been argued to be the key factor for a good outcome in case management (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003). The challenges for case managers in balancing the care and control dimensions of their practice has been discussed by Furlong (1997) who recommends that case managers need to expand their skills, and the resources of their agencies, in being able to develop collaborative relationships with individuals and families while also effectively responding to the pressure to manage risk. Brophy, Campbell and Healy (2003) investigated the dilemmas faced by case managers when caring for people on CTOs and considered their role in MHRB hearings. The incentives and barriers to case manager involvement in MHRB hearings were identified and it was apparent that case managers could make an important contribution to hearings but this was often not occurring because of the lack of a formal role for case managers, especially apparent in the degree to which they were ‘overlooked’ in legislation. Unlike ASWs in the UK, case managers do not have any
statutory role. This is despite case managers being actively involved in ongoing work with consumers who are subject to CTOs and at times having the most thorough knowledge of the person and their family/carers circumstances. Due to legislation in Victoria, decision-making remains the formal domain of medical practitioners, in particular authorised psychiatrists, and the MHRB. Amendments to the Mental Health Act 1986 in 2003 did at least include a requirement that case managers be notified about MHRB hearings. These amendments also increased the powers of mental health practitioners (nurses, social workers, psychologists and occupational therapists) employed in crisis assessment roles to be able to make Involuntary Treatment Orders (ITOs), but the authority of case managers in relation to people on CTOs remains formally unrecognised in legislation. This is despite the considerable authority that is evident at a more informal level (Furlong, 1997). Case managers are likely to be involved in monitoring the compliance with treatment of people on CTOs, determining and managing risk and are likely to have an active role in decision-making outside the formal legal processes. Brophy, Campbell, et al. (2003) found that:

It was generally agreed that the case manager often provided emotional and practical support for the client in the stressful situation of MHRB hearings. For example, it was argued by some participants that “knowing the art of respectful compromise” was important; expressing a sense of openness and honesty about the purpose and necessity of involuntary treatment might encourage compliance and enhance the therapeutic relationship and lessen the negative impact of the Board’s decision. There was also a consensus that the case manager was usually in a strong position to inform the Board about provision for care and treatment, particularly through the use of individual service plans. In doing so they could provide a more holistic picture of the client’s past, present and predicted circumstances, whilst making a judgement about the tensions between the ‘duty of care’ and the client’s ‘best interests’. (p.159-160)

Like the ASW study (Campbell, et al., 2001) it was found that case managers attempting to combine advocacy regarding involuntary status with their provision of care and treatment was problematic. Hence it was more appropriate for case managers to advocate in relation to positive, or what Ife (2001) describes as second generation,
human rights, those emphasising access to care and treatment, citizenship and empowerment (Brophy, et al., 2003). This relates to what Bland and Renouf (2006) identify as:

Best practice in mental health social work should be based in a clear understanding of the social work domain, with an emphasis on the social context and consequences of mental illness, and social justice. (p.15)

Roche’s (2001) view, when discussing social work values and the law, is that while social workers do require knowledge about the law and ‘the language of rights’, this is only a ‘necessary but not sufficient condition for good practice’ (p.18).

In developing an understanding of CTOs and social workers’ engagement with them, a group of social workers collaborated in an international project that produced the following typology (Campbell, Brophy, et al., 2006 p.1114-5):

Table 1: Typology of Social Workers and CTOs in three international jurisdictions

<table>
<thead>
<tr>
<th></th>
<th>Australia (Victoria)</th>
<th>Canada (Ontario)</th>
<th>UK (Scotland)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Law</strong></td>
<td>Mental Health Act 1986 (Vic)</td>
<td>Mental Health Act, 2000 Province of Ontario</td>
<td>Scottish Mental Health (Care and Treatment) Act, 2003</td>
</tr>
<tr>
<td><strong>Criteria for involuntary order:</strong></td>
<td>1. The person appears to be mentally ill</td>
<td>1. The person has a mental disorder</td>
<td>1. The person has a mental disorder</td>
</tr>
<tr>
<td></td>
<td>2. It is necessary for his/her health or safety or for the protection of public</td>
<td>2. They are likely to cause serious bodily harm to himself, or suffer substantial mental or physical deterioration</td>
<td>2. There is sufficient risk if treatment is not provided</td>
</tr>
<tr>
<td></td>
<td>3. The person requires immediate treatment and treatment can be obtained</td>
<td>3. The required treatment, care or supervision, is available in the community</td>
<td>3. There is available medical treatment which could alleviate symptoms or effects</td>
</tr>
<tr>
<td></td>
<td>4. They have refused necessary treatment or is unable to consent</td>
<td>4. The person or their substitute decision maker consent to the plan</td>
<td>4. There is impaired capacity</td>
</tr>
<tr>
<td></td>
<td>5. They cannot receive treatment less</td>
<td>5. If the person is not</td>
<td>5. A CTO is necessary</td>
</tr>
</tbody>
</table>
| **CTO powers** | 1. If the person does not comply with treatment then the CTO is revoked and they are sent to an inpatient unit.  
2. Residence conditions can be applied if this is essential to maintaining person in the community.  
3. It is not acceptable to use any physical force in the community to impose treatment. | 1. If the person is non-compliant with the treatment plan they may be apprehended by the police and brought to the hospital for psychiatric examination.  
2. Non-compliance is defined in the plan. | 1. If the person is not compliant they may be detained in hospital and/or required to accept treatment.  
2. The person may be required to accept residency conditions.  
3. The person may be required to attend for treatment. |
| **The mental health social work role** | 1. Social workers have significant case management roles but limited formal involvement during the process of implementation of CTOs. | 1. Social workers are not named in the Act nor do they have any official role. They are, however, involved throughout the CTO process in various capacities. | 1. The Mental Health Officer is centrally involved in the application to the Tribunal for a CTO and will probably be involved in case management. |
| **Perceived strengths** | 1. CTOs strongly emphasise community based care and treatment.  
2. The case management of CTOs enables individual service planning.  
3. Resources often accompany CTOs | 1. CTOs allow for earlier intervention when a person is non compliant  
2. Greater attention given by the treatment team than is the case in other services  
3. There are clearly defined expectations about CTO usage  
4. There is a clearly defined obligation to communicate between caregivers | 1. Separate Mental Health and Capacity Acts may safeguard human rights  
2. The statutory role of mental health workers is enhanced.  
3. The introduction of an independent system of advocacy should protect clients’ rights. |
| **Perceived weaknesses** | 1. Clients are often left on CTOs for too long  
2. There is an | 1. There is a lack of community resources to service CTOs | 1. There will be an increased professional workload in servicing tribunals and the administration of CTOs. |
Of particular interest to this discussion is the mental health social work role across these jurisdictions as described above. It appears that in Scotland, social workers undertaking the Mental Health Officer role have more formal power and authority than the social workers undertaking direct practice with people on CTOs in Ontario and Victoria. However, all three groups have the potential for involvement whether they are given formal power or not and each jurisdiction was found to have strengths and weaknesses relevant to the social workers involved. The potential clash with the code of ethics is raised in the Ontario and Scottish contexts but not Victoria. Perhaps this reflects the relative familiarity of Victorian mental health social workers with CTOs and general findings that mental health service providers in Victoria tend to be relatively at ease with CTOs (Brophy & Ring, 2004; Dawson, 2005; Jaworowski & Guneva, 2000; Muirhead, et al., 2006).

Campbell, Brophy, et al. (2006) comment that:

The role of mental health social workers in the implementation of CTOs typifies many of the challenges facing contemporary social work. Social workers often have a struggle to balance a commitment to empowerment and recovery whilst managing risk in the midst of resource constraints. (p.1112)
Victoria is described as using a clinically based decision-making model that does not include the more significant human rights protections that are apparent in the other jurisdictions. It is suggested that, as a result, more people are being caught up in the ‘net’ of CTOs (Campbell, Brophy, et al., 2006). This increased inclusiveness may lead to more ethical and practice challenges for social workers, potentially challenging the prevailing views in Victoria about the ethical validity of CTOs. In conclusion, Campbell, Brophy, et al. (2006) make the following comments:

It is imperative, therefore, that mental health social workers and their professional organisations have strong views on involvement in tribunal processes, working with independent advocates, and encouraging less medication-focused regimes. In addition what appears to be crucial in the successful and ethically sound administration of CTOs are complementary, well resourced community services and support, important factors in any social work intervention. Mental health social workers in this field also need to acquire good skills in engaging and sustaining relationships with service users who are often understandably resistant and fearful of authority figures. At the very least competency standards are required for this work and these should reflect the requirement that mental health social workers have to balance aspects of care with control. Support and training should be used to ensure that such practice is as empowering as possible.

There seems little doubt that, now and into the future, mental health social workers will face increasing pressures by government, policy makers and the general public to accept this more coercive role in the implementation and management of CTOs. (p.1116)

Gibbs, et al. (2006), after presenting generally positive findings about the implementation of CTOs in New Zealand, discuss the implications of CTOs for social workers. As well as the roles and responsibilities that social workers may be required to undertake in the implementation of CTOs, there is a recommendation that social workers remain mindful of research findings that suggest that people on CTOs will have a diversity of experiences, both positive and negative. Again the prevailing view here is that CTOs can be therapeutic but it is important to consider the persons experience, and also that of their families and carers, in exploring the potential value of the CTO.
As discussed earlier, one of the concerns about CTOs is the degree of medicalisation of treatment that they appear to encourage. Fawcett (2007) describes a focus on a ‘diagnose and treat’ approach that ‘particularly comes to the fore at times of compulsory intervention’ (p.1027). This approach challenges social work’s ability to make a discipline specific contribution to mental health services. She summarises a conference paper by Bland (2005, cited in Fawcett, 2007) who suggested that in Australia, social workers struggled to ‘be both relevant and critical’ (p.1037). Furthermore, what is described is a professional group who are not well equipped for their roles and confused about what contribution they can make that is proactive rather than reactive. Fawcett (2007) suggests that social workers are well positioned to be:

Engaging in community activities, operating as advocates, supporting self advocacy networks, focusing on human rights issues and ensuring that what is important for service users directly relates to the support systems negotiated. (p. 1038)

The above discussion suggests that, even in the context of positive findings about the outcomes for people on CTOs, there is difficult terrain for social workers to negotiate in the implementation of CTOs. The challenge for social workers includes remaining consistent with their ethical principles and also responding to the need for the development of competence as practitioners required to carefully balance the care and control dimensions of their practice.

**Critical Theory and Social Work**

The critical social work tradition encourages social workers to be mindful of the imbalance of power that is relevant to all social work practice and the impact of macro-social structures in shaping relationships (K. Healy, 2005). In discussing the relevance of critical social work to corrections practice Baldry and Sotiri (2009) observe:

Critical social work, with its emphasis on social justice, provides an important framework for the exploration of social work and imprisonment and ensures a realistic analysis of the individual, social and systemic factors contributing to
imprisonment and of the individual and institutional factors involved in breaking the cycle of crime and imprisonment. (p.364)

Critical theory can be divided into modern and post modern critical theory. Modern critical theory has been informed by the critical social science paradigm represented by theoretical traditions such as Marxism and Feminism. What these theoretical traditions have in common is the emphasis given to macro-social structures being central to understanding social relationships. Critical theory is sensitive to the experience of those oppressed by these macro social structures and encourages the use of empowerment to achieve social change (K. Healy, 2005). Mullaly (2002) describes how critical social theory has been revitalised by the contribution of postmodernism, post structuralism and post colonialism. These theoretical perspectives have contributed to the development of a critical social work approach that is mindful of dominant and subordinate relationships and the multiple forms of ‘otherness’ that exist in the relationships between and within social groups, particularly in relation to age, gender and ethnicity.

Thompson (2000) describes emancipatory values which have emerged out of the growing awareness of structural oppression that the application of critical theory has enabled. He argues that social work has moved away from the individualistic value base characterising its early history. Dominelli (2002) describes how individualism in social work was linked to therapeutic helping approaches, and approaches focused on ‘maintenance’ which tended to not engage with social factors in both understanding the problems of consumers or in interventions. Thompson’s (2000) list of emancipatory values (p.116) includes the process of deindividualisation whereby there is recognition that individuals with problems usually belong to a group of similarly oppressed individuals. The next is equality, which involves a willingness to acknowledge, and a preparedness to tackle, inequalities. The third emancipatory value is that of seeking to address social injustice caused by oppressive structures, commonly known as social justice. Working in partnership with consumers and other service providers is also included, along with citizenship, a value that emphasises rights, social inclusion and
participation in community. The final two values are: empowerment, via connecting the personal to the political and recognising the broader socio political context of any situation, and authenticity. Authenticity is of particular relevance to working with involuntary clients because it asks the social worker to recognize their responsibilities and the freedom and responsibilities of consumers in relation to their own choices and actions. An authentic relationship is one based on honesty and clarity about roles.

Healy (2005) explains that anti-oppressive social work ‘has emerged, and developed, as a dominant theory of critical social work practice’ (p.178). She argues that:

Anti-oppressive theory extends existing critical practice theory in a number of ways, most particularly in its insistence that the personal and cultural bases of oppression must be integrated with the structural analysis of oppression and its recognition of interpersonal and statutory work as legitimate sites of anti-oppressive practice. (p. 179)

In relation to CTOs, therefore, anti-oppressive theorists would seek recognition of specific kinds of oppression, such as paternalism and discrimination, and how they interact with each other and in turn are represented in the consumer’s experience. In relation to discrimination, Thompson (2000) encourages a broad interpretation that goes beyond the legalistic framework commonly used to define and deal with discrimination. In Thompson’s (2000) definition, discrimination includes the person’s experience of marginalisation and loss of full citizenship rights and is located in the process or set of processes that lead to oppression.

Important to a discussion about oppression, discrimination and CTOs is Healy’s (2005) claim that, unlike those from a radical social work perspective, anti-oppressive practice does not reject statutory powers because no action at all in attempting to deal with problems such as child abuse or, in this case, serious mental illness, might also represent oppression. Furthermore, important to this research question is Dominelli’s (2002) observation that:
Procedural considerations or questions of how relationships are conducted and on whose terms are also critical to the realisation of anti-oppressive practice. Furthermore process provides the means whereby the experience of anti-oppressive practice or its absence will be confirmed. This is in contrast to traditional understandings of ‘client’ worker relationships in which ethics focus more on the ends to be achieved than on the mechanisms whereby these are to be reached. (p.8)

Healy (2005, pp. 183-188) identifies five practice principles for anti-oppressive practice:

1. Critical reflection on self in practice
2. Critical assessment of service users’ experience of oppression
3. Empowering service users
4. Working in partnership
5. Minimal intervention

Anti-oppressive practice is ‘a practice theory that stands on the cusp of modern and postmodern practice’ (K. Healy, 2005 p.191). Postmodern theorists are more sceptical about the claims of modern forms of social work that have been informed by theoretical traditions that make claims on ‘the truth’. Postmodern critical theorists have encouraged a further evolution of a critical social work approach, in particular, through the location of consumers as experts and the need for greater recognition of mutual interdependence, diversity, difference and multiplicity (Mullaly, 2002). Dominelli (2002) supports this and suggests:

Transcending common-sense attitudes about ‘difference’ requires the exercise of an empathy which goes beyond placing oneself in another’s shoes by daring to put these on and wear them for a while at the same time reflecting on the privileged nature of one’s own. (p.9)
Applying Critical Theory to CTO research.

Fossey, Harvey, McDermott and Davidson (2002) described how a critical paradigm encourages the researcher to see social reality as ‘multi layered’ (p. 719). Critical social research challenges theories of knowledge that claim the superiority of objectivity, neutrality and rationality (Everitt, 2002). Such a perspective has proved useful when reflecting on CTOs. Political and social factors inevitably influence not only what’s driving CTOs but also what questions are asked about CTOs and what methods are used to answer these questions. As Everitt (2002) suggests:

The work of critical social scientists, feminists and members of other new social movements provides social work with credible alternatives that recognise research and development as political activities. (p.115)

Thus a critical social researcher is required to be aware of the relationship between knowledge and power and how research can be shaped and controlled by the dominant hegemonic order which seeks to maintain potentially oppressive structures in its own interests.

Young (1990), a feminist political theorist, divided oppression into five categories: exploitation, marginalisation, powerlessness, cultural imperialism, and violence. She argued that the language of oppression needs to be applied to the study of injustice and that it makes sense of people’s experience. Oppression is not necessarily outside people’s day to day experience and can be the result of a well meaning liberal society’s actions. It is reproduced by the systemic structures that such a society maintains. This perspective has been important to understanding the experience of people in psychiatric institutions, an excellent example of how marginalisation and powerlessness were supported by an approach to the ‘care’ of people with disabilities (Rosenhan, 1973). The shift of people out of institutions was partly a response to emerging understandings of the oppressive nature of institutions. However, as
previously discussed, many of the oppressive elements of the institutions appear to have been recreated in community based mental health care (Sapouna, 2006).

People on CTOs, as discussed in Chapter One, are the potential subjects of multiple sources of oppression, including stigma, discrimination and paternalism (Patel, 2008). They are marginalised; perhaps the most marginalised within an already disempowered group of mental health service consumers. Even so, they are relatively ‘invisible’, particularly in Victoria, where their experience is part of the ‘mainstream’ (Carney, 2003; Rees, 2007). Social factors such as fiscal restraint and risk management also impact on people on CTOs. Furthermore, people on CTOs are subject to legislation and administrative review that, it could be argued, identifies more with the major economic, political and cultural institutions that tend to be the sources of oppression (such as the psychiatric service system, the professions and the legal system) rather than protecting them from human rights abuses (Young, 1990). Mullaly (2002) contends that:

By defining social problems in terms of dominant-subordinate relationships, an anti-oppressive practice must clearly work towards: (1) changing the personal attitudes and behaviours that portray a negative image of marginalised groups, (2) combating those cultural stereotypes, values and thought patterns that endorse superior/inferior group relationships; and (3) eliminating institutional patterns, practices and policies that discriminate against subordinate groups. (p.x)

Reflecting on CTOs in this way opens up many possibilities for research questions. As Young (1990) suggests people generally do not see themselves as agents of oppression; they just see themselves as doing their jobs or living their lives. Assisting in ‘consciousness raising’ about people and their experience of oppression when on a CTO is a research activity consistent with critical social work. It presumes that, even inadvertently, service providers and the service system contribute to the experience of oppression in the implementation of CTOs.

The above discussion of critical theory and how it might be applied to CTO research also presumes the existence of CTO recipients as a social group. However,
Young (1990) encourages reflection on how social groups are defined and draws on postmodern theory in encouraging a view of groups that recognises that although people may be ‘thrown’ together into a particular category, such as ‘old’, ‘black’ or in this case, ‘mental health consumer’ and ‘CTO recipient’, they are likely to be a diverse group, representing many other social divisions, such as age, gender, ethnicity and socioeconomic status. This perspective has helped to generate the first stage of this research activity which has been to understand more about who is on a CTO and has not sought to presume who might be on a CTO, even on the basis of the overall descriptions obtained from other studies (Power, 1998; Segal & Burgess, 2006c). The overall data about people most likely to be on CTOs internationally is available and very well summarised by Churchill, et al. (2007). However, Segal and Burgess (2006c) have already found a contrasting finding in Victoria where people are placed on CTOs after their first admission, rather than after having an established history of non-compliance, as is more likely elsewhere. Young (1990) suggests that although there is an argument that identifying people with particular groups can be discriminatory and oppressive, she contends that ignoring the experience of particular groups does not allow for the value of recognising group differences and group identification. Thus one of the emancipatory values of social work, ‘deindividualisation’ (Thompson, 2000), is relevant to an investigation focusing on people on CTOs. It presumes that they are a social group who, although potentially as diverse in their demographics as the wider community, has particular experiences and power relationships because of their membership of this group. Similarly the family/carers of people on CTOs and service providers represent social groups who may also have experience of oppression and discrimination. Carers experience stigma and marginalisation in the community because of having a mentally ill relative (Lewisohn, 2008). Meanwhile service providers can feel oppressed and powerless in a service system often characterised by a ‘new managerialism’ that seeks to control the autonomy, creativity and critical thinking of professionals (Everitt, 2002 p.117).
Young (1990) describes marginalisation as one of the most dangerous forms of oppression because it leads to exclusion from full citizenship and encourages dependency. Dependency can result in marginalised people being legitimately subject to the powers of the state that may be arbitrarily and invasively applied by those in authority who presume to know what is good for the recipients of their services. Thus people’s rights to privacy, respect and individual choice may be suspended. Here Young (1990) could be describing people on CTOs, and her arguments support another phase of this research that seeks to reduce the marginalisation of people on CTOs and their family/carers through attempting to take a respectful position that assumes the value of their ‘voice’ and the importance of hearing about their experience. This also relates to an assumption in this study that service providers, especially those who wish to practice in a way that reduces oppression in their relationships with consumers, will benefit from research that explores the lived experience of service users.

The discussion so far has enabled increased awareness of CTOs operating in a very complex, social, policy, legal and ethical context. It has also established that they have significant implications for social workers and other mental health practitioners. Also confirmed is that there is a considerable value in undertaking an investigation of CTOs from a social work perspective.

Inevitably a social work researcher who is informed by a critical theory approach is required to recognise that powerlessness and oppression are often features of the relationship between service provider and service recipient and therefore relevant to the implementation of CTOs. There are two ways of approaching these issues. One is to fundamentally challenge CTOs because of the power imbalance they undoubtedly represent. The other is to consider the possibility of reducing the disempowering effects of CTOs through strategies such as, critical reflection, further investigation, analysis and consciousness raising (K. Healy, 2005). The second stance is also supported by Szmukler (2008) who has stressed the importance of reducing the experience of coercion, humiliation and disempowerment that is likely to result from any form of involuntary treatment. Szmukler’s (2008) position comes less from a critical theory approach but
more from the perspective of an experienced psychiatrist and researcher who is aware of how little attention is paid to this important aspect of practice - what might be described as a liberal-humanist approach (Mullaly, 2002). This is also reflected in the updated code of practice that accompanies the new legislation in England (Department of Health, 2008). This code of practice is for all professionals who are practicing under the Mental Health Act 2007, so it includes doctors, nurses, social workers, occupational therapists and psychologists. The code of practice sets out five key principles to guide decision-making in relation to the use of involuntary orders and they include ensuring that patients are treated with respect in the least restrictive way possible. The principles also encourage awareness of cultural diversity and the importance of patients participating in the planning of their treatment (Hall & Ali, 2009).

The response here to the potential for contrasting action on these issues has been to seek a compromise. The overall aim is not necessarily to critique the concept of CTOs, but the research does not deny the paternalism that CTOs represent. The research seeks to bear in mind the various debates and search for some agreement regarding how to ‘do CTOs well’ while attempting to ensure that the opinions and voices of service users are heard, and if possible privileged, amongst the key stakeholders. Baldry and Sotiri (2009) argue that:

Anti-oppressive and anti discriminatory practices seem to privilege the stories and experiences of prisoners and their families, and as much as possible allow these historically silenced voices to influence policy and practice directions. (p.364)

While this quote refers to prisoners, it has relevance to people on CTOs and their family/carers who, it could be argued, represent a similarly marginalised and disadvantaged group whose situation is hidden while they are also demonised and feared. Research, particularly qualitative research, provides an opportunity to understand more about the experiences of people on CTOs and develop links between their individual circumstances and broader social and structural issues.
The overall aim of this thesis is to develop theory that informs mental health practitioners regarding their work with people on CTOs. It is anticipated that it is not only social work practitioners who are seeking more guidance in their work implementing CTOs, but a broad range of key stakeholders who have suggested the value of more practice focused research (Dawson, 2005; Jaworowski & Guneva, 2000; Mullen, et al., 2006; O'Reilly, et al., 2006). The overall aim includes the development of an improved understanding of the implementation of CTOs that reflects the social and historical context in which they operate (Fossey, et al., 2002).

**Risk, Social Work and Involuntary Treatment in the Community**

Ideas of the unmanageable and incorrigible riskiness of certain monstrous individuals transfixes much public debate in psychiatry in the ‘post-carceral’ era, and leads to new demands for preventative detention. Risk thinking thus transforms the role of mental health professionals, the nature of their work and their place in regimes of control (Rose, 1998 p.178).

Who wants to be the social worker and/or case manager of a client who suicides or (perhaps even worse) hurts somebody else? In the contemporary service environment all mental health workers are encouraged to maintain vigilance when the consequences are not just carried by grieving relatives and a terrible loss of, often, a young life or an innocent victim. The mental health workers involved are also likely to face a combination of their own sadness and remorse, the doubt that they could have done something to prevent this tragedy, and also more public scrutiny of their practice (Ramon, 2006). It is not uncommon for the media to give considerable attention to these issues, especially if high profile individuals are involved. This has already been the case, especially in Canada and New York (Rolfe, 2001), increasing the likelihood that mental health services might be blamed for the behaviour of their clients. There is other evidence suggesting that:
Tragic events in the community can be the basis of legislative changes, which deeply affect the lives of people with a mental illness living in the community (Rolfe, 2001 p. 84).

Rolfe (2001), in his review of CTOs on behalf of the Western Australia chief psychiatrist’s office, provides an international comparison of developments in mental health law and many of these developments can be traced to tragic events. In the UK, a man with a mental illness jumped into the lion’s cage at the zoo, resulting in considerable public concern about people with apparently untreated mental illness. In New York, state legislation enabling limited involuntary outpatient treatment is commonly referred to as ‘Kendra’s law’ because it can be seen to have resulted from the death of Kendra Webdale who was pushed in front of a train by a man who had not been taking the medication prescribed for his mental illness. In Canada, ‘Brian’s Law’ followed the murder of a popular sports commentator by a man with a severe mental illness who lived in the community (Rolfe, 2001). Behnke (1999) refers to another incident in July of 1998, when two security guards in Washington were shot by a man with inadequately treated paranoid schizophrenia.

Mental health workers may also be required to prepare for coronial inquiries, which many fear and find to be an arduous experience despite the best attempts of the coroner to make recommendations rather than judge individuals. As previously discussed, here in Victoria, when a man who committed an offense was already on a CTO, the coroner concluded her investigation by recommending the power of CTOs be extended to include more conditions (Victorian State Coroner’s Office, 1997). Administrative and resource issues were raised in the coroner’s enquiry, perhaps accounting for why the CTO had not been as effective as it might. However, a CTO is unlikely to be able to substitute for adequate staffing, accountability and supervision – or prevent drug and alcohol abuse, another significant risk factor in this and other cases (Castle & Ho, 2003).

It may be argued that managing risk has become an all pervasive feature of the modern, particularly Anglo-Saxon, society. The English speaking world holds a considerable lack of tolerance for the possibility that something will go wrong or that
someone will get hurt, especially if there is any possibility of prediction (Ramon, 2006). Hence, these cultural and political trends have inevitably influenced the practice of psychiatry and supports what Rose (1998) describes as a shift from binary assessments of dangerousness to the process of considering all clients as being on a risk continuum, with nobody representing ‘no risk’ – just the possibility of low risk. Thus people on CTOs appear to have become scapegoats in the context of the risk society (Mullaly, 2002). Ramon (2006) argues that social workers are increasingly being limited in their practice as a result of the ‘risk discourse’ (p.41) and asserts that:

Within this perspective, empowerment is no more than a fiction and a con, because it is aimed to offer the illusion of being in control over one’s life, when one is merely toeing the line in terms of being a good – i.e. conforming – citizen. (p.41)

Ramon (2006) suggests that CTOs are an example of how social work practice in mental health has become increasingly focused on avoidance of risk and has become wary of creativity. This is influenced by at least three factors that have already been introduced above. First the issue of how increasingly important it has become to preserve resources, particularly inpatient beds, in the context of being required to use resources more effectively and efficiently (Everitt, 2002). Second, and as a result, clinicians may be most likely to see failure in their practice in terms of high rates of service usage by consumers, such as readmission rates. The third factor, apparent in many jurisdictions, is the ‘culture of blame’ (Muijen, 1996; Webb, 2006 p.12). Fears about blame may be increasing the anxiety of workers and encouraging a more procedural and instrumental approach built around defensive practice, particularly in case management (Furlong, 1991). This is referred to by Webb (2006) as ‘technical rationality’ (p.20).

Sawyer (2008) develops an understanding of risk in mental health practice when she explains:
In mental health practice, “risk” is very narrowly defined within a clinical or symptom based framework. (p. 351)

This requires the worker on crisis teams to be constantly monitoring whether someone is at risk of harming themselves or others or have symptoms linked to the potential for vulnerability or high risk behaviour. As Rose (1998) has previously observed, they are required to provide predictions of the person’s level of risk and increasingly to define their role in relation to risk management. Therefore:

Each mental health professional in the post welfare state must manage the tension inherent in “the contradiction between the emancipatory possibilities of clinical case management and the imperative of the surveillance of risk” (Healy and Renouf, 2005, p.45 in Sawyer, 2008 p.332).

Risk orientated practice in this ‘culture of blame’ therefore increasingly dominates how mental health practitioners subjectively define what they do, and avoidance of risk and untoward events is how ‘good’ practice, ‘good’ management and ‘good’ services are defined. Meanwhile, as both Sawyer (2008) and Webb (2006) contend, the social worker can become de-skilled as the consumers problems are increasingly individualised and decontextualised while workers are relieved of having to engage with complex and diverse psychosocial, or socio-cultural issues. Trotter (2006) also argues, in relation to child protection workers, that as systems become more legalistic and surveillance orientated, with an emphasis on assessing risk rather than providing treatment and care, there is a risk of workers becoming increasingly de-skilled. Similarly, CTOs could also be de-skilling as they provide a temptation to resort to coercion in attempting to manage risk. Members of the Victorian MHRB have expressed concerns that service providers are devolving responsibility for decision-making and clinically indicated risk taking to the MHRB rather than acknowledging their own capacity and responsibility for making difficult decisions (Freckelton & Lesser, 2003).
Revisiting CTOs as a contested concept

Despite an increasing reliance and acceptance of the validity of involuntary community treatment in mental health, these developments are not uncontested, and, as the discussion in Chapter One revealed, reservations have been expressed by many involved (McIvor, 1998; Patel, 2008; Ring, et al., 2001).

The Victorian mental health legislation regarding CTOs and involuntary admissions attempts to ensure checks and balances to protect the rights of people subject to these orders. But, even so, this legislation represents power and social control. Moynihan (1996) states that:

The challenge for social policy in the mental health area has been to find a way through four competing claims: the state’s interest in protecting the well-being of its citizens; the traditional value placed on medicine as a means of addressing issues of illness; the normative demands of citizens for the elimination of danger; and the recognition of rights of individuals. (p.13)

Moynihan (1996) argues that the justifications for enabling involuntary detention may be located in the state holding a responsibility to intervene which has traditionally been seen to reside in the domain of medicine and its ability to provide treatment and care. One of the great challenges for psychiatry has been the fundamental questioning of the value of institutions in terms of their ability to provide any kind of effective treatment and care, with the accusation that such institutions were warehouses offering little more than exclusion and marginalisation to their residents (Scull, 1989). The shift to care in the community may be seen to have satisfied many sources of criticism of the power of psychiatry and mental health treatment, and the corresponding mental health legislation and international human rights developments may be seen to have significantly enhanced the capacity of the state to meet its obligations and balance the competing demands. However, in the current climate of increased use of CTOs, it is possible to argue that, although the territory has changed, the power of public
psychiatry is actually in ascendency through what Arrigo (2002) summarises as the ‘promise’ of outpatient civil commitment. Perhaps this is not necessarily, from a broad community perspective, a less than positive development. After all, the community makes claims for safety, not only for community members but also for the untreated mentally ill who some claim continue to ‘rot with their rights on’ (Appelbaum & Gutheil, 1979; Schmidt & Geller, 1989). Hence, enhancing the ability of psychiatry to take back some potential for control of the situation might be given broad community support. However, such control has been justified through the provision of treatment and care. But does involuntary treatment in the community provide sufficient trade-off, or what has been called elsewhere, reciprocity (Bartlett & Sandland, 2007)? Here is one of the potentially strongest critiques of CTOs, in that they are seen to risk forming an inadequate substitute for discharge planning or quality service delivery, or that they might be unfairly applied (Appelbaum & Redlich, 2006). Recent research, which attempted to engage consumers in discussing their experience of CTOs, found that many of them could identify their treatment as little more than medication (Brophy & Ring, 2004). They may have had a case manager, but they still identified problems around having little choice in relation to treatment and, in particular, limited opportunity to air their concerns about what they were experiencing (Brophy & Ring, 2004; McDonnell & Bartholomew, 1997; Ring, et al., 2001). This suggests that little has changed despite strong criticism by the Report of the National Inquiry into the Human Rights of People with Mental Illness (Burdekin, 1993) regarding how often medication is offered as the only form of treatment by mental health services in Australia.

If research shifts from a focus solely on outcomes, what else is worthy of investigation regarding CTOs? One example relates to the considerable variation between mental health acts in different states and territories (Brophy & Healy, 2009; B. Healy & Brophy, 2001). One obvious difference is the length of time people are initially placed on a CTO and the period between reviews. In Victoria people have their involuntary treatment order reviewed within six to eight weeks unless they appeal and then the order is not again externally reviewed for 12 months. However, in Western
Australia these periods are much shorter, with 6 monthly reviews. Hence the question, what is it like to be on a CTO for a long time? There is also a further important consideration: are CTOs here to stay? The introduction of CTOs through new legislation worldwide does suggest that they are. It seems no amount of questioning of the value or effectiveness of CTOs is going to prevent their implementation - and this is true of Australia and other countries. So why are CTOs so attractive to legislators? The literature and the driving forces discussed in Chapter One tend to suggest a number of explanations. First, CTOs are located in benevolence, paternalism and best interest considerations in the provision of adequate treatment and care (Brophy & Healy, 2009; Campbell, Brophy, et al., 2006; B. Healy & Brophy, 2001). Another, and perhaps complementary, justification is that at all costs it is better to treat people in the least restrictive environment, as established in the principles underlying contemporary legislation. So, rather than consumers enduring long inpatient stays they can be safely discharged on a CTO which provides a less restrictive option. The CTO then provides the necessary ‘leverage’ to ensure that consumers continue with treatment on discharge from hospital and become engaged with community based services, even when their insight into their illness may remain poor and there are doubts about their capacity to achieve compliance with treatment voluntarily.

These justifications are at their very best tenuous and have been significantly challenged by consumer advocates (Minkowitz, 2006). It is no longer possible to construct the purpose and function of deinstitutionalisation as being solely located within the civil liberties movement, or even advances in medical technology, particularly medications. Deinstitutionalisation as a policy has come to represent a considerable opportunity to devolve the care of people with disabilities to community based services and rid governments of the responsibility of large, expensive institutions. Although some would argue that good community care is also expensive, we have seen in Victoria not only the closure of large institutions but also the sale or redevelopment of the prime real estate often taken up by them. Gerrand (2005) has defended these developments in Victoria, suggesting that a considerable effort was undertaken to transfer resources
into well structured community based services. Even so there is an increasing emphasis on responsibility for treatment and care being handed over to informal supports and primary health care with an expanding non-government sector. Mental health services are now mainstreamed with large health providers. Inpatient units are no longer the ‘hub’ of mental health services and, if recruitment and retention are indicators, many even have become the ‘poor cousins’ in the network of mental health service providers (Department of Human Services, 2005b). Key performance indicators encourage throughput and, like all areas of health care, reduced ‘bed days’ are rewarded (Commonwealth Government of Australia, 2008). Hence it may not necessarily be that a patient is discharged early from hospital because it is in their best interests and respectful of their human rights. Other factors, including pressure on beds and the likelihood of the CTO ‘working’ are likely to be factors. However, if the above reference to the legislation is considered then, although an early discharge may reduce involuntary hospital stay in the short term, the consumer may remain longer as an involuntary patient than they would have done ten or fifteen years ago. How can this be weighed up? Is there equivalency between, for example, twelve months on a CTO versus extra time in hospital? The twelve months on a CTO is cheaper and more expedient to service providers but what is the effect on the consumer? Does their ability to achieve insight and compliance speed up – or slow down - once out of hospital? Many have argued that a CTO interferes with engagement with some consumers as much as it might enhance engagement with others (Power, 1998). If a CTO is disempowering, as suggested by Brophy and Ring’s (2004) studies exploring both service provider and consumer perspectives, then is it more or less disempowering over time? In other words, the question of what is an optimal length of time for someone to be placed on a CTO is important on a number of different levels because of the legal, ethical and practice implications. Furthermore, how can it be established when a CTO is in the best interests of clients and not a decision ‘contaminated’ by the contemporary pressure on inpatient units? This question relates to both early discharges and efforts to avoid admission via a CTO.
It is also unclear how decisions are made about CTOs. Although there is considerable speculation, it remains unclear how much importance risk holds in these decisions. And finally there is the issue of what people need to demonstrate to be discharged from a CTO. Dawson and Mullen (2008) have attempted to understand this in their study in New Zealand and found that although the development of insight was an important factor in decision-making, the perception that the person continued to represent a risk of harm to self or others was a central consideration.

As previously discussed, Rose (1998) describes increased emphasis on the imperative to manage risk in psychiatry, and, in that context, it can be predicted that discharge from any form of involuntary admission is complicated by the issue of risk. One of the risks generally being avoided is that the consumer will be non-compliant with treatment. Non-compliance may lead to relapse which is potentially risky to the person and others and, especially if an inpatient admission is required, expensive. But are the non-compliant easy to distinguish from the compliant? Thorne (1990) discusses non-compliance as a common feature of the reaction of patients to chronic illness. She found that often patients agreed to treatment recommendations with no intention of following through and that for many patients non-compliance served an important function in their own ability to develop confidence, feeling in control of their own health and addressing power imbalances between themselves, as the patient, and medical staff. Furthermore, patients found that much of the treatment they were apparently required to have had significant limitations, which were poorly acknowledged by the treating doctor. Thorne’s (1990) key argument is that although non-compliance is often understood as irrational or difficult behaviour, her study suggests that for many patients it may be constructive. She comments that:

Compliant behaviour involves two parties.... (and) systematic enquiry into the role of the professional in non-compliance is rare. (p.68)

Although Thorne’s (1990) study focuses on general health care it resonates with the commonly described experiences of consumers in mental health – especially those
of disempowerment when it comes to decisions about treatment and the emphasis on medications that often have unpleasant or poorly understood side effects (Minkowitz, 2006).

As previously discussed, medication has become the central treatment in psychiatry and compliance with medication is an important goal of intervention. In Herrman and Harvey (2005)’s study they found that 91% of consumers with psychosis in community based care were on medication while only 19% had received psychosocial rehabilitation. However, most medications result in side effects for many consumers and are generally understood to be crude and unattractive treatments (Wales & Hiday, 2006). The range of side effects includes weight gain, dry mouth, muscle stiffness and also risks of developing serious illness such as heart disease and diabetes. These medications are also aggressively marketed by large and powerful private pharmaceutical companies and often, in the long term, criticised in that the promised benefits are exaggerated or never established despite the health risks associated with them (Cohen, 2003). Furthermore studies suggest that while consumers and carers can tolerate continuance of some symptoms on lower doses of medication, treating teams tend to favour higher doses of medication, with higher tolerance of side effects required by the patient (Lenert, Ziegler, Lee, Roger, & Ramy, 2000).

Muirhead, et al. (2006) found that, in Victoria, people on CTOs tended to be treated more commonly by injectable forms of medication or ‘depot’, presumably because it was easier to monitor and did not rely on as much co-operation from the patient as did oral medication. However, his study suggested that compliance with oral medication could be achieved more readily with people on CTOs than what was common practice. Oral medication tends to be preferred by consumers due to less unpleasant side effects and sometimes improved effectiveness in managing symptoms. He recommended that more people on CTOs be trialled on oral medication. Muirhead, et al. (2006) found that people on CTOs taking oral medication tended to do better overall than those on depot. This improvement in outcome may be explained by the characteristics of people who are prescribed oral medication over depot but it also may
relate to the link between perceived coercion and outcomes in mental health (Swartz, et al., 2006). It may be that when people are receiving treatment they perceive as less coercive, their long term outcomes improve.

**Coming to a question**

The foregoing discussion suggests that any thorough investigation of the current state of play in relation to CTOs needs to acknowledge that they are fundamentally contentious and a rather crude method of addressing a very real and critical set of problems. Coercive and involuntary community treatment appears to be inevitable while we have people in our community who:

- Are unwell because they refuse treatment,
- cannot expect to stay long in hospital,
- are cared for by services that lack adequate resources, skills and methods to meet their needs,
- mainly rely on treatments that can be unpleasant and create problems themselves,
- have families who are sometimes overwhelmed by the burden of caring for them, and,
- are required to co-operate in order to enable the community services to assist them.

The above summary should be very familiar to all social workers familiar with a critical perspective. It suggests that CTOs exist not just as a result of individual pathology characterised by non-compliance and lack of insight, they are also the product of systemic and structural issues (K. Healy, 2005). As Szmukler (2008) observes in response to the varying rates of involuntary orders internationally and over time:

There is no reason to believe there has been any change in the nature of mental illness or the frequency of mental disorders over time. Evidently then, the use of involuntary treatments is not predominantly, perhaps not even significantly, determined by the nature of mental illness itself, nor by the absolute level of
associated risk. The structure of mental health services and the details of relevant legislation account for some of the differences. But so do cultural attitudes to the mentally ill, as well as what might be termed local ‘custom and convention’.

A fundamental premise of this study is that if CTOs are here to stay, as current developments suggest they are, despite a lack of strong, convincing evidence regarding their effectiveness, then the ethics, practice and policy associated with CTOs needs to be addressed to ensure that CTOs do not lead to human rights abuses and stagnation within psychiatric services. This is particularly to ensure that less restrictive treatment options are developed and maintained to both provide care and treatment and protect the community.

Here lies another aspect of the critique of CTOs. Even if CTOs are seen to be effective do they challenge the moral integrity of the service provider (Goldstein, 2001)? Is the CTO a substitute for something better but harder to learn, develop or implement?

The central question for this thesis is: ‘What represents ‘good’ practice with people on CTOs’ but from whose point of view? The driving forces that have been discussed in Chapter One suggest many different perspectives supporting particular practices in implementation. If the general communities, and service providers, fears about risk are at the forefront then what is ‘good’ may represent care, caution, control and a high tolerance for ‘false positives’. Maybe this imperative could even support formulas such as ‘one hundred people on CTOs is worth one less death by suicide’, perhaps ‘thousands to prevent one murder’. Webb (2006) discusses this in relation to:

The modern societies need to develop new system of rationalisation whereby the rules, regulations and procedures prioritise the ends to be achieved rather than the means used to obtain them. (p.21)

These questions are also consistent with what Creswell and Plano-Clark (2007) describe as postpositivism. Postpositivism favours a deductive methodology that tests a particular hypothesis using objective measures. This worldview is represented in CTO research that favours large, long term demographic studies involving establishing
evidence for decreasing rates of suicide and homicide and establishing a link to the use of CTOs, or at the very least, support for further attempts to establish decreased offending rates amongst those subject to CTOs. Whilst the Cochrane review (Kisely, et al., 2005) claimed that these studies had so far been inconclusive, there are ongoing attempts being made by Segal and Burgess (2006) and others (Hough & O’Brien, 2005).

If the medical and diagnostic issues were foremost in research then perhaps the reliance would be on medical evaluation, which may increasingly become biomedically focused, whereby capacity for insight would be measured not only in relation to what the person says and does but also indicators associated with brain functioning. Perhaps all people on CTOs should be subject to a battery of tests which determines their prognosis in relation to their capacity to develop insight. Their scores may then determine their suitability to be on a CTO and assist with decision-making regarding discharge. This research, again informed by postpositivism, attempts empirical observation and measurement and the testing of hypotheses and has its place in CTO research (Creswell & Plano Clark, 2007). However, such research does little to address issues of power, oppression and the social work practice implications that have previously been discussed. Furthermore, research that sees brain function and development as separate from social and environmental factors might also be challenged by contemporary understandings in neuroscience that are currently having an important impact on social work theory and practice (Cameron & McDermott, 2007).

From an individualistic human rights perspective the definitions of good practice are likely to be located in minimising as much as possible interference with personal autonomy and bodily integrity. Hence emphasis on rights focused legislation, external accountability measures such as review tribunals, access to appeal and external review and the application of the principles of natural justice might be foremost resources in establishing what represents good practice (Rees, 2003).

The current socio-political landscape, at least in Australia, continues to accept deinstitutionalisation and community based care as the preferred policy direction in mental health care. Gathering further support for these developments indicates another
complex array of good practice measures. This is likely to be located in treatment occurring in the least restrictive environment possible, staff accountability, meeting duty of care requirements, improvements in levels of functioning of consumers and effective use of resources, particularly the increasingly scarce resource of inpatient beds (Jaworowski & Guneva, 2000).

The emergence of consumers and carers as increasingly powerful stakeholders in the way in which services are developed and implemented suggests further ideas about how good practice may be defined. The consumer movement has tended to emphasise collaborative treatment approaches whereby consumers are actively involved in the planning, delivery and evaluation of their care and treatment (Minkowitz, 2006). Their ‘lived experience’ is both acknowledged and used as a guide to enable services to better meet their needs.

Similarly carers ask that their ongoing caring role is acknowledged and that their needs as ‘frontline’ carers who are there for the ‘long haul’ both prior to and following any formal intervention is considered in the planning, delivery and evaluation of care and treatment (Lewisohn, 2008). Therefore both carers and consumers may define good practice in relation to CTOs in terms of their participation and satisfaction with the service.

What underscores the above is that all stakeholders are likely to have some common ground regarding what they would want to achieve through the use of CTOs. It is suggested that this can be loosely described as improved quality of life for the consumer. Even so, how ‘quality of life’ is defined and measured is likely to be contested and to reflect the perspective and ideology of those measuring it (Lenert, et al., 2000). Outcome measures have been incorporated into the Victorian mental health system but this is not without some tension about what should be measured and how (Happell, 2008).

How then should a social worker start her enquiry regarding the implementation of CTOs and what represents good practice with people on CTOs? Researchers from the discipline of psychiatry have shown an interest in not only issues around service usage,
but also whether there is an improvement in social functioning (Muirhead, et al., 2006) and they have been interested in the question regarding whether CTOs can be more carefully targeted towards different groups of people who are most likely to benefit (Power, 1999). They have also made attempts to define some principles regarding decision-making about who should be placed on CTOs (Geller, 1990; McIvor, 1998) and guidelines regarding who should be discharged from a CTO (Jaworowski & Guneva, 2002). But, again, these seem more focused on outcomes, what service providers want to achieve, rather than what is the best way to go about it. This is where social work comes in. As explained by Furlong (1991), social work has traditionally been interested in the process of working with involuntary clients, and has tended to define a good process as a good outcome. The emancipatory values of contemporary social work emphasise entering into a partnership with consumers and developing authentic relationships. These relationships attempt to empower consumers with an overall aim of achieving a greater degree of social justice while attempting to address social inequalities (Thompson, 2000). Such goals are difficult to achieve in a service environment dominated by the interests of a much more powerful profession, psychiatry, and monitored by another powerful profession, law.

Even so, social workers play important roles, as case managers, supervisors, community members of the MHRB, policy makers and managers. It was suggested once by a much admired colleague that: ‘If risk management and case management are here to stay – how can social workers smuggle in their ideas and encourage a more critical discourse?’

The dilemma of a focus on process and practice issues

A significant conundrum existed in the course of this research and in the development of the research question because it included an acceptance that CTOs are here to stay. The focus became placed on what is good practice, keeping in mind the social justice and human rights issues and ensuring that the restraint suggested by those concerns is acknowledged when working with people on CTOs. The problem is the
evidence. Is it worth spending time researching what is good practice with people on CTOs because this assumes their value? Can such research be meaningful when it appears that there is not enough evidence to support the very existence of CTOs? Therefore should all research on CTOs currently be contributing to establishing a body of evidence for or against the use of these orders? Such is the dilemma created by a focus on process and implementation.

Dawson (2005) identifies that, because of the many differences of jurisdiction and experience with the orders as well as lack of uniform preparedness by different states to use them (Petrila & Christy, 2008), the effectiveness of CTOs is difficult to establish. The implementation of CTOs relies on the resources available to implement them and this varies significantly in different jurisdictions. As a result, making comparative judgments about the use of involuntary treatment in the community is extremely difficult. Studies can be compared in relation to the different outcome measures that have been used. They can also be criticised because of the different methods adopted to achieve the results but either way the mental health community of consumers, practitioners and academics seems a long way from being able to say definitively, ‘Yes, CTOs work’. Work at what? With whom?

The use of CTOs in Victoria has been readily embraced, and relied on, by mental health service providers (Jaworowski & Guneva, 2002; Muirhead, et al., 2006; Power, 1999; Segal & Burgess, 2006d). There is a growing local consensus that people are better off on a CTO, and this may be for a variety of reasons, but particularly for protection of the person, their family/carers, and general community safety issues. This ‘clinical wisdom’ is supported by relatively small scale studies undertaken in Victoria (Muirhead, et al., 2006; Power, 1998). Furthermore there is also the relevance of previously existing methods of involuntary outpatient or community treatment through extended or trial leave from hospital. This may suggest just a new method of naming and regulating a long standing practice – albeit with some new regulations attached (Rees 1997, cited in Carney, 2003). It may be in doubt whether people spent years on trial or extended leave but there is no doubt that many people did spend years in hospital. Now it seems that
many of the people who spent years in hospital are spending years as involuntary patients in the community. Many are living in sub-standard accommodation or in privately operated supported residential facilities, barely managing on minimal pocket money while full room and board is deducted from their social security benefits. Indeed they remain ‘involuntary patients’ in that they may remain indefinitely on CTOs, so the rounds of tablets and injections, whether you like it or not (or even understand why you are having it or not), continue (Green 2001, cited in Carney, 2003). It could be argued therefore that CTOs have simplified deinstitutionalisation. Indeed one of my colleagues referred to cases where administrative bungling had meant that some people living in circumstances such as those described above had not had their CTOs renewed and it seemed that no-one noticed the change in legal status. Such complacency about the administration of CTOs was soundly challenged by the Supreme court’s decision in the Richard Wilson V Mental Health Review Board and Others, 2001 (Delaney, 2003). This is probably more about disempowerment and commitment to routine than a sudden surge in insight and preparedness to comply, but even so it leads to a question about why keep the person on a CTO at all? Unfortunately this refers in particular to people with the most serious and enduring forms of mental illness, and they present particular problems in being discharged from a CTO. Mostly this relates to their capacity to give informed consent. Many of these people can perhaps never understand that they have a mental illness or understand the purpose of the medication they are taking. They are unlikely to cope anywhere other than in supported accommodation and, without the treatment, they are likely to relapse and require inpatient admission. However, the question remains about whether they need to be on CTOs as many, due to the long term nature of their problems and their reliance on others for day to day support are likely to be as co-operative with treatment either on or off the CTO (Freckelton, 2003b).

The foundation of this research question is located in a genuine interest in what it is like to be on a CTO? It seeks to explore how an ethical practitioner can work within the boundaries of the CTO in a way that is most likely to be helpful and sensitive to the needs of people on CTOs. It is proposed that by exploring with research subjects what is
it like to be on a CTO, what’s it like implementing them and when CTOs seem to work best and why, then a contribution is being made to the overall question most likely to be asked in the literature and in practice – ‘are they effective’ or ‘do they work’? This is without the quest for effectiveness being driven by a neoliberal agenda, rather one based on social work values that locate effectiveness in both process and outcome.

**Conclusion**

This chapter has explored the theoretical underpinnings of this research. It has reviewed how theory has informed social work practice with involuntary consumers and how critical theory can assist in formulating questions about the implementation of CTOs. It has established that while CTOs have so much momentum – and in recognition that they have been actively used in Victoria for almost 15 years - it seems justifiable to put the question aside about whether or not they should exist at all and focus on, accepting that they are here to stay, what represents principles of good practice with people on CTOs? Coming to a definition of good practice is somewhat unknown. It might even be more relevant to describe ‘best practice’ or ‘better’ practice – or simply ‘doing CTOs well’. Even so, a starting point is what is known about good practice in social work as reflected in the profession’s commitment to emancipatory values. Most importantly, an aim of this thesis is to define good practice in a way that includes what people on CTOs think helps them. Furthermore, this research is also based on a view that social work judges good practice in relation to the process of the work as well as what outcomes are achieved. The discussion of the risk society and the increased reductionism that has been the result is reflected in the narrowness of seeing CTOs as a single intervention, the impact of which can be measured or evaluated. The position taken here is that CTOs are implemented in complex and diverse situations where a number of different factors or variables are likely to be influencing the experience of those involved and what meaning they give to the CTO. The research begins with an acceptance that people on CTOs are in treatment and have a doctor and a case
manager. These are all the ‘givens’ and this thesis has to investigate from this baseline. The doctors and the case managers will have a view on what they think is good practice, as will any informal support people such as family/carers and friends and other service providers such as Psychiatric Disability Support Services (PDSS). The other people likely to have a view on what represents good practice are the managers and the policy makers. Also, because of their role in meeting so many people on CTOs, reviewing their files and confirming decision-making in relation to them, it is presumed that MHRB members will also have ideas about good practice. Hence, along with the CTO recipients themselves, other key stakeholders involved in the implementation of CTOs will be asked their opinion, from their general experience and through focusing on the circumstances of a particular case study. Most central will be the feedback from people subject to the orders themselves because of the use of case studies as the primary method of investigation. In each case study a CTO recipient’s experience is considered through multiple perspectives in order to enable the complex interplay of experiences with family/carers and service providers to be explored as thoroughly as possible.
Chapter Three: Project Overview, Methodology and Methods

Introduction

In this chapter, the research methodology is introduced and justification is given as to how this methodology fits with the questions being asked and the theoretical underpinnings discussed in Chapter Two. The methods of investigation are described. Methods of analysis are also discussed with a view to presenting how such an analysis has enabled recognition of the processes and principles that represent good practice with people on CTOs.

Foundations of the research

This study explores what represents good practice with people on CTOs using the emancipatory values of social work as a guide to the investigation. The research method involves a combination of quantitative and qualitative methods, what Cresswell and Plano Clark (2007) describe as mixed methods research. They define it as follows:

Mixed method research is a research design with philosophical assumptions as well as methods of enquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of the data and the mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analysing and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone (Cresswell & Plano Clark, 2007 p.5).

Table 2 provides an overview of how a mixed methods approach has been applied. In this mixture of methods, case studies are the primary method of investigation, but quantitative data collection and analysis has been embedded into the research. The quantitative data enabled the selection of case studies and assisted in
providing broad indicators about the implementation of CTOs, while case studies provided in-depth understanding of the lived experience. Developing an understanding of lived experience relies on providing opportunities for people to express themselves and describe their experiences, and also the process of interpretation and data analysis. The semi-structured group interviews provided another source of qualitative data that enabled further integration of thoughts, observations and ideas from a range of key stakeholders.

Table 2: Overview of the underlying values, research methods, purpose and related activity

<table>
<thead>
<tr>
<th>Values</th>
<th>Research Method</th>
<th>Purpose</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deindividuation</td>
<td>Cluster Analysis</td>
<td>An exploratory technique used to investigate whether there were ‘types’ of people on CTOs in one area mental health service. To act as a sampling technique for recruitment of the case studies.</td>
<td>Snapshot of 164 people on CTOs. Three different clusters identified. “Connected” “Young males” “Chaotic”</td>
</tr>
<tr>
<td>Diversity</td>
<td>Case studies</td>
<td>To identify and explore the experience of consumers who represented each of the clusters.</td>
<td>Recruitment of four consumers each representing a cluster. Cluster three represented by a woman and a man.</td>
</tr>
<tr>
<td>Equality</td>
<td>Case studies: Initial semi-structured</td>
<td>To ask people on CTOs, their carers, case.</td>
<td>Total of: 4 interviews with consumers.</td>
</tr>
</tbody>
</table>
challenged through providing opportunities for all to have a ‘voice’ about practice

**Empowerment**
Research can provide consumers and carers with an opportunity to influence the socio-political context

<table>
<thead>
<tr>
<th><strong>Partnership</strong></th>
<th><strong>Social justice and Citizenship</strong></th>
</tr>
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<tbody>
<tr>
<td>Working with consumers and carers jointly enhances the review and evaluation of practice. (Thompson, 2000)</td>
<td>Enabling contributions from a range of key stakeholders. This models <em>social inclusion</em> and an emphasis on <em>human rights</em> (Thompson, 2000)</td>
</tr>
<tr>
<td>Case studies: Follow-up semi-structured group interviews (within approximately 6-12 months)</td>
<td>Semi-structured group interviews</td>
</tr>
<tr>
<td>To ask the questions again and compare responses. To obtain information about the impact of the CTO over time.</td>
<td>To obtain perspectives of key stakeholders on their experience with CTOs and obtain their ideas and opinions about good practice</td>
</tr>
<tr>
<td>Total of: 4 interviews with consumers 1 interview with a carer (the other interviewee declined a second interview) 2 interviews with case managers (CM) (two consumers no longer had an active CM, one of the other consumers had had a change of CM) 4 interviews with doctors (2 new doctors had replaced doctors in the initial interviews)</td>
<td>Total of 4 interviews conducted with: Consumers Carers MHRB members Senior managers, executive and policy advisors</td>
</tr>
</tbody>
</table>

| 2 interviews with carers 4 interviews with case managers 4 interviews with doctors | |
The epistemology, or ‘theory of knowledge embedded in the theoretical perspective and thereby in the methodology’ (Crotty, 1998 p.3) underlying this research is one that moves away from the objective demands of positivist research and alternatively values subjectivism as a source of knowledge (Creswell & Plano Clark, 2007). However, in line with Crotty’s (1998 p.9) arguments, this research is not based on subjectivism; rather it is more appropriately described as ‘Social Constructionism’. Constructionism refers to the construction of meaning that occurs between people and their interaction with the world, and is the most common theoretical underpinning for qualitative research. ‘Social Constructionism’ refers to the historical and social perspective that is essential to the development of meaning. People organise their experiences and are constantly in a process of interpreting and making meaning of them. Therefore this study assumes that when people are interacting with CTOs there are a range of experiences and subsequent understandings being developed.

As discussed in Chapter Two, the worldview guiding this research is critical theory. An attempt has been made to engage in conducting ‘emancipatory research’ that acknowledges a set of emancipatory values as the foundation of the investigator’s approach (Alston & Bowles, 1998). Combining quantitative and qualitative research enables attention to the relevance of social and structural issues – in this case the gender, cultural, age, socioeconomic and diagnostic issues relevant to being on a CTO – along with an opportunity to also explore the ‘lived experience’ of key stakeholders. Case studies serve as the main research method because they aid with:

A critical process of inquiry that goes beyond surface illusions to uncover the real structures in the material world (Neuman, 1999 p.67).

Case studies enable the involvement of consumer, carer, case manager and doctor as ‘equals’. Each participant is valued for their contribution and this is not related to traditional power dynamics and imbalances. The research perspective presumes that each person involved has a valuable and legitimate perspective. Diversity and conflicting experiences and ideas are expected in the context of this multi-layering. A case study
enables a critique of the current conditions surrounding the implementation of CTOs and provides a depth of understanding that can drive ideas about achieving change. According to Ramon (2006), qualitative methods are more suited to the needs of user respondents and promote subjective experience as an important source of knowledge.

As will be discussed in more detail below, pragmatism has also informed the research. Pragmatism is a common worldview underlying a mixed methods approach because of its interest in multiple perspectives and practicality (Creswell & Plano Clark, 2007). This study focuses on practice issues with a goal of providing guidelines about good practice for a range of people involved in working with or caring for people on CTOs that would be meaningful, authentic and well supported by the data collected and its subsequent analysis. The involvement of multiple key stakeholders encouraged many people involved in implementing CTOs to think about practice. This has enabled a range of voices to be heard; these voices may subsequently be persuasive for an equally broad group who could potentially be influenced by the research. Hence the consistency with a critical (or transformative-emancipatory) paradigm that is ultimately focused on achieving change and shifting power relationships - through greater empowerment and reduced marginalisation for people on CTOs (Creswell & Plano Clark, 2007). Whilst the voices of consumers are not necessarily privileged in the collection and analysis of the data, their experience is central to the research.

**Methodology**

Dare we learn how those who are not “us” – who are from working class, or mentally ill, or urban teenagers, .....- make sense of the world? And further, do we dare learn the ways in which they are us? (Marecek, Fine, & Kidder, 1997 p.4)

Within this mixed methods research design qualitative methodology is the stronger element. Marecek, Fine and Kidder (1997) help to provide a justification for the use of a qualitative approach when they describe ‘the heart of a qualitative stance is the desire to make sense of actual lived experience’ (p.1). The same authors suggest that a qualitative stance:
Invites broad based inquiry into spaces that are undocumented in other studies... to pry open territory about which they have only vague hunches, (and) qualitative researchers embark on an intellectual adventure without a map or even a clear destination. (p.2)

A qualitative approach can assist with studying and understanding process issues. It promotes the potential for service users or consumers to be involved in defining what is good practice, that is in turn consistent with the values guiding the research (K. Healy, 2005). There are many possible definitions of good practice; qualitative analysis provides an opportunity to move beyond arguments for and against effectiveness to thinking about good practice as process.

Case studies are suggested as a research method when the research area is ‘new or particularly problematic’ (Punch, 1998 p.156). A case study can also assist in developing a conceptualisation of phenomena and processes that may enable further research questions to be generated and assist where previous researchers have gone ‘straight to measurement and quantitative mapping (p.156)’ without giving recognition to the complexity of the subject (Punch, 1998). Hence the relevance for the research reported here, given that much current research on the effectiveness of CTOs is contentious and ambivalent (Dawson, et al., 2003). Dawson, et al. (2003) suggest that:

There is a need for comparative work to identify best practices across jurisdictions: for qualitative work on patient, family and clinical perspectives, especially patients’ views of how CommTOs (sic) affect their freedoms; and for further work on downstream decisions in the CommTO process, such as revocation, extension and discharge decisions. (p.12)

The research reported on here is fundamentally guided by the emancipatory values of social work (Thompson, 2000), and therefore assumes the relevance of these values to not only good practice, but also how the research is conducted. The emancipatory values of social work lead to an interest in issues related to empowerment, deindividualisation, equality, social justice, citizenship, partnership and authenticity (Thompson, 2000 pp. 116-123 see Table 2). Mullaly (2002) adds diversity and appreciation of difference to this list because of the influence of post-modern
critical theory on social work values. Qualitative research seeks to ensure that consumer and carer voices are heard. This is consistent with the goals of modern critical social work in that it engages in partnership with service users and promotes service user empowerment (K. Healy, 2005).

Case studies are most strongly associated with the field of sociology because this methodology has enabled a focus on both the ‘actors’ in the case study and also the relevance of social and structural dimensions - such as poverty, unemployment and culture - to what is being observed and analysed (Tellis, 1997). Positivists, rationalists or those committed to the scientific method of experimental research have been critical of case studies because of a supposed lack of rigour and the difficulties in generalising from a single case study (Yin, 1993). Case studies are also time-consuming. However, advantages of case studies include the exploratory depth they enable, along with the relevance they offer when describing, understanding and explaining (Tellis, 1997).

Whilst case studies are generally concerned with replicating a phenomenon rather than sampling, the use of the cluster analysis to assist in ensuring that the subsequent individual case studies represented the diversity of people on CTOs is consistent with the proposition that:

Selecting cases must be done so as to maximize what can be learned, in the period of time available for the study (Tellis, 1997 p.5).

This supports a goal of the research design: of wanting to have the depth that a case study offered, but also wanting to have the opportunity to apply the same set of questions to people on CTOs whose demographic characteristics were different, yet recognisable, as a ‘type’ of person who might be on a CTO. Flyvbjerg (2006) discusses how random selection may not be the most appropriate strategy when using case studies. He recommends strategic selection of cases that might be either finding atypical or extreme cases or, as has been done here, ‘maximum variation cases’ (Flyvbjerg, 2006 p.230).
Flyvbjerg (2006) challenges the common criticisms and misunderstandings about case study research. He contends that case studies, in being able to provide context and depth, contribute to learning and building expertise, more than scientific methods and the search for ‘predictive theories and universals’ (Flyvbjerg, 2006 p.224). According to Flyvbjerg (2006) the power of an example is underestimated, as is the example’s ability to challenge any subjective bias that the researcher may bring. In my own experience, as the researcher in this study, I often found my own preconceptions falsified rather than verified. Furthermore I personally experienced the power of talking to people and reading transcripts. People involved in the case studies often challenged various assumptions and normative ideas about CTOs and the people and processes that surround them.

The challenge with this study is the lack of generalisability of the case study data. However, Flyvbjerg (2001) explores the considerable value of including case studies in social science research. He contends that a case study enables the complexities and hinterland of phenomena, such as CTOs, to be understood. Flyvbjerg (2001) acknowledges that summarising and generalising from case studies is difficult and actually undesirable in the context of the very purpose of case studies, which is the opportunity for depth and awareness rather than ‘summaries, concepts or theoretical formulas’ (p.86). Even so, themes that give meaning to each case study are identified through the data analysis in this research.

Therefore it needs to be acknowledged that the interpretation of the case studies and themes that have been developed in Chapters Six through to Eight represent the voice of the researcher in attempting to provide meaning to what she has initially determined to be a ‘case’.

Case studies have a particular synergy with the strengths that I bring to the research as an experienced social worker who was confidently able to interview all the participants in the individual case studies⁴. Case studies were also a particularly useful

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⁴ Here I am drawing a distinction between the individual, replicating case studies that occurred within what was one large case study in the overall design.
technique for exploring good practice because so much of the discussion was able to focus on relationships and decision-making. The use of case studies also had a logical consistency with critical theory. As explained by Tellis (1997):

Case studies are multi-perspectival analyses. This means that the researcher considers not only just the voice and perspectives of the actors, but also of the relevant groups of actors and the interaction between them. This one aspect is a salient point in the characteristic that case studies possess. They give voice to the powerless and voiceless. (p.5)

Even so, in the context of this strong justification for reliance on qualitative methods, a mixed methods approach was taken. Cresswell and Plano Clark (2007) discuss how a mixed methods approach can be useful by being able to mix data and can provide more comprehensive evidence for studying a research problem. They suggest that mixed methods research is often based on the use of multiple world views or paradigms and is most commonly linked with pragmatism. Pragmatism is described as:

The focus is on the consequences of research, on the primary importance of the questions asked rather than the methods, and multiple methods of data collection inform the problems under study. Thus it is pluralistic and orientated towards ‘what works’ and practice (Creswell & Plano Clark, 2007 p.23).

The decision to make use of a mixed methods approach is partly explained through blending pragmatism with a critical theory approach. My intention was to ensure that the choice of case studies was informed by quantitative data that gave their stories greater legitimacy because it could be argued that they could be identified with particular clusters. Conducting a cluster analysis, as a quantitative research method, was exploratory (StatSoft, 2003). Unlike other quantitative research methods it did not rely on a hypothesis and remained consistent with the emancipatory values stance that invited a critical perspective in relation to how CTOs were being implemented. The cluster analysis enabled the beginnings of a search for exceptions and diversity and what this might indicate about the implementation of CTOs. It provided a richer picture than
the data generally available which tends to report on means and averages rather than exceptions and difference. Embedding this quantitative data into the subsequent case studies and semi-structured group interviews helped to strengthen the findings. It compensated for the relatively small number of case studies by suggesting that they were more representative than would have been the case if they had been randomly selected. This data was also able, at times, to support the findings of the qualitative data analysis; for example, by confirming that there are different overall patterns for women on CTOs than men, that young men tend to have particular problems with substance abuse, and that men and women are equally likely to have a complex (or ‘chaotic’) set of problems. The cluster analysis was also able to make the findings more meaningful by offering support to the eventual finding that it was important to appreciate the diversity of experience for people on CTOs.

Undertaking semi-structured group interviews with key stakeholders was partly the result of a deliberate attempt to strengthen the voices of consumers and carers in the study. The group interviews were held with groups that were already partly established and could be facilitated by consumer and carer consultants employed in advocacy roles by the service. In this context it was anticipated that the input of carers and consumers would be less dependent on the participants in the case studies. Appropriately, carers could only be interviewed in the case studies if the consumer in the case study agreed, due to ethical constraints. Also, input from other consumers was seen to be valuable because otherwise the consumer voice would have been limited to the consumers at the centre of each case study. While this was very important to the overall credibility of the research, the group interview was able to ‘value add’ by offering more opportunity to compare and contrast consumer and carer experiences.

The other two semi-structured group interviews, with MHRB members and senior managers, executive and policy advisors, enabled further contribution from key stakeholders who would not be included in case studies. As discussed earlier, the MHRB have a considerable stake in good practice with people on CTOs as they are required to meet with people on these orders, along with their service providers, to provide
administrative review of decision-making. They are also required to view treatment plans and determine whether they have been developed in compliance with the law. Critical comments made by the MHRB about services and their performance (Mental Health Review Board, 2008) are balanced by the critical comments made about the MHRB by human rights advocates (Topp, Thomas, & Ingvarson, 2008). Interviewing MHRB members presumed their interest in contributing to the research and benefiting from the findings. It gave recognition to the breadth of their perspective on CTOs and acknowledged that they too practiced from a constrained position within the service network.

The senior managers, executive and policy advisors group represent those behind documents such as the ‘Chief Psychiatrist CTO guidelines’ (Chief Psychiatrist, 2005) and other efforts to achieve what is currently seen as good practice with people on CTOs at a management and policy level. This research provided an opportunity to compare and contrast the perspectives of those in leadership roles with those ‘at the coalface’.

**The case study**

This research essentially focuses on one large case study. The case study is of the implementation of CTOs in one area mental health service in Victoria, Australia\(^5\). Within the larger case study there is a cluster analysis of all the people on CTOs at one point in time, four smaller case studies (each representing someone on a CTO, their carers and service providers), and four semi-structured group interviews (see Figure 1). Understanding more clearly who the people on CTOs are in the area mental health service was aided by the cluster analysis. The cluster analysis provides helpful insights into how age, gender, socioeconomic and cultural issues are relevant to understanding the implementation of CTOs, thus establishing the relevance of social and structural dimensions, as well as individual characteristics, when discussing who might be on a

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\(^5\) North West Area mental health service is one of 22 area mental health services in Victoria and more details are provided in Chapter Four
CTO. Each of the four individual case studies revolve around a particular person and each person interviewed was asked to think about the implementation of CTOs and their ideas and decision-making in relation to that person, as well as also being asked their general ideas about CTOs and good practice. Other input was invited via the semi-structured group interviews. This is where more permeability was introduced to the overall boundary because the group interviews did involve people from outside the area mental health service. All the groups, other than the MHRB⁶, combined people from ‘within and without’. This enabled triangulation of research data, whereby the semi-structured groups enabled some testing of the consistency of ideas and enabled the possibility of new or competing themes to emerge from participants who had a more state-wide perspective than those within the area mental health service. In particular this included consumer advocates, MHRB members and senior policy advisors from the Department of Human Services.

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⁶ The MHRB is in some ways part of the activity of the AMHS because they are regular visitors, reviewing the use of involuntary treatment orders and CTOs
**Research design and process**

The first stage of the research was a cluster analysis of all the people currently on CTOs in North West Area Mental Health Service. In the project proposal it was explained that once clusters were identified they would be used as a guide in the choice of case study subjects, such that they represent at least four of these clusters. It was anticipated that if clusters did not emerge, case studies would be randomly selected. Each case study included the consumer, a carer (if one could be nominated by the consumer and their permission could be obtained to involve the carer), the case manager and treating doctor.

In conjunction with the cluster analysis and case studies a series of semi-structured group interviews were conducted with key stakeholders involved in the implementation of CTOs. (see Table 2).

The research design or strategy involves considerable triangulation. Having multiple but related sources of data enabled ongoing ‘testing’ of the validity of the processes and gave greater confidence in gaining meaning and theory building. This is
recommended as a necessary aspect of case study research in order to strengthen its legitimacy as a research method (Tellis, 1997).
Figure 2: Visual representation of research design

164 people on CTOs – A Cluster Analysis 2003

Cluster One
N=27
Connected

Cluster Two
N=33
Young Males

Cluster Three
N=68
Chaotic

Case Study One
Joan
Initial interviews

Case Study Two
Peter
Initial interviews

Case Study Three
Maria
Initial interviews

Case Study Four
Joseph
Initial interviews

Follow up interviews

Group Interview
Carers

Group Interview
Mental Health Review Board Members

Group Interview
Senior Managers and Policy advisors

Group Interview
Consumers
Methods

The proposal to use combined qualitative and quantitative methods to address this question was partly located in the broad nature of the question. My interest is in whether someone is seen to have benefited or not from being on a CTO and also in uncovering the ‘layers’ of process and practice issues. This approach embraces the importance of adopting a critical and reflective perspective. The mixture of methods supports being able to explore whether a CTO has different meanings for the people involved when compared across the different clusters via the case studies and whether what is good practice varies depending upon the characteristics of the person on the CTO. All this material can then be related back and compared to the findings of the semi-structured group interviews where more general experiences and expectations have been identified.

Cluster analysis

Cluster analysis is a technique for grouping individuals into clusters based on statistical distance algorithms so that the individuals within each cluster are more like one another than they are like individuals in any other clusters (Hair, Anderson, Tatham, & Black, 1984). The goal is to maximise the variability between clusters relative to the variability within clusters (StatSoft, 2003). Cluster analysis is an exploratory rather than a hypothesis-testing technique, so it is important that the variables used for clustering are theoretically relevant to the purpose of the clusters, and that the clusters that emerge are able to be interpreted in light of the construct under investigation.

In this study, the purpose of the cluster analysis was to explore whether there were statistically reliable and interpretable sub-groups within the sample of people on CTOs. Whilst the primary purpose of this investigation was to identify case studies that represent identifiable or familiar types of people on CTOs, the findings of the cluster analysis holds its own interest and importance (and has been independently published) (Brophy, et al., 2006). The identification of sub-groups or clusters has assisted in informing further questions regarding how the involuntary admission criteria are
interpreted, whether CTOs are currently being targeted towards particular groups, and in establishing the relevance of social factors in decision-making about CTOs. The involvement of carers, how to best give people information about rights and how to make best use of external review are factors that may vary depending on the purpose of the CTO and the recipient. In the long term, it may also assist in planning the most appropriate service response as a similar research design did in relation to people identified as having multiple and complex needs in Victoria (Department of Human Services, 2003).

There is some difficulty in establishing the representativeness of the overall group that was eventually used for the cluster analysis. This population of CTO recipients begs comparison with other area mental health services, which may have different overall demographic characteristics. However, in order to contain the study and enable the qualitative research to proceed, the generalisability of the data to other areas of Melbourne or Victoria was necessarily limited. The patterns that emerged reflected a limited sample. Even so, there were opportunities to make comparisons with similar data represented and discussed in the literature – so some comparisons have been drawn.

Another important set of questions posed by this study is: who is most likely to be placed on a CTO, for how long and are they also the people most likely to benefit? This research can only make a small contribution to these questions, but an initial cluster analysis was proposed to enable the selection of case studies representing different ‘types’ of cases and, therefore, may be recognisable to those who have an interest in the findings of this research. A cluster analysis was used to identify whether there are, at least in one area mental health service, particular ‘types’ of people on CTOs. It was anticipated that identification of ‘types’ and ‘clusters’ of people on CTOs might offer suggestions about the clinical, social and structural impacts on decision-

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7 For example, in Victoria, there is increased emphasis placed on deterioration in health and well being in supporting CTOs, rather than limiting decision-making to issues of dangerousness.
making regarding who is placed on a CTO that goes beyond the involuntary admission criteria. The cluster analysis was the source for selection of case studies, such that each of the case studies represented a similar group of people who were previously found to be on CTOs.

The cluster analysis, as anticipated, enabled more selectivity to the choice of case study participants. The results of the cluster analysis also contribute to the overall CTO case study through enabling some more refined appreciation of the implementation of CTOs.

**Case studies**

A case study provides an opportunity to conceptualise and develop propositions that may be applicable and transferable to other situations (Punch, 1998). The method anticipates that the findings will make a contribution to theory development and will stimulate further research questions being developed. A case study offers an opportunity for in-depth understanding and analysis of process. Because of the depth offered by a case study, the relevance of social and structural dimensions can more clearly be identified. For example, when someone is placed on a CTO, whose needs are being met? If there are multiple sources of need, how are needs prioritised? Case studies also enable follow-up of the interviewees. Tracking someone’s experience of a CTO is of interest in attempting to address the question of the impact of a CTO on consumers. It was expected that it may be possible to estimate whether the reaction to being on a CTO fluctuates over time and changes ideas or opinions about good practice. The follow-up interviews provided an opportunity to gain information about the outcome of the CTO for the consumer and others involved.

It was anticipated that individual case studies would provide depth in understanding why a consumer was understood to be non-compliant with treatment and what evidence and factors were considered. This provided an opportunity to explore the degree to which non-compliance was linked to the role of professionals, and the methods attempted to achieve compliance; thus enabling a study that focused on
the complexity of the relationships involved. This also opened up potential for discussion of subjects such as power and authority.

Other ways of understanding why the person represented a significant risk to themselves or others are also useful. How are these judgements made? What role does risk play, not only in the decision to place a patient on a CTO but also in the decision to discharge the patient from the CTO? Who in the case study is mindful of risk and how is risk understood? Risk appears to also have the potential to influence the nature and extent of CTOs as an intervention.

Semi-structured interviews were chosen as the preferred method for the interviews as they enabled some structure to the questions, consistent with the overall general inductive approach (Thomas, 2004). This approach was interested in the response of the interviewees to particular issues but also allowed opportunities for new or unexpected issues to emerge. Semi-structured interviews allowed the interviewees subjective experience, interests and values in relation to the topic to emerge. This was particularly relevant in relation to some of the more open questions including, for example, asking interviewees about their general ideas about how CTOs could be improved.

**Semi-structured group interviews**

There are multiple perspectives arising from key stakeholders who are able to inform the questions of what represents good practice with people on CTOs, including consumers. Carers are an important group of key stakeholders, and the impact of a CTO when in a caring role was explored. Inevitably, managers and policy makers already have ideas, expectations and guidelines regarding what represents good practice with people on CTOs and are in a strong position to locate these expectations in the broader organisational environment. The MHRB was also chosen as another key stakeholder because it was expected that Board members would have ideas about what represents good practice through making their own observations of interactions during Board
hearings, and also through their perusal of clinical files. In order to capture the views of this range of key stakeholders one of the research methods chosen was semi-structured group interviews.

**Quantitative Data Collection—A Cluster Analysis.**

The data was obtained via the Mental Health Client Management Interface (CMI) and all current demographic, diagnostic and service usage information available was requested. All consumers of public mental health services in Victoria are registered on CMI, and demographic and clinical information is obtained via a standardised registration form, which is regularly updated, particularly when changes in treatment location, or team, occur. The data dated back to 1989. This data was extracted from the North Western Mental Health CMI, and therefore other mental health service data in Victoria outside North Western Mental Health was not included due to ethics approval restrictions. However, North Western Mental Health is the largest mental health service provider in Victoria with a catchment of 1.2 million people including the central business district. North Western Mental Health is divided into 4 area mental health services, including the North West area mental health service (NWAMHS), the area mental health service that is the focus of this study. At the time of the data collection, 164 people were on CTOs with NWAMHS representing approximately 17% of all registered clients.

**Qualitative Data Collection**

**Case Studies**

Following the findings of the cluster analysis, the sub types of people identified on CTOs led to case study subjects being selected who represented the sub-types. The number of case study subjects was necessarily limited by the scope of the study, and whilst five case studies were anticipated, only four were selected due to the smaller number of clusters being identified than initially anticipated and the difficulties in recruiting case study participants.
Each of the four individual case studies has a boundary around the four potential participants - the consumer, carer, doctor and case manager. Participation in the case study was contingent upon the relationship between the participants, such that as long as the person interviewed was identifiable as the case manager or doctor involved in the case study they could be interviewed, even if different people fulfilled these roles at follow-up. This is because a common feature of mental health public service systems is changes of staff, with the consumers frequently experiencing a new case manager or doctor.

Each case study was designed to potentially include a carer. The inclusion of a carer was dependant on the consumer being able to nominate one and provide their permission. A carer, for the purposes of the study, depended on the consumer’s definition but could have included a family member, partner, friend or other service provider such as an outreach worker.

Subjects were interviewed twice to enable some longitudinal, comparative data. The gap between interviews was approximately 6-12 months. This was considered enough time to enable change to be evident and for some decision-making to have occurred regarding the CTO. The second interview occurred even if the person had been discharged since the first interview. I conducted and digitally audio-recorded the interviews.

Recruitment of case study participants

After the cluster analysis was completed, the next step was to identify any clusters and try to recruit case study participants representing, what was initially hoped would be at least four, but turned out to be three, clusters. I then decided that because one of the clusters was so large it would be useful to have two people ‘representing’ that cluster: one male and one female. Another factor was that the findings of the cluster analysis suggested that within this large cluster (‘Chaotic’) there was an equal likelihood, in terms of the overall group of 164, that men and women would be in this
The recruitment was via the case managers and medical staff who were asked through general communication strategies (including a group email and personal communication) if they have any current patients/clients on CTOs who match particular characteristics (e.g. males aged between 18 and 25 who live with their parents and have a diagnosis of schizophrenia). The only exclusion criteria were consumers who were my current clients. People unable to give informed consent or too unwell to participate were also excluded. The assumption was made that these people would be ‘selected out’ by the recruitment strategy, which indeed was the case. I then arranged to discuss the project with the four potential consumer case study participants and in all of these initial interviews the consumer consented. It was then confirmed that the case studies could proceed because all three or four other case study participants (doctor, case manager and carer) also agreed to be involved and were prepared to give informed consent. However, a carer was only approached in two cases. In one case the consumer did not identify any family members or others as carers, and did not want them to be interviewed. In another case the consumer did not have a nominated carer.

**Individual semi-structured interviews**

Semi-structured interviews were the favoured method because they enabled some structure to the interview but also allowed exploration of additional information that the respondent had raised. This allows a skilled interviewer, such as myself, to take more initiative and pick up on, and explore in more depth, the themes, issues and priorities that appeared to be most relevant to the respondent (Alston & Bowles, 1998). Throughout the interview I used summary techniques and controlled non-directive probing to assist in ensuring that the respondent was being understood and invited to make further comment or build on comments made in response to the questions (Alston & Bowles, 1998).

All the initial interviews were held in interview rooms in various locations across North West Area Mental Health service. However, some of the follow-up interviews
were held in the interviewee’s own home. All were digitally audio-recorded and Table 3 lists the questions that formed the basis of the interviews.

**Table 3: Questions for semi-structured individual interviews**

<table>
<thead>
<tr>
<th>Questions for Consumers</th>
<th>Questions for the case manager and doctor</th>
<th>Questions for Carers (when nominated):</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What do you understand about why you are on a CTO?</td>
<td>• What is your understanding regarding why this person was placed on a CTO?</td>
<td>• What is your understanding of why your relative has been placed on a CTO?</td>
</tr>
<tr>
<td>• What’s it like to be on a CTO?</td>
<td>• What do you think it is like for them?</td>
<td>• Do you think it is of benefit to them? Why?</td>
</tr>
<tr>
<td>• Have you ever thought it was useful? Why?</td>
<td>• Have you ever thought it was useful? Why?</td>
<td>• Is it of benefit to you? Why?</td>
</tr>
<tr>
<td>• What is the best thing about it?</td>
<td>• What is the best thing about it?</td>
<td>• Are there negative aspects to you?</td>
</tr>
<tr>
<td>• What is the worst thing?</td>
<td>• What is the worst thing?</td>
<td>• Are their negatives for the person you are caring for?</td>
</tr>
<tr>
<td>• Whose needs are being met? Or, is the CTO of benefit you or somebody else?</td>
<td>• Whose needs are being met? Or, is the CTO benefiting the client/patient or somebody else?</td>
<td>• What, to you, represents good practice by the practitioners involved?</td>
</tr>
<tr>
<td>• Does your case manager do anything helpful? What?</td>
<td>• Do you do anything helpful? What?</td>
<td>• What represents poor practice?</td>
</tr>
<tr>
<td>• Does your doctor do anything helpful? What?</td>
<td>• How often are you in contact? Is that enough?</td>
<td>• Whose needs are being met by CTOs?</td>
</tr>
<tr>
<td>• How often do you see them? Is it enough?</td>
<td>• What factors most influence your decision-making regarding whether this person should remain on a CTO?</td>
<td>• Have things changed over time?</td>
</tr>
<tr>
<td>• Do you think CTOs could be improved? How?</td>
<td>• Do you think CTOs could be improved? How?</td>
<td>• Do you have any other ideas or comments about CTOs that you think would assist my research?</td>
</tr>
<tr>
<td>• Do you have any other ideas or comments about being on a CTO that you think would help my research that’s trying to find out how best to assist people on CTOs?</td>
<td>• Do you have any other ideas or comments about what are the principles of good practice with people on CTOs?</td>
<td></td>
</tr>
</tbody>
</table>

At the follow-up interviews, each of the above questions was revisited with those having their second interview. In one case the follow-up interviews involved both a new doctor and a new case manager, so the questions were new to these participants.
Following either revisiting the questions, or going through the questions for the first time, the following question was added for all participants:

- What has changed since the last interview and how?

For the new doctor and case manager this required some explanation of themes that had been raised in the initial interviews.

**Semi-structured group interviews with key stakeholders**

Semi-structured group interviews were held with the key stakeholders involved in the implementation of CTOs as all of these participants, as anticipated, had their own understandings and observations regarding what represents good practice, and the study provided an opportunity to ‘capture’ those different perspectives. A group interview was favoured in order to create a supportive atmosphere where participants could find the comments of others useful in generating their own ideas. I facilitated the sessions and worked to try to help participants feel validated and acknowledged regarding their ideas and opinions (Alston & Bowles, 1998). Semi-structured group interviews were the preferred method because this enabled some guidance for the interviews while also enabling the sharing of ideas and perspectives. Providing some structure to the group interviews, such that each group were asked similar questions enabled more comparison of the common and divergent views that were anticipated and did emerge (see Table 4). The questions were also similar to those used in the individual interviews so further comparison could readily be made between responses in the individual and group interviews.

Each group interview had approximately 10 participants and lasted for approximately 90 minutes. The interviews were digitally audio-recorded.

The venues for three of the four group interviews were meeting and interview rooms available across NWAMHS. The MHRB members were interviewed at the MHRB offices.
An interview with a group of people who care for people with serious mental illness who are current clients of the North West Area Mental Health Service was included to enable their perspective on CTOs as key stakeholders to be heard. The definition of carer was confined to family members, partners or friends who care for people who have a serious mental illness and have the potential to be on a CTO, are currently on CTOs, or have been in the past.

The semi-structured interview questions were developed with the potential to convert the series of questions into a written survey if attendance at the group interview was poor. This option was only used on one occasion when a consumer was unable to attend but was interested in contributing. In order to accommodate her, the semi-structured interview questions were converted into a written survey that she was able to respond to.

For the carer group, the area mental health service carer consultants were able to assist with recruiting people for the interview group, and acted as co-facilitators to enable a more supportive environment to stimulate discussion. Similarly, the Area Mental Health Service employs two consumer consultants, and their advice was sought in recruiting approximately ten consumers of public mental health services, preferably people either currently on a CTO, or who have been on a CTO in the past, to participate in a semi-structured group interview.

The senior managers, executive and policy advisors were recruited from the managers and discipline seniors of NWAMHS (including the area manager and director of clinical services or their representatives). The group also included representatives from the Mental Health Branch of the Department of Human Services who are responsible for state-wide policy development and implementation. The current CTO guidelines, plus the Mental Health Act 1986, were considered likely to form the basis to the comments of this group. However, it was also anticipated that through supervision, complaints and other sources, senior managers would be able to comment on practice issues as well as broader policy and legal expectations. It was planned that up to ten
people would be asked, in the main via email, although some were approached directly, to participate in a semi-structured group interview.

Members of the MHRB were asked to participate in a semi-structured group interview via the president of the Board. It was anticipated that up to 10 members would participate representing community, legal and psychiatrist members. Recruitment of members of the MHRB relied on liaison with the president of the Board and followed his advice regarding recruiting volunteer participants. Again email was the main form of communication with MHRB members for the purposes of recruitment.

Table 4: Questions guiding the four semi-structured group interviews

<table>
<thead>
<tr>
<th>Consumer group</th>
<th>Carer group questions</th>
<th>Senior managers and policy advisors group</th>
<th>The Mental Health Review Board Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is your understanding of why people are placed on CTOs?</strong></td>
<td><strong>What is your understanding of why your relative has been placed on a CTO?</strong></td>
<td><strong>What do you see as the purpose/function of CTOs?</strong></td>
<td><strong>What do you understand to be the purpose of a CTO?</strong></td>
</tr>
<tr>
<td><strong>What do you think it is like to be on a CTO?</strong></td>
<td><strong>Do you think it is of benefit to them? Why?</strong></td>
<td><strong>What represents good practice with people on CTOs?</strong></td>
<td><strong>Who seems to do well on CTOs? How do you know?</strong></td>
</tr>
<tr>
<td><strong>Do you think there are any benefits? Why?</strong></td>
<td><strong>Is it of benefit to you? Why?</strong></td>
<td><strong>How many contacts per month would you expect someone on a CTO to have with the area mental health service?</strong></td>
<td><strong>Do you know when practitioners are working well with their clients/patients?</strong></td>
</tr>
<tr>
<td><strong>Are there negative aspects?</strong></td>
<td><strong>Are there negative aspects to you?</strong></td>
<td><strong>Are their current examples of poor practice that you have observed?</strong></td>
<td><strong>What demonstrates good practice, in general, from your perspective?</strong></td>
</tr>
<tr>
<td><strong>What, to you, represents good practice by the practitioners involved?</strong></td>
<td><strong>Are their negatives for the person you are caring for?</strong></td>
<td><strong>What are the barriers to good practice?</strong></td>
<td><strong>What demonstrates good practice specifically in relation to review board hearings?</strong></td>
</tr>
<tr>
<td><strong>What represents poor practice?</strong></td>
<td><strong>What, to you, represents good practice by the practitioners involved?</strong></td>
<td><strong>How could these be overcome?</strong></td>
<td><strong>Do you think the implementation of CTOs could be improved? How?</strong></td>
</tr>
<tr>
<td><strong>Whose needs, do you think, are being met by CTOs?</strong></td>
<td><strong>What represents poor practice?</strong></td>
<td><strong>Whose needs are being met by CTOs?</strong></td>
<td><strong>Do you have any general recommendations regarding what represents principles of good practice with people on CTOs?</strong></td>
</tr>
<tr>
<td><strong>Do you have any other ideas or comments about CTOs that you think would assist my research?</strong></td>
<td><strong>Whose needs are being met by CTOs?</strong></td>
<td><strong>Do you have any other general recommendations regarding what represents principles of good practice with people on CTOs?</strong></td>
<td><strong>Do you have any other ideas or comments about CTOs that you think would assist my research?</strong></td>
</tr>
</tbody>
</table>
**Feedback**

Ensuring participants were informed about the progress of the research and had access to the data relevant to them, and the findings of the research, was an important reflection of the values guiding the investigation. Feedback involved each participant, in individual and group interviews, having access to summary documentation in the form of research newsletters (see Appendix) and access to summaries, transcripts and publications as requested.

**Quantitative data analysis**

For the cluster analysis, the two-step clustering procedure in SPSS 13.0 was adopted because of (1) its ease and efficiency in analysing categorical variables, (2) its ability to handle relatively large data files, and (3) the flexibility that it offers the analyst in terms of either automatically generating cluster solutions or forcing a particular number of clusters into the final solution.

The final cluster solution was based on the default SPSS 13.0 options for conducting a two-step cluster analysis: log-likelihood distance measurement, a clustering criterion based on Schwarz’s Bayesian Criterion, and automatic determination of the number of clusters. Variable importance plots were also produced in order to help identify which variables were most important for the determination of each cluster.

**Qualitative data analysis**

The process of qualitative data analysis involved reading and re-reading the transcribed pages of each group and individual interview. The results of the cluster analysis were also included such that there was a triangulation of information from various data sources, enabling the development of relevant codes and, through the coding process, themes to emerge. The aim of the analysis was to code and interpret the data such that meaningful themes and patterns emerge. Themes are the result of a number of influences. First, the frequency that particular codes achieved was recorded. I
gradually grouped codes in relation to each other such that themes developed through these connections between codes. Using NVivo 7 is a very helpful way of organising and classifying the data, making use of nodes where data can be stored for analysis. Frequency of responses enabled some themes to emerge. For example, in 19 sources (sources equalled a total of 29 interviews and one written response) I identified 46 references to the node “continuity in practice”. In NVivo 7, a node equates to what Alston and Bowles (1998) call an ‘open code’ (p.199). Beazley (2007) discusses how frequency can sometimes be meaningful to a qualitative investigation and it is presumed here that frequency will be of interest to the reader, although it is important to clarify that frequency does not provide a full resolution of the question. Even so, in relation to some nodes and subsequent themes, frequency of responses, such as those for continuity of care, does help to support the idea that there is considerable consensus among key stakeholders about the importance of this issue.

The method of data analysis was based on the matrix based method for ordering and synthesising data described in Ritchie, Spencer & O’Connor (2005). The codes (or nodes) were identified through a process of both deductive and inductive reasoning. Deductive reasoning refers to the predetermining of many of the original codes (what Alston and Bowles (1998 p.200) refer to as ‘constructed’ codes) via the influence of the literature review, the research objectives, theoretical foundation and the focus of the semi-structured interview questions. My own observations and practice wisdom also contributed as a source of knowledge and ideas. A general inductive approach was then taken as ‘in–vivo’ codes (Alston & Bowles, 1998 p.200) and subsequent themes emerged from careful reading and re-reading of the data (Thomas, 2004). However, themes did not only rely on frequency of occurrence. Some themes developed from what was glaringly ‘unspoken’. For example the general lack of reference to particular models or therapeutic interventions specifically designed for people on CTOs, or specific groups overlooking issues that seemed very important to others. Tree nodes (or what Alson and Bowles (1998) call ‘Axial’ codes (p.203)) proved to be the most useful aspect of the use of NVivo 7. This greatly assisted in both recognising common topics but also enabled the
recognition of diversity of responses in relation to the topic, thus creating a ‘tree’ built out of a particular node. Some of these nodes were from an original set of nodes and some emerged from the data as a general inductive approach would expect (Thomas, 2004). Alston and Bowles (1998) suggest that:

During qualitative analysis the researcher is constantly searching for the ‘main’ story, concern or theme. (p. 203)

The identification of axial codes thus enabled a return to the question of what processes and principles represent good practice with people on CTOs and how the tree nodes had emerged in relation to this overall topic. This enabled the development of core categories (Alston and Bowles, 1998) that were no longer based on direct quotes from interviewees or the context of particular questions that had been asked. These core categories became summarising phrases that, in turn, emerged as the five principles that are discussed in Chapter Eight. This was a satisfying and exciting part of the analysis and can be directly attributed to the relationship that developed between me and the data and how, as Alston and Bowles (1998) anticipated, the story the researcher is searching for can emerge to enable theory generation. Once these principles, and the processes required to implement them, had been identified it became clear that they could be ‘tested’ through considering the relevance of the principles and processes to each of the case studies. This enabled even further refinement of the analysis, because new themes emerged that interconnected and contextualised the principles.
Seidal (1993) suggests that there is a potential ‘dark side’ (p.107) to the use of computer technology in qualitative research. I was particularly interested in his comments about the ‘reification of the relationship between the researcher and the data’ (p.112). I became aware of how I was developing a rather passionate relationship with my data that was, in many ways, facilitated by the ease with which I could navigate around and through it with NVivo 7. What I would add to Seidal’s (1993) cautionary comments is the value of good supervision when one is in the process of analysing and going beyond coding, and at times being almost overwhelmed by frequency or multiple occurrences. My supervisor was able to ask very simple questions such as ‘who was most likely to say that?’ or ‘what do you think wasn’t said that was surprising to you?’ This helped me to refocus and look at the data with fresh eyes, less seduced by codes and volume.
Validity and Generalisability

Winter (2000) contends that validity for qualitative research:

Resides in the representation of the actors, the purposes of the research and the appropriateness of the processes involved. (p.6)

Qualitative research is focused on the development of theory rather than a focus on findings that are generalisable to other populations. In this research, the findings and development of principles for good practice with people on CTOs have enhanced understanding of how CTOs are implemented. A ‘valid’ argument has been built on multiple sources of data that have enabled triangulation and opportunities to establish internal validity. Using the results of the cluster analysis to assist in the recruitment of case studies is an example of how this study was clear about what sampling technique was used, and how it related to the question being asked. Having multiple sources of qualitative data also enabled differences and similarities to emerge that could be represented in the findings and contribute to theory development.

Having a semi-structured interview schedule also assisted to develop a consistent approach to all the interviews, enabled more standardised data collection, and assisted the consistency of the approach I took and the degree of relevance to the question that was maintained in the discussion.

The cluster analysis, while ostensibly a quantitative research method, is generally not concerned with issues of ‘validity’ because it is an exploratory statistical technique rather than a method of hypothesis testing. Its credibility is established in the clear representation of the data used, transparency about the statistical program, its strengths and limitations (as discussed in Chapter Four) and the presentation of the findings.

A critical test of the value of this research is how useful it is to have distilled from all the data gathered and analysed particular principles and processes. What this involves is a quintessentially modernist activity, one that relies on the conviction that if
a ‘better argument’ can be developed, here being one about good practice, there can be a contribution to the further development of a more civil and just society, in the present case ensuring the ‘proper’ implementation of CTOs (Flyvbjerg, 2001). However, there are challenges to this concept already in the theoretical domain and in the very findings of this research. Foucault, as quoted and summarised in Flyvbjerg (2001), criticises the modernist ideal as being naive because of the neglect of the importance of power in relationships and context, indeed:

Few things have produced more suffering than strong commitments to implementing utopian visions of the good. (p.100)

According to Flyvbjerg (2001) it is important to consider Foucault’s observation that:

The law, institutions- or policies and plans- provide no guarantee of freedom, equality or democracy. Not even entire institutional systems, according to Foucault, can ensure freedom, even where they are established with that purpose. Nor is freedom likely to be achieved by imposing abstract theoretical systems or “correct” thinking. (p.101)

This could potentially be interpreted as a catastrophe for this thesis. However, an alternative perspective is that these cautionary comments are confirming. Firstly they confirm the value of gaining data from multiple stakeholders and the use of the cluster analysis to select very different case examples. It also helps support the work done in Chapter Seven that enabled recognition of the importance, rather than minimisation, of the exceptions and anomalies that appeared to be in the findings. One important example is the theme of “talking and listening”. This highly valued aspect of practice emphasised by the majority of research participants surely enables it to form the basis of evidence about good practice. However, immediately the case of Joseph (see case study four, Chapter Five) comes to mind. A case where doubts emerged about the value of “talking and listening”, a case that even suggested that such an expectation might inadvertently create problems rather than resolve them, as frustrations and inertia might follow when something established as a key aspect of good practice cannot be fulfilled. What this research indicates, via the cluster analysis, is that although Joseph in
some ways represents an exception, he is unlikely, because he also seen to belong to a cluster, to be alone. Consider the possibility that all, most, or even some, of the other members of Cluster two – Young Males - share Joseph’s difficulties with talking and listening. Are they at risk of being subject to new forms of injustice as they struggle to articulate their needs?

Therefore, Foucault might support such an attempt to ‘open up’ the problem in this way. Hence the value in this thesis of ensuring that the richness of the data is preserved, rather than overly synthesised, to ensure that the emancipatory values underpinning the research are not lost or overlooked for the sake of coming up with a formula that may prove to be oppressive in itself.

Furthermore, this study has ‘authorised to speak’ those predominantly seen as usually ‘outside of theory’, in particular consumers, carers and front line workers who – in this study – are the case managers and treating doctors (Pease & Fook, 1999 p.vii).

Ethical considerations

Undertaking this research from a sound ethical base is an important representation of the value base guiding the research and has involved the following ethical considerations:

Ethics approval

Approval to conduct the research was requested and received from the North Western Mental Health Behavioural and Psychiatric Research and Ethics Committee and from The University of Melbourne Human Research Ethics Committee. The committee suggested that the formal title of the research project was too complex and suggested an alternative, more simple title for the participant information and consent forms and this was agreed to. The alternative title was: “Understanding how to provide better assistance to people on CTOs by learning more about their experience” (see the Appendix for copies of the consent form and participant information forms).
Written consent was required from all participants and relied on the capacity of each participant to sign a consent form that outlined the purpose of the study and expectations of participants. Each of these consent forms was also witnessed and signed. Written information was provided and a verbal explanation also offered to ensure that differences in levels of literacy were taken into account. Interpreting and translation services were offered to ensure that people whose first language is not English could participate in the research.

Since many people on CTOs have a long-term disability it was important to confirm that the Consultant Psychiatrist supervising the care of the consumer had assessed that the consumer was able to give informed consent and the researcher relied on the case manager to confirm this as participants were recruited.

The only exclusion criterion was any current clients of mine and although this slightly limited the potential pool of participants at the recruiting phase, I was only one of over 20 case managers and only had a quarter of the average caseload at any one time.

**Dual relationships**

There was potential for dual relationships when undertaking research in my own workplace. Therefore I was mindful of ensuring that this did not compromise the ethical base of the research. In cases where I was the supervisor of a case manager involved in a potential case study, extra care was taken in recruitment by involving an independent person to recruit the person into the study, or, if it was the person’s preference, to suspend the supervisory relationship for the period of the research and arrange an alternative professional supervisor. In the one relevant case where this was discussed, the case manager said he thought this was not necessary.
Confidentiality

It remained important throughout the period of the study to ensure the maintenance of the participant’s confidentiality and also to ensure that information gained in the context of research was not be used for any other purpose.

Differences of opinion within a particular case study may be identifiable to those directly involved, even though de-identifying pseudonyms are used at all times. This may be particularly sensitive in relation to consumers and their carers. This was partially addressed by ensuring that carers were only involved in the case studies with the consumer’s permission but it was also important that carers, consumers and other participants were made aware of the potential risks regarding their comments being identifiable to others directly involved in the case study, even where pseudonyms were used. Therefore, there was always an option to withdraw any comments that might cause difficulties in ongoing relationships. This was enabled by participants receiving transcripts, or if they declined the transcripts (as some did) going over a summary of what they had said and checking with them that this is what they remembered saying. Even so, I made particular care to present the material in a way that was respectful and mindful of the potential to harm enduring relationships. I do not believe that this compromised the integrity of the research.

Potential adverse events and safeguards

It may be that discussing the impact of being on a CTO could be distressing to the consumers, and when interviewing I was sensitive to this issue and ensured debriefing as required. The consumer and carer consultants, case managers and medical staff involved were all available for debriefing depending on the interview participant’s preference. I also offered follow-up contacts to ensure that the interviewees were able to obtain debriefing and to confirm that any distress directly associated with the interview had been alleviated. At completion, no-one had requested, or appeared to require, extra help or support as a result of the interviews. One carer did decline to be
interviewed a second time but she said this was due to the inconvenience of having to find time for an interview and her poor health at the time, rather than any distress that resulted from the initial interview.

Similarly the carers and consumers involved in the group interviews may have been distressed through discussing the impact of CTOs. The involvement of the consumer and carer consultants assisted to provide participants with extra support and options for debriefing. Although these precautions were implemented and discussed with participants, no requests were made for follow-up of this kind.

Having to give up time to participate in the interviews was the main source of inconvenience; therefore every effort was made to be flexible regarding venue and times. Ongoing support for the project from senior management was relied on to ensure that staff of NWAMHS were supported in their participation.

It was also anticipated that in the case of any adverse events, such as a participant becoming distressed, there would be discussion with the principal researcher and appropriate reports completed. Again this did not prove to be necessary.

The use of quotes

Ethical issues arose when one interviewee could not be located to receive a copy of his interview, and some people also decided to refuse copies. It is hoped that the respectful representation of all participant’s voices compensates for this problem of not all participants having the opportunity to comment on their transcript (Nunkoosing, 2005). None of the participants who received transcripts objected to any of the content, providing some evidence about the accuracy of the transcripts and the value of the use of a professional transcribing service, who were able to provide significant objectivity in the transcription process.

The use of quotes has been an important part of communicating findings and ideas but, as might be expected, it has also raised ethical problems (Forbat & Henderson, 2005). In the main, quotes are de-identified, other than the person’s role in
the case study or which semi-structured group interview they were a member of. Even so, there is the likelihood that some participants may be identified by others known to them, as this research has been carried out, in the main, in one particular service. The other difficulty with quotes has proved to be balancing the comments made by the different interviewees. Inevitably some interviewees have proven to be more articulate and able to summarise ideas more readily than others and the dilemmas created by this are not uncommon in qualitative research (Corden & Sainsbury, 2006). In response, care was taken not to favour the quotes of the more articulate interviewees. Therefore there were deliberate occasions when quotes chosen were not necessarily the ‘best’ but were chosen in an attempt to include different voices. Also, there were times when, in selecting the quote that best illustrated the idea, a deliberate choice was made to use a surprising, less stereotyped, or atypical interviewee’s comment; for example selecting a doctor’s quote when it came to focusing on strengths, or a consumer in relation to mutual accountability or support for CTOs. This seemed important to ensure that it was not presumed that particular ‘types’ of interviewees were routinely most likely to say particular things. Whilst this was established and even predictable in the semi-structured group interviews, it was notably less uniform amongst case study interviewees – and perhaps this represents a finding all of its own.

Privacy considerations

To ensure the privacy of all participants, all the raw data (e.g., tapes and printed transcripts) were stored in a locked filing cabinet in the School of Nursing and Social Work at The University of Melbourne. Anonymous data (e.g., interview transcripts) continue to be kept as password protected computer files on the researcher’s own computer.

Following completion of the study the raw data will be stored, for seven years, in a locked filing cabinet in the School of Nursing and Social Work, The University of
Melbourne in accordance with ethical requirements (see Appendix for information regarding ethics approval and relevant documents).

**Strengths and Limitations**

The most significant limitation of the study was having a single, part time researcher. This inevitably limited what could be done in the time frame available and is evident in having to settle on four individual case studies when initially it was hoped to have included up to six. This also meant that I was not able to use another researcher or colleague, who had also participated in the interviews, to cross check my data analysis. There were also problems in not having access to the consumer’s clinical files. As a result, I was relying on self-report or the recollections of the service providers regarding some details, for example, about the length of the CTO. Also, having case studies that ‘exactly’ or ‘best’ matched each cluster was not possible because of the pressure to recruit case studies within a reasonable time frame. Even so there was very little difficulty in being able to find consumers who case managers thought fitted the general description provided for each cluster.

As already discussed, the strengths of the project were in the amount of support I was able to achieve from the NWAMHS. This included support for data gathering, having access to case managers, being able to discuss the findings of the cluster analysis in staff forums, gaining assistance with recruitment, the provision of interview rooms and, most importantly, the NWAMHS staffs’ preparedness to give up their time to the project. The willingness of people within the area mental health service and from outside to participate in the group interviews was also a strength.

There is also a potential for weakness in the study associated with me being both an ‘insider’ as an employee of the service, and an ‘outsider’ as a researcher. There is also the possibility that I was biased by my ‘insider’ status. Potential factors mediating this bias included my relative seniority in the service and my awareness of the need, along with many other senior staff, for service improvement in relation to working with people on CTOs. Also my confidence as an interviewer assisted in being able to engage
with interviewees and encourage an open and trustworthy discussion. Also being explicit about the underlying values of the research was important. This helped maintain awareness for myself and others about ‘where I was coming from’ and reduced the potential for misunderstandings or even avoidance of issues that might ordinarily be difficult to discuss.

Fossey, Harvey, et al. (2002) state that:

The implication of methodologies informed by this perspective (critical research) is that they aim to foster self reflection, mutual learning, participation and empowerment. (p. 720)

The degree to which this research has fulfilled this aim is demonstrated in the involvement and privileging of the voices of key stakeholders in the research findings. The limitations have been in the limiting of some voices, for example carers, because they are relatively underrepresented in the case studies. Also the research design has limited the discussion to, in the main, one area mental health service and has focused in particular on four case studies who were volunteers. There is undoubtedly a group of people whose situation is only referred to in this research, those who are in much greater conflict with their treating teams, who are much more reluctant and, therefore, unlikely to volunteer for research. Because these people did not participate, perhaps the research did less to reflect on one part of what Dawson (2005) describes as ‘downstream’ decision-making, particularly revocation of CTOs. Only Maria (Case study three) had had an experience of being sent back to hospital but there is evidence to suggest in Victoria there are many people who have their CTOs revoked much more frequently and who, therefore, may be subject to very high levels of coercion (Mental Health Review Board, 2008). While their situation is referred to in the group interviews, there has been less opportunity to more thoroughly explore their situation and therefore provide greater guidance about this kind of decision-making. Decision-making, as it has been referred to in this study, has been much more confined to whether a person should be on or remain on a CTO rather than when they should be returned to hospital.
Returning to the strengths of the study, the use of NVivo 7 appears to have been very helpful in organising the responses. It has enabled valuable extra data around frequency and sources that has given some rigour to the presentation of the qualitative findings.

This study’s greatest strength is in the triangulation achieved through the use of multiple methods to collect data, enabling links between the findings of the cluster analysis, the case studies and the semi-structured group interviews. Being able to go back to actual case studies to ‘test’ the relevance of the principles identified has also assisted in giving them more meaning and deepened the interpretation which could be made.
Chapter Four: A Cluster Analysis

Introduction

This chapter presents the findings of the cluster analysis undertaken on all of the people on CTOs at one point in time in 2003 at North West Area Mental Health Service. As discussed in previous chapters, the cluster analysis was initially proposed as one way of attempting to ensure that the selection of case studies would represent different ‘types’ of people on CTOs.

The cluster analysis was exploratory. There was no particular hypothesis about what ‘types’ of CTO recipients might be found. There was always the risk that no clusters would emerge from the analysis. However, as explained here, the cluster analysis was able to shed significant light on the implementation of CTOs, at least amongst this sample. Clusters were found and, considering the information from the literature review, there was considerable opportunity to discuss and reflect on the implications of these findings. The findings of the cluster analysis have been published in a peer reviewed international journal (Brophy, et al., 2006).

Sample

The 164 people in this sample are the people in an area mental health service that has access to 25 acute beds, a small number of extended care or rehabilitation beds, and a 20 bed Community Care Unit (CCU) that is focused on long term rehabilitation. The area has two Continuing Care Teams (CCTs), a Mobile Support and Treatment Team (MSTT) and a Crisis Assessment and Treatment Team (CATT). There are approximately 1,000 registered clients at any one time. The 280,000 person catchment area has one of the highest representations of people born outside of Australia (approximately 40%) by comparison with other parts of the state. The area has a high rate of unemployment (up to 20% amongst young people) and a relatively large group of...
Aboriginal and Torres Strait Islander people (approximately 1,100) for an urban area in Melbourne (Primary Care Partnerships, 2008). Of relevance to these results is that this area mental health service is within the catchment of an early intervention, first episode psychosis service. This service focuses on people aged 16 – 25 with first episode psychosis. Although their involvement with the early intervention service is relatively short term (18 months) it is likely to influence the age range of people on CTOs in this sample.

**Descriptive Profile of the Sample**

The descriptive statistics for the sample are presented in Tables 5 and 6. The majority of the sample were single men (n=114) who had never married (n =94), aged between 20 and 71, while women tended to be older (M = 38.5 years for men versus 43 years for woman) and more likely to be partnered or divorced (n=34). The majority of the sample was reported to be living in rental accommodation in inner city or low socio-demographic suburban areas, and was significantly underrepresented in the ‘dormitory outer suburbs’. Most were on unemployment or disability pensions and had experienced multiple admissions.

Considerable diversity in country of birth was represented in this consumer group (31% were born outside Australia) and this reflects the diversity of the catchment area. Only one person was recorded as being Aboriginal or Torres Strait islander. Many of the people on CTOs in this sample had multiple principal and additional diagnostic codes recorded during their contact with the service, so some interpretation was required to determine their main diagnosis. However, it was clear that schizophrenia was the most common principle diagnosis.

The four main categories of principle diagnosis were: Other schizophrenia, schizoaffective disorder, paranoid schizophrenia and other (a category that included bipolar affective disorder, delusional disorder and one person with borderline personality disorder).
In relation to diagnoses, some people had over 100 entries of principle and additional diagnoses recorded throughout their history with the service. In part this is due to the number of repeat admissions and the need to update this diagnostic data so the same principle and additional diagnoses describing the person’s condition were re-recorded on multiple occasions. Even so, for some people there was evidence of significant changes in primary or principle diagnosis; for example, from bi-polar affective disorder to schizophrenia and then finally schizoaffective disorder. It appears that for some people there had been difficulty in coming to a diagnosis in the context of a complex presentation, which also included factors such as isolation, homelessness, drug and alcohol abuse, anger and irritability described in CMI via additional diagnoses. More than half the group had an additional diagnosis related to problem use of drugs and alcohol, including cannabis and opiates, which carries with it a high probability of an extra additional diagnosis of infection with hepatitis C. Just over half the sample had an additional diagnosis that described a history of isolation or difficulties in relationships, and the majority had no nominated carer, although this can be somewhat contested as there has been significant doubt in Victoria about whether clinicians accurately record carer information.

As might be expected, most people on CTOs were being managed by the area’s CCTs, receiving case management and medical treatment. A much smaller number were clients of the MSTT, and even fewer were residents of the CCU. The shortest CTO length was 64 days; the longest was 1,601 days. The shortest admission was 1 day, and the longest was 362 days. The minimum number of admissions recorded was 1; the maximum was 54 (it is possible that the consumers had more admissions that were not recorded on this data base if they had at any time had a permanent address outside the large north western catchment).

**Results of Cluster Analysis**

The following variables were entered into the two-step cluster analysis procedure in SPSS 13.0:
Categorical variables (with groups in parentheses):
1. Individual principle diagnostic category most often recorded (Paranoid Schizophrenia, Other Schizophrenia, Schizoaffective Disorder, Other)
2. History of homelessness (yes, no)
3. History of drug and/or alcohol use (yes, no)
4. History of violence or irritability/anger (yes, no)
5. History of self-harm (yes, no)
6. History of difficulties in relationships (yes, no)
7. Sex of client (male, female)
8. Whether a carer was nominated (no nominated carer, carer nominated)
9. Marital status (never married, separated/divorced/widowed, married/de facto)
10. Country of birth (Australia, overseas)
11. Living situation (lives alone, lives with family, lives in residential service, other)
12. Employment category (pensioner, unemployed, employed/student/home duties)
13. Educational level (lower secondary, upper secondary, tertiary, other)

Continuous variables:
1. Number of admissions
2. Mean number of days per admission
3. The number of recorded referrals to the crisis assessment and treatment team
4. Age (in years)
5. The length of the current CTO (in days) at 31 December 2004
6. The period (in years) between the first and most recent admission data available
7. The total number of times a principle and additional diagnosis was recorded in CMI (this is a rather crude statistic as it is influenced by the number of times the persons CMI data was re-entered due to admissions or changes in treatment team. However, the researchers noticed that some people had high numbers of additional diagnoses repeatedly recorded).

The data for many of the categorical variables required considerable recoding to reduce the number of groups and increase the cell size in each group while still
adequately capturing the important variability in the data. Further, all the variables included in the cluster analysis were considered *a priori* to be clinically and theoretically important in defining different types of people on CTOs.

Three clusters emerged in the final solution, with 128 of 164 participants (78%) successfully incorporated into a cluster. There were 27 people in cluster one, 33 in cluster two, and 68 in cluster three. Descriptive statistics for the continuous variables for each cluster are shown in Table 5, and frequency counts for the categorical variables for each cluster are shown in Tables 6 to 9. Table 10 summarises the key characteristics of each cluster. Cluster one was labelled *Connected*, cluster two, *Young Males*, cluster three, *Chaotic*. 
Table 5: Descriptive Statistics for Continuous Variables for Total Sample and by Cluster

<table>
<thead>
<tr>
<th>Clustering Variable</th>
<th>Cluster</th>
<th>Total Sample&lt;sup&gt;a&lt;/sup&gt;</th>
<th>1 (n=27)</th>
<th>2 (n=33)</th>
<th>3 (n=68)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td></td>
<td>M</td>
</tr>
<tr>
<td>Number of Admissions</td>
<td></td>
<td>6.85</td>
<td>7.27</td>
<td>2.96</td>
<td>1.87</td>
</tr>
<tr>
<td>Mean Number of Days Per Admission</td>
<td></td>
<td>24.08</td>
<td>36.46</td>
<td>16.94</td>
<td>17.01</td>
</tr>
<tr>
<td>Number of Recorded Referrals to CATT</td>
<td></td>
<td>1.48</td>
<td>1.83</td>
<td>1.15</td>
<td>1.06</td>
</tr>
<tr>
<td>Age (Years)</td>
<td></td>
<td>40.47</td>
<td>11.58</td>
<td>37.43</td>
<td>8.22</td>
</tr>
<tr>
<td>Length of Current CTO (Days)</td>
<td></td>
<td>452.04</td>
<td>377.24</td>
<td>385.96</td>
<td>357.05</td>
</tr>
<tr>
<td>Period Between First and Most Recent Admission (Years)</td>
<td></td>
<td>4.43</td>
<td>3.95</td>
<td>2.93</td>
<td>3.22</td>
</tr>
<tr>
<td>Number of times a primary or additional diagnoses was recorded</td>
<td></td>
<td>33.47</td>
<td>27.84</td>
<td>16.85</td>
<td>10.03</td>
</tr>
</tbody>
</table>

<sup>a</sup> Includes participants who were not organised into one of the three clusters (Total Sample N = 164).
Table 6: Frequencies and Percentages (Within Clusters) for Categorical Variables by Total Sample and Cluster

<table>
<thead>
<tr>
<th>Clustering Variable</th>
<th>Total Sample(^a)</th>
<th>Cluster 1 (n=27)</th>
<th>Cluster 2 (n=33)</th>
<th>Cluster 3 (n=68)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n )</td>
<td>( % )</td>
<td>( n )</td>
<td>( % )</td>
</tr>
<tr>
<td><strong>Main Diagnosis Category</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoid Schizophrenia</td>
<td>61</td>
<td>37.4</td>
<td>2</td>
<td>7.4</td>
</tr>
<tr>
<td>Other Schizophrenia</td>
<td>51</td>
<td>32.13</td>
<td>17</td>
<td>63.0</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
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<td>18.5</td>
</tr>
<tr>
<td>Other</td>
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<td>12.3</td>
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<td>11.1</td>
</tr>
<tr>
<td><strong>History of Homelessness</strong></td>
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<tr>
<td>Yes</td>
<td>38</td>
<td>23.2</td>
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<tr>
<td>No</td>
<td>126</td>
<td>76.8</td>
<td>27</td>
<td>100</td>
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<tr>
<td><strong>History of Drug/Alcohol Abuse</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>96</td>
<td>58.5</td>
<td>11</td>
<td>40.7</td>
</tr>
<tr>
<td>No</td>
<td>68</td>
<td>41.5</td>
<td>16</td>
<td>59.3</td>
</tr>
<tr>
<td><strong>History of Violence, Irritability or Anger</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27</td>
<td>16.5</td>
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<tr>
<td>No</td>
<td>137</td>
<td>83.5</td>
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<td>100</td>
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Table 7: Frequencies and Percentages (Within Clusters) for Categorical Variables by Total Sample and Cluster (Continued)

<table>
<thead>
<tr>
<th>Clustering Variable</th>
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<th>Cluster</th>
<th>Cluster</th>
<th>Cluster</th>
<th>Cluster</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>History of Self-Harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29</td>
<td>17.7</td>
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<td>3.7</td>
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<tr>
<td>No</td>
<td>135</td>
<td>82.3</td>
<td>26</td>
<td>96.3</td>
<td>29</td>
</tr>
<tr>
<td>History of Difficulties in Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>86</td>
<td>52.4</td>
<td>2</td>
<td>7.4</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>78</td>
<td>47.6</td>
<td>25</td>
<td>92.6</td>
<td>22</td>
</tr>
<tr>
<td>Sex</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>114</td>
<td>69.5</td>
<td>9</td>
<td>33.3</td>
<td>32</td>
</tr>
<tr>
<td>Female</td>
<td>50</td>
<td>30.5</td>
<td>18</td>
<td>66.7</td>
<td>1</td>
</tr>
<tr>
<td>Was a Carer Nominated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>14.8</td>
<td>24</td>
<td>88.9</td>
<td>30</td>
</tr>
<tr>
<td>No</td>
<td>122</td>
<td>85.2</td>
<td>3</td>
<td>11.1</td>
<td>3</td>
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</tbody>
</table>

\(^a\) Total sample includes all individuals, regardless of whether they were nominated as a carer.
Table 8: Frequencies and Percentages (Within Clusters) for Categorical Variables by Total Sample and Cluster (Continued)

<table>
<thead>
<tr>
<th>Clustering Variable</th>
<th>Total Sample&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Cluster</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>94</td>
<td>59.1</td>
<td>8</td>
<td>29.7</td>
<td>29</td>
<td>87.9</td>
</tr>
<tr>
<td>Separated/Divorced/Widowed</td>
<td>45</td>
<td>28.3</td>
<td>10</td>
<td>37.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Married/Defacto</td>
<td>20</td>
<td>12.6</td>
<td>9</td>
<td>33.3</td>
<td>4</td>
<td>12.1</td>
</tr>
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<td>Country of Birth</td>
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<tr>
<td>Australia</td>
<td>113</td>
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<td>9</td>
<td>33.3</td>
<td>31</td>
<td>93.9</td>
</tr>
<tr>
<td>Overseas</td>
<td>51</td>
<td>31.1</td>
<td>18</td>
<td>66.7</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>Living Situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>49</td>
<td>30.1</td>
<td>2</td>
<td>7.4</td>
<td>9</td>
<td>27.3</td>
</tr>
<tr>
<td>With Family</td>
<td>81</td>
<td>49.7</td>
<td>25</td>
<td>92.6</td>
<td>23</td>
<td>69.7</td>
</tr>
<tr>
<td>Residential Service</td>
<td>25</td>
<td>15.3</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>4.9</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
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</table>
Table 9: Frequencies and Percentages (Within Clusters) for Categorical Variables by Total Sample and Cluster (Continued)

<table>
<thead>
<tr>
<th>Clustering Variable</th>
<th>Clustering Variable Details</th>
<th>Total Sample&lt;sup&gt;a&lt;/sup&gt;</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Employment Category</td>
<td></td>
<td>99</td>
<td>60.4</td>
<td>12</td>
<td>44.4</td>
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<tr>
<td>Pension</td>
<td>includes disability support pension, supporting parent benefit, aged pension</td>
<td>99</td>
<td>60.4</td>
<td>12</td>
<td>44.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>includes those on unemployment benefits</td>
<td>44</td>
<td>26.8</td>
<td>7</td>
<td>25.9</td>
</tr>
<tr>
<td>Employed/Student/Home Duties</td>
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<td>19</td>
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<td></td>
<td>2</td>
<td>1.2</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Educational Level</td>
<td></td>
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<td>46.5</td>
<td>8</td>
<td>29.6</td>
</tr>
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<td>Lower Secondary</td>
<td></td>
<td>35</td>
<td>22.0</td>
<td>5</td>
<td>18.5</td>
</tr>
<tr>
<td>Upper Secondary</td>
<td></td>
<td>21</td>
<td>13.2</td>
<td>6</td>
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</tr>
<tr>
<td>Tertiary</td>
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<td>29.6</td>
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<td>Other</td>
<td></td>
<td>29</td>
<td>18.2</td>
<td>8</td>
<td>29.6</td>
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</tbody>
</table>

*Note. <sup>a</sup> Includes participants who were not organised into one of the three clusters. Total sample N = 164, but some total frequency counts are less than 164 because of missing data. Percentages are valid values (i.e., not including missing data).*
The Clusters: Connected, Young Males and Chaotic

Visual inspection of the variable importance plots revealed that the following variables were important in distinguishing each of the clusters (comments in parentheses refer to comparisons with the other two clusters):

Cluster 1 (n=27) (Connected): History of difficulties in relationships (low); sex (predominantly female); country of birth (high proportion born overseas); marital status (high proportion married/de facto); living situation (high proportion living with family); history of homelessness (none); number of admissions (relatively low); number of diagnoses recorded (fewer); history of drug and alcohol use (relatively low); recorded referrals to CATT (low).

Cluster 2 (n=33) (Young Males): Main diagnosis category (high proportion with paranoid schizophrenia as the principle diagnosis); sex of client (almost all male); marital status category (high proportion never married); country of birth (almost all born in Australia); number of diagnosis recorded (between clusters 1 & 3); age (youngest group); number of admissions (between clusters 1 & 3). A high percentage had a history of drug or alcohol abuse.

Cluster 3 (n=68) (Chaotic): History of difficulties in relationships (high proportion); living situation (high proportion living either alone or in residential services); history of violence, irritability or anger (high proportion); number of diagnoses recorded (over twice as many as the nearest cluster); number of admissions (high); period between first and most recent admission (longer). Also, a high proportion with a history of drug abuse.

An analysis of the 36 people who did not fall into the three clusters did not reveal any notable trends in their profiles on the clustering variables. It is worth noting that the two-step cluster analysis procedure, unlike hierarchical and k-means clustering, does not require all cases to be included in a cluster; hence the need to examine those cases who were not included in one of the three clusters.
<table>
<thead>
<tr>
<th>Cluster</th>
<th>Key Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ((n = 27)) <strong>Connected</strong></td>
<td></td>
</tr>
</tbody>
</table>
- Mean age is 37 years and more likely to be female  
- Lowest number of admissions and days per admission  
- Mean length of CTO 359 days (shortest)  
- Lowest number of times a primary and additional diagnosis recorded  
- Most likely to have main diagnosis of “other schizophrenia”  
- No history of homelessness recorded  
- No history of violence or irritability/anger  
- More likely to be born outside of Australia  
- Most likely to be married/defacto and live with family |
| 2 \((n = 33)\) **Young males** |  
- The youngest (mean age 34 years)  
- The most likely to be male (32 male/1female)  
- The least likely to have ever had a partner  
- The most likely to be born in Australia  
- The most likely to have a diagnosis of paranoid schizophrenia  
- The least likely to be tertiary educated |
| 3 \((n = 68)\) **Chaotic** |  
- Largest group  
- 54 percent of cluster males and 50 percent of clustered females  
- Average age 42  
- History of homelessness, drug use, violence or irritability/anger, live alone or in a residential service, usually on the Disability Support Pension  
- Highest in number of admissions, mean number of bed stays, referrals to CATT, length of CTO, number of diagnoses recorded  
- Most likely to have schizoaffective disorder  
- Average number of times a primary and additional diagnosis was recorded =50  
- Mean length of current CTO 436 days |
Discussion

The overall statistical profile of this group of 164 people on CTOs shares common characteristics with both local and international studies regarding the profiles of people on CTOs (Dawson, 2005; A. M. O'Brien & Farrell, 2005; Segal & Burgess, 2006c). The data tend to confirm the perception that people in Victoria can stay on CTOs for notably long periods and, on average, for longer than one year. The data do not support concerns that particular ethnic groups may be targeted, but certainly supports the predominance of males under the age of 40, with a diagnosis of schizophrenia, and experiencing a range of social disadvantage factors, as being the most likely people to be on a CTO, if overall means are considered.

The results of the cluster analysis do appear to suggest the possibility of different ‘types’ of people being targeted by CTOs. Cluster three represents the largest and, in the context of the driving forces discussed in Chapter One, least surprising and most recognisable group of people on CTOs. 54 percent of the overall group of men and 50 percent of the overall group of women incorporated into any cluster were in cluster three, suggesting that both males and females on CTOs have a high chance of falling into this cluster. The existence of this cluster reflects the attempts to use CTOs to enable treatment of people who have complex needs and represent high levels of risk. On face value they appear to clearly meet the involuntary admission criteria, with histories commonly featuring violence, self harm and homelessness. This group is similar to those who Power (1998) found in his large Victorian based study were most likely to benefit from CTOs – those who appear to be the most disadvantaged by both their illness and their circumstances who are in their middle years and middle phase of illness. This group represents the observations made by Dawson (2005) that CTOs are part of a strongly community based mental health service focused on the seriously mentally ill. However, despite their potential to obtain benefit from a CTO this cluster also includes people who have been on CTOs for lengthy periods, perhaps years and have relatively high
service usage. This is consistent with Churchill, et al. (2007)'s observations that perhaps readmission rates and length of stay in hospital, for example, are not a useful indicators of CTO efficacy because the most complex people are on CTOs and perhaps CTOs actually enable treatment, thereby inflating, rather than decreasing, service usage.

The members of cluster one, who have been described as ‘Connected’, are a group that appear to reflect the cautious decision-making taking place in Victoria about who is suitable for treatment on a CTO. Whilst this group does not appear to have the complex range of problems of the more chaotic people in cluster three, they are subject to a broad interpretation of the involuntary admission criteria, one that emphasises the risks of deterioration of health, carer burden and the impact of relapse on dependent children (Freckelton, 2003); hence, the higher proportion of women and the higher likelihood of shared households.

The small, but notably uniform, cluster two group appears to be very important in what is says about the treatment of paranoid schizophrenia in relatively young males who have been launched from a low socio-economic base. Although a large proportion continues to live with their families, they appear to be disconnected from their broader community, as represented by the high proportion who were either unemployed or on disability support pensions. They also have low engagement in education or training and a lack of partners. It is also consistent with the findings that poor adherence remains a major contributor to relapse in schizophrenia, therefore supporting the necessity of involuntary treatment in many cases (Munetz & Frese, 2001). Furthermore, cautious decision-making with this group may be justified via concerns about the potential for relapse to further interfere with a relatively young person’s ongoing level of functioning. The members of this group may also be more at risk of being recommended for involuntary treatment due to their significant lack of social supports and the generalised risk indicators attached to their age and gender. The potential to relieve carer burden may also be a factor with this group, to attempt to maintain stability and safety in the home (Freckelton, 2003).
Dawson (2005) has suggested that there is some controversial use of CTOs in Victoria because the use of CTOs in Victoria extends beyond ‘revolving door’ patients. This occurs even when there is minimal evidence for the effectiveness of CTOs with recipients such as those represented by Clusters one and two. It appears that factors such as the pressure to manage risk, reduce carer burden and attempting to keep people out of the criminal justice system may be factors influencing the use of CTOs in these circumstances. These findings also suggest that concerns that CTOs are used too readily in Victoria are somewhat supported when such a range of people can be on CTOs.

In order to find out more about the people in each of these clusters the next chapter reports on the finding of four individual case studies. Each of these people represents a particular cluster due to having characteristics similar to those in each cluster. Two people represent cluster three because they have a set of characteristics similar to those listed earlier in this chapter. While each is not an exact match by any means they are identifiable as people meeting the general profile, not only by the researcher but most importantly their case manager who were asked to identify people matching the clusters. Both of these people were being case managed by the mobile support and treatment team at the time they were interviewed and this immediately establishes that they had complex needs in the context of serious mental illness because this team restricts its caseload to people with this profile in the area mental health service. Similarly someone was recruited who represented cluster one and another cluster two. It is noteworthy that the presentation of the clusters to the clinical staff (case managers and doctors) at NWAMHS resulted in a ready acceptance of the findings and no obvious difficulties in being able to recruit research participants who matched the clusters. This suggests that the cluster analysis findings were consistent with the experience of service provision in the area and that the goal of having clusters that might be recognisable in the context of service providers day to day experience with people on CTOs was achieved.
Chapter Five: Case Study Findings and Analysis

Introduction

This chapter introduces the findings from four case studies. As planned in the methodology, each case study represents one of the three clusters identified and discussed in Chapter Four. There are two case study participants representing cluster three, ‘chaotic’: one male consumer and one female consumer. Having equal gender representation seemed a good development when men and women were equally likely to fall into this large cluster. Case study participants were located after the findings of the cluster analysis were presented to the staff at NWAMHS and they were asked to think about whether they had people on their case loads who represented the different clusters. There was relative ease in this step of the process and the clusters seemed recognisably identifiable, as was initially hoped. The person easiest to recruit was someone representing cluster one. It was much more difficult to recruit someone from cluster two, with more than one attempt made by case managers resulting in the person declining to participate.

As described in Chapter Three, the individual case studies are made up of initial and follow-up interviews with the CTO recipient, their doctor and case manager. If the person subject to the CTO agreed, a carer was also interviewed. The analysis of the interviews connected to each case study enabled particular themes to emerge for each of the case studies. These themes are contrasted in the next chapters with overall themes about good practice.
Case study one

Introduction and brief case description.

Joan is a woman in her mid 50s who lives with her adult daughter and two dogs in rental accommodation. Another son lives interstate but maintains regular contact. Her principle diagnosis is described as bi-polar affective disorder. She had been on a CTO, and a client of the continuing care team (CCT), following an involuntary admission to hospital, for approximately three months prior to the first interview. She was subsequently discharged from the CTO by the time the follow-up interview was held. She had also been discharged by the CCT to her General Practitioner (GP). The first interview was held at the clinic, the second was conducted in her home. Joan agreed to her doctor (Dr Singh – Consultant Psychiatrist) and case manager (Sally – Occupational Therapist) being interviewed but refused to allow the researcher to interview her daughter (Julie). The case manager was a single interview because she had moved to another job at follow-up. The doctor agreed to be interviewed at follow-up, even though Joan had been discharged from the CCT.

Joan was identified by her case manager in the recruitment phase as representing cluster one or ‘connected’. This was particularly because of her age, gender, living arrangements and lack of recorded history of violence and anger. As discussed in Chapter Four, the 27 people in cluster one tended to be female and often lived with family. They did not have a history of homelessness and rarely had histories of violence or irritability and anger. So Joan shared many of the characteristics of people in cluster one, even though she was not married or in a de facto relationship and did not share the other common characteristic of being born outside of Australia. She had a history of previously being on a CTO two years earlier but in the intervening period between her discharge and her readmission she had gained employment and been under the care of her GP who also treats her significant physical health problems.
Key themes.

Using NVivo 7 nodes and tree nodes as a tool, the content of five interviews specific to Joan’s case were analysed in order to identify key themes.

Table 11: Joan (Cluster one: Connected) Nodes and Number of References

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive experience</td>
<td>14</td>
</tr>
<tr>
<td>Carers Interests</td>
<td>13</td>
</tr>
<tr>
<td>Talking and Listening</td>
<td>10</td>
</tr>
<tr>
<td>Flexibility</td>
<td>10</td>
</tr>
<tr>
<td>Potential for over use</td>
<td>9</td>
</tr>
<tr>
<td>Rapport</td>
<td>9</td>
</tr>
<tr>
<td>Engagement</td>
<td>8</td>
</tr>
<tr>
<td>Comparative liberty</td>
<td>7</td>
</tr>
<tr>
<td>Negative experience</td>
<td>7</td>
</tr>
<tr>
<td>Education</td>
<td>7</td>
</tr>
<tr>
<td>Continuity</td>
<td>6</td>
</tr>
<tr>
<td>Focus on recovery</td>
<td>6</td>
</tr>
<tr>
<td>Maintaining regular contact</td>
<td>6</td>
</tr>
<tr>
<td>Respect</td>
<td>6</td>
</tr>
<tr>
<td>Thoughtful decision-making</td>
<td>6</td>
</tr>
<tr>
<td>Engagement</td>
<td>5</td>
</tr>
<tr>
<td>Team Approach</td>
<td>5</td>
</tr>
<tr>
<td>Caring</td>
<td>4</td>
</tr>
<tr>
<td>Neutral/ambivalent</td>
<td>3</td>
</tr>
<tr>
<td>Manage Risk</td>
<td>3</td>
</tr>
<tr>
<td>Genuineness</td>
<td>2</td>
</tr>
</tbody>
</table>
In the early stages of each of these five interviews the purpose of the CTO was explored and there were many common themes in the responses. In particular the theme of “carer’s interests” emerged. All the respondents, in one way or another, discussed the relevance of Julie (her daughter)’s needs in relation to why Joan was placed on a CTO. For example:

I wanted to get out of hospital quickly and come home to help my daughter with the household (Joan).

The events leading up to admission were identified as:

A trauma for her daughter (Joan’s Case Manager).

There seemed to be a link between the increased stability that a CTO might represent and increased stability in the home, therefore intervening in the interests of the Joan’s daughter. One interviewee described Julie actively seeking the support of the MHRB to keep Joan on the CTO:

Julie was present, ... and she strongly wanted her mum on the CTO because she had quite a traumatic experience when she went into hospital and just wanted the reassurance that her mum was going to get better and stay on the medications. (Joan’s Case Manager)

Joan and her treating team provided different perspectives in relation to her daughter’s needs. Whilst Joan appeared to accept that her daughter was less worried about her due to the CTO, Joan also saw the CTO as very helpful in getting her out of hospital and back to being able to help her daughter, who also had a disability, to run the household. Whilst her doctor identified “involving carers” as an indicator of good practice, Joan was not necessarily happy to have her daughter involved as follows:

Researcher: Do you think there is a possibility that they could have decided to put you on the CTO so that Julie didn’t have that worry?
Interviewee: That would have been all right too. No I don’t need it on paper it’s between her and I; it’s nothing to do with this system it is Julie and I that’s all.
Researcher: But nobody ever said anything like that?
Interviewee: No, no. I wouldn’t put Julie under stress.

Joan’s case also identified the consistent theme of “comparative liberty”. All three respondents were aware that Joan would much rather be at home than in hospital although it was Joan who spent a lot of time in the interview, especially at follow-up, reflecting on how abhorrent she thought the inpatient unit had been. For example:

Too many idiots over there (the hospital), there’s not enough over there that care. There’s a handful but there’s not enough that really care. They spend far too much time in that glass wall, behind that glass wall, and not enough time out with the people. And they should because it does help if you’ve got someone to talk to (Joan).

Joan was convinced that the CTO enabled her to be moved out of hospital quickly but this appeared to be contested by her doctor who was not as convinced about this and did not think the CTO had speeded up her discharge. However Joan made the comment:

I came back from being on leave and I was told to go and get my stuff out of the bedroom because the bed was needed (Joan).

Joan’s doctor and case manager both emphasised the relevance of “engagement” and “continuity” to the purpose of the CTO. For example:

(Supporting) the process of engaging her in the treatment. (Joan’s Doctor)

Joan made no links to engagement but she tended to make contradictory comments about whether the CTO was necessary to get her to attend for community based treatment. On the one hand she said:
I didn’t need it no. I take my psych dose now because of Julie because she worries. I think I would have gone anyway, like I said you need debriefing when you come out of a place like that (the inpatient unit) definitely. I think I would have gone anyway I can’t say for sure because I wasn’t in that position.

But she also said:

Well, yes, I guess... not make me do it, I think that’s a bit severe, I think if I weren’t on the CTO I wouldn’t come here. But because I am I will come here.

And:

Yes, well, I know it’s the law for me at the moment to adhere to this CTO or go back to hospital and I don’t want to go back to hospital because I am not unwell. So I will adhere to the CTO.

Hence, the relevance of comparative liberty to Joan’s compliance with the CTO.

Joan’s previous non-compliance and subsequent relapse was a key theme in relation to the purpose of the CTO for the treating team. Joan speculated that she was placed on a CTO because she had been on one before and it was “procedure”.

This related to a number of comments made in the interviews about the “potential for over use” of CTOs although not all of them were specific to Joan’s case. For example:

I wonder now whether we can do this with the other patients as well, whether we can cut down on the use of CTO. I think the CTO can make for instance the change and then it might cease to be effective after a while if you got a good rapport. (Joan’s Doctor)

She saw the main value for attending community based treatment as located in “talking and listening” and, in particular, debriefing about her experience in hospital. Joan did not believe she could have got that anywhere else.

In relation to the series of questions in the interviews related to being on a CTO there was no doubt that the large majority of comments described a positive experience
even though both case manager and treating doctor were aware of negative aspects and thought:

In the beginning she was quite stigmatised. (Joan’s Doctor)

Whilst Joan, in the main, made positive comments including:

I don’t see anything that should be improved from my point of view as it’s worked out well. (Joan)

She also made some ambivalent or neutral comments such as:

I’m happier [laughs] (now that I am discharged). I hated bloody going up there, but I did, I do my time and that’s about it. (Joan)

Another area of apparent ambivalence was in relation to her discharge from the service following her discharge from the CTO. She initially said she was happy to get away from service providers, who in many ways she continued to see as having too much power over her, as described below, but she also expressed feelings of abandonment when interviewed at follow-up:

But you see Dr Singh kicked me off really early I wasn’t hardly there long at all, but he was good about it, but he cut me off that cold. (Joan)

In relation to problems with CTOs Joan discussed the limitations of CTOs in being able to facilitate people returning to work. This also came up in discussions regarding good practice when all respondents referred to the importance of a focus on recovery and treatment beyond medication. For example:

I think there’s a lot of disabled people could work and I think the CTO, with the time they spend here I think they should be encouraged to do something productive, not just come here, “See you later”, come back next fortnight, whatever, I think they should... whatever that is, whether it be working or hobby
crafts, whatever, I think that they should be encouraged to be more active. (Joan)

A key issue for Joan in good practice related to “talking and listening”. This is what she saw as profoundly lacking in the inpatient setting and placed considerable importance on. Meanwhile, although her treatment team also referred to “talking and listening”, they placed greater emphasis on treatment planning and being focused on recovery.

The kinds of factors described by all in relation to questions about what represented good practice seemed consistent with normative ideas about good therapeutic relationships. Engagement, focusing on recovery, maintaining regular contact, offering respect, being caring and genuine were all mentioned. Two other themes received more attention. The first was being flexible. It seems that “flexibility”, in some ways, was seen by respondents as a way to mediate the power that the CTO represented as suggested by the following two quotes:

Now both of us are very flexible and if she says, “I can’t come today”, I say, “That’s fine I can see you next week”. And she will come up... (Joan’s Doctor)

As long as it doesn’t interfere with my life, and they’re very understanding with that, like if I get a job they work around it for me so I can’t ask for more, really. (Joan)

The other was being able to build rapport as represented by the following quote which also links back to the theme of flexibility:

And I think in the process she has attended down the line as needed for her needs and so if it turns out we should see her a bit more frequently, yes, she has made appointments. So in that respect helped her to achieve a level of rapport which was very reasonable for her in that sense. (Joan’s Doctor)

Managing risk, particularly long term risks in relation to carer burden and mental and physical health was also evident particularly from the case manager and doctor. The case manager seemed the most concerned about potential risks, for example:
Dr Singh was kind of keen to discharge her maybe a month ago but kind of set back once I’ve said I’d like to give it another month to review it, see if she is still compliant and still is back on track. And now I’d definitely say yes, I’d support it. (Joan’s Case Manager)

Only Joan pointed out the role of, and risk to, her neighbours in decision-making about the CTO when she said:

I know I do some pretty weird things and it does protect the neighbours from me making an idiot of myself. (Joan)

The emphasis on caution and risk in the initial interviews contrasted with the considerable confidence expressed at follow-up about Joan’s ongoing compliance level of functioning:

So this time I think CTO really helped her to engage very well with the service and we could see that she had a great deal of insight and we could really trust her to take medication in the long run. (Joan’s Doctor)

One of the quotes above relate to another two themes identified in relation to good practice – “thoughtful decision-making” and having a “team approach”. For example:

Like I said, I like Sally and Dr Singh’s relationship when it comes to me and I’m sure with all their patients, clients. (Joan)

Another issue that may prove to be specific to this case study is that of “education”. Sally was a very inexperienced case manager who described the following:

Researcher: Yes, and that brings me to a question about did you do anything, any preparation like in your degree about working with involuntary clients?
Interviewee: No, nothing.
Researcher: Yes, you just...
Interviewee: Absolutely nothing so it’s been a totally new experience. I remember my first hearing and I had no idea, it was within a couple of months of
working, and I’ve totally freaked out because I didn’t know what I had to say and it was up at the CCU but... yes, I had no idea what was going on so I’ve been to a couple now

The doctor expressed the idea that it had been helpful to Joan’s situation that he was both her treating doctor and the authorised psychiatrist because this enabled “continuity”.

In summary, a number of themes were evident in this case study although, with the assistance of coding, three key themes appear to predominate. They are:

1. Comparative liberty
2. Family/Carer\(^8\) interests
3. Flexibility and rapport.

These three themes appear to a foundation to understanding the purpose of the CTO in this case, why it was a relatively positive experience and what seemed central to a mutual recognition of good practice.

**Discussion of findings – Case Study One.**

This case study revisits many of the themes identified in the qualitative literature review and also highlights many of the driving and restraining forces around CTOs discussed in the Chapter One.

The node “comparative liberty” was initially included, consistent with a general inductive approach (Thomas, 2004), as a potential node in the analysis because it had featured in other studies. It appears that Joan’s experience was very consistent with those in New Zealand and elsewhere that found a CTO to be a much less restrictive option than, as in this case, hospital or potentially for others, prison (Dawson, 2005).

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\(^8\) Joan’s case suggests the value for the study of using the more inclusive description ‘family/carers’ rather than simply ‘carers’ due to competing ideas about who is a ‘carer’.
The degree of abhorrence Joan had for the inpatient unit was noteworthy, supporting the driving forces around CTOs that inpatient units are potentially toxic environments for some people that should be avoided if possible.

Concerns about the potential for over use of CTOs and the net widening effect (Geller, et al., 2006) are evident here although this is potentially mediated by the relatively short time the person was on a CTO which was approximately three months.

The importance of family members and carers in decision-making regarding CTOs is highlighted by this case and potentially this CTO cluster. Offering family member’s peace of mind and having the treating team share responsibility for the person remaining compliant with medication is consistent with findings elsewhere about CTOs addressing the needs of family members and carers (Gibbs, et al., 2006).

Ideas about good practice, as highlighted by this case study, will be considered elsewhere in this thesis as a general topic when all relevant comments from all respondents are collated. However, the potential connection between the type of case, cluster one “Connected”, and the two important themes regarding good practice identified seems relevant to discuss here. It is possible that flexibility and the emphasis on building rapport in this case study represented a particular view of the consumer, as a person who generally welcomed engagement, and what could potentially be achieved through the use of a CTO. It may also recognise that, in this instance, the CTO was cautionary. As a result of this context it may be that particular emphasis on factors that may mediate the CTOs coercive elements were invested in by the service providers.
Case Study Two

Introduction and brief case description.

Peter is a 43 year old man who lives alone in a one bedroom flat. He has regular contact with his father and brother but they are not actively involved in his care. He was described by one respondent as inclined to “keep his family at arm’s length”. Peter’s principle diagnosis was described as Schizophrenia. Peter says he had been on a CTO continuously for eight years although this is disputed by his case manager. The case manager thought it was four, perhaps five years. She described Peter as having a time when he was discharged from CTO and, due to non compliance, being readmitted on to the CTO in a matter of months. So, perhaps, Peter’s subjective experience of eight years counts this period of not being on CTO as part of the whole. Even so it seems safe to say that Peter has been on a CTO – on and off – for approximately eight years.

Both initial and follow-up interviews with Peter were held at the clinic. Peter was a client of the Mobile Support and Treatment Team (MSTT). Peter agreed to his doctor (Dr West – Psychiatric Registrar) and his case manager (Angela) being interviewed. By the time the follow-up interviews occurred (between 8/6/06 and 25/7/07) Peter had a new case manager (Karen – Social Worker) and a new doctor (Dr Nguyen – Psychiatric Registrar) and he agreed to them being interviewed as well. A carer was not interviewed because there were no family members or other informal support people considered to be active enough in his care.

Peter was identified by his case manager in the recruitment phase as representing cluster three or “Chaotic”. He is very close to this cluster’s average age of 42 and he shares many of this cluster’s common features. Peter’s complex presentation was characterised by isolation, vulnerability to victimisation and self neglect, drug use, past significant risk history both in relation to suicidal ideation and potential harm to others (including previously being in possession of a firearm), persistent symptoms of serious mental illness and complex general medical needs. Like many of the people in
cluster three he lived alone and was on the disability support pension. He was also subject to an administration order under the Victorian *Guardianship and Administration Act, 1986* and, as a result his financial affairs were managed by the state trustees.

**Key themes.**

Table 12: Peter (Cluster three: Chaotic) Nodes and Number of References

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery focused and holistic</td>
<td>23</td>
</tr>
<tr>
<td>Talking and Listening</td>
<td>15</td>
</tr>
<tr>
<td>Mutual obligation</td>
<td>15</td>
</tr>
<tr>
<td>Authenticity</td>
<td>13</td>
</tr>
<tr>
<td>Dealing with complexity</td>
<td>12</td>
</tr>
<tr>
<td>Mutual accountability</td>
<td>12</td>
</tr>
<tr>
<td>Achieving compliance</td>
<td>11</td>
</tr>
<tr>
<td>Manage Risk</td>
<td>11</td>
</tr>
<tr>
<td>Focus on wellness</td>
<td>11</td>
</tr>
<tr>
<td>Flexibility</td>
<td>10</td>
</tr>
<tr>
<td>Collaborative Team Approach</td>
<td>9</td>
</tr>
<tr>
<td>Coercion and Power</td>
<td>8</td>
</tr>
<tr>
<td>Loss of agency or personhood</td>
<td>8</td>
</tr>
<tr>
<td>Reduce Vulnerability</td>
<td>7</td>
</tr>
<tr>
<td>Comparative liberty</td>
<td>7</td>
</tr>
<tr>
<td>Positive experience</td>
<td>7</td>
</tr>
<tr>
<td>Neutral/ambivalent</td>
<td>7</td>
</tr>
<tr>
<td>Negative experience</td>
<td>5</td>
</tr>
<tr>
<td>Volunteer for compulsion</td>
<td>2</td>
</tr>
<tr>
<td>Safety</td>
<td>1</td>
</tr>
</tbody>
</table>
Using NVivo 7 nodes and tree nodes as a tool, the content of six interviews specific to Peter’s case were analysed in order to identify key themes.

In the early stages of each of these six interviews the purpose of the CTO was explored and there were many common themes in the responses. “Achieving compliance” was a frequently discussed topic here. For example:

Peter is compliant, and he’s compliant because the CTO is in place. If we took the CTO, Peter may not remain compliant. (Peter’s Case Manager)

Compliance generally related to taking medication, though other aspects of Peter’s care and treatment, for example, (as with case study one), his engagement with the service, were considered. The following quote demonstrates how “Achieving compliance” was persistently raised as an important issue in Peter’s case:

Researcher: And you had that period - you mentioned that you had a time when you went off the CTO and then you went off your medication?
Peter: Yes, I could do without it. I still feel that way about it. Every day is a new story with medication.

The other themes that predominated in relation to why Peter was on a CTO included “Dealing with complexity” and it was through this theme that his complex needs were identified. As with case study one, “Comparative Liberty” was a theme but in Peter’s case he discussed this much more in terms of remaining out of the criminal justice system rather than fears about going back to hospital. For example:

But there was another thing about - if I’m on a CTO the law think it’s enough problems to deal with without me coming down on your back. (Peter)

And:

But if I didn’t do my bit I wouldn’t have got where I am now. I’m not that flash, but I try to keep out of trouble. (Peter)
Although “Family/Carer interests” was not the significant theme it proved to be in case study one it was mentioned elsewhere in relation to how Peter’s history of dangerousness had impacted negatively on his family and perhaps accounted for the current distance in their relationships.

In relation to the commonly occurring theme of “manage risk” the following illustrates the issues:

So there was a very significant history there of self-harm, and he does become – without treatment he does become more at risk of self-neglect. He can be quite abusive and argumentative and aggressive towards family, and also to mental health clinicians as well. (Peter’s Case Manager)

“Reduce Vulnerability” was another area of importance when exploring why Peter was on a CTO. Peter’s vulnerability was closely linked in a number of comments made about his isolation by everyone involved. Here is one doctor’s perspective:

There’s always the risks of a negative syndrome- neglect, vulnerability, and I guess all the risks that come with social isolation. (Peter’s Doctor)

This was also expressed as “Safety”:

So if that deteriorated 20% more, you know, if someone was becoming unwell, he actually hasn’t got that far to fall, if you know what I mean, before it could become, just in terms of daily living, a risk to himself in terms of self care and stuff. (Peter’s Case Manager)

A theme of “coercion” developed and the relevant comments are linked to those related to the CTO being a negative experience for Peter at times.

In relation to Peter’s experience of being on a CTO there was a spread of responses. There was equal reference to the CTO being described as positive or neutral/ambivalent and a slightly smaller number of references to it being a positive experience. “Negative” comments included:
Sometimes it makes it very hard if they try to make judgements and to say no. (Peter)

Yeah and what does that do, you know the thing to be human is to have your own locus of control to live your life in an authentic manner for yourself. So that’s what I sort of imagine is the worst side of things. (Peter’s Doctor)

“Neutral or ambivalent” comments included:

Researcher: So what’s it like to be on a CTO?
Peter: You have to live sort of half in, half out, so the people could do work and help and that and reiterate or whatever, you know, and sort of try to manage around this mental illness business. (Peter)

I think it’s that kind of ambivalence almost in terms of its controlling, which he doesn’t like, and he links it with the police and unpleasant experiences and being told what to do, and yet on the other side he likes having the support and the contact and I think he has a feeling that without the CTO he wouldn’t get that, which isn’t the case, but I think he has some sense that he wouldn’t sort of do that. (Peter’s Case Manager)

There were also these examples of “positive” comments:

Well, yes, it’s a commitment and it’s useful for the staff to know that I’m on a CTO and have to be looked after and stuff like that, but I’m minimum supervision now. I’ve worked up to minimum supervision. (Peter)

CTOs can be seen quite negatively. In Peter’s case I think there’s a – it sort of sustains the relationship, and that’s what I see as a positive thing, in having a CTO on board. (Peter’s Doctor)

Throughout the interviews Peter’s situation is seen by the service providers to be somewhat unusual because of the degree to which he valued the CTO as a kind of safeguard or method of ensuring “mutual accountability”. Two particular comments seemed to link with the concept described in the literature as “volunteers for compulsion”. For example:

He wants the CTO in place, and he likes it there. Not many of my other clients, in fact I can’t think of any of my other clients really that actually behave in a way
that means that they actually keep the CTO, or they indicate that they need that
CTO or the way it’s keeping us involved. (Peter’s Case Manager)

An important finding here is that when the codes “mutual accountability” (a tree
node under “good practice”) and “mutual obligation” (a tree node under “impact of
CTO”) are combined there were 27 coding references. This seems also evident in Peter’s
“neutral or ambivalent” comments about the CTO.

Some other new nodes or potential themes were evident in this analysis and
they included reference to the impact of the CTO on “loss of agency or personhood” and
the following quote perhaps most remarkably, although simply, illustrates this:

I’m an involuntary status. (Peter)

And it is further explained by his Case Manager:

Peter actually finds the CTO to be – or verbalises the CTO to be quite a barrier to
him in getting on with his life. And he talks about it being a very prominent part
of his life, that there’s this order on him that forces him to abide by treatment.
(Peter’s Case Manager)

In relation to Peter’s case and what represents good practice the key themes
identified were, “flexibility”, “achieving compliance”, “authenticity”, “talking and
listening” and taking a “collaborative, team approach”. What appeared to be most
important about good practice for those interviewed, both in relation to Peter and in
general terms, was being “recovery focused and holistic” and this was related to the
topic of “focus on wellness”. These findings are summarised as follows:

Helping him work on his quality of life. And being able to build other things into
his life, that are meaningful, that he might benefit from, like socialising with
people at The Exchange, going on respite holidays, having more contact with his
family. (Peter’s Case Manager)
There were a number of comments in this category about the role of the MST and how the leadership of the team encouraged this focus on wellness and recovery, for example:

So, at least, he knows that Dr Howard (the consultant psychiatrist) is in for the long haul, with a rehab focus, and most of her questions are addressing his rehabilitation needs. (Peter’s Case Manager)

A number of positive outcomes of being on a CTOs were identified by the respondents, particularly Peter being able to have more responsibility for his medication, increased activities outside his flat and being well engaged with the team, especially through his long term and consistent engagement with the team’s consultant psychiatrist. It appears that this relationship in some ways mediated the other changes in treatment team he had experienced. Other benefits had included maintaining some contact with his family and staying “out of trouble” (Peter).

There did appear to be ongoing limitations in addressing the purpose of the CTO around achieving compliance and this is summarised below:

But that’s where he draws a line, and he says I’m not prepared to do that. I’m not prepared to tell you that I need my medication, and I’m not prepared to tell you that I have a diagnosis of schizophrenia, and the medication’s an anti-psychotic and I understand how it works. He just won’t draw – won’t go to that next level or that next step. Because I really do feel that he’d be at a loss. I’m not sure – I don’t think he knows what would keep him going or keep him driving, if he didn’t have the CTO, and he didn’t appeal to the Mental Health Review Board. (Peter’s Case Manager)

In summary, a number of themes were evident in this case study although, with the assistance of coding, four themes appear to predominate. They are:

1. Mutual Accountability
2. Achieving Compliance
3. Recovery focused or holistic approach to treatment
4. The impact of the CTO on personhood
These four themes appear to a foundation to understanding the purpose of the CTO in this case and the significant impact it had on the person subject to it. These themes also potentially explain the length of the CTO and the ongoing mixture of positive, neutral or ambivalent and negative responses that were generated, especially for the CTO recipient.

**Discussion of findings – Case study Two.**

As with case study one, case study two revisits many of the themes identified in the qualitative literature review and also highlights many of the driving and restraining forces around CTOs discussed in the introduction. It demonstrates the relevance of “comparative liberty” and how this varies from fear of returning to hospital, as in case study one, and staying out of the criminal justice system, as in this case.

The consumer’s emphasis on the CTO providing him with an experience of mutual obligation or accountability was a strong feature of this case study. The service providers seemed to think this was out of the ordinary but it is interesting that from a research perspective it does not seem so atypical. This experience is consistent with international literature, especially findings from New Zealand, that have identified the phenomena of “volunteers for compulsion” and it is also supported by the numerous findings that CTOs are an expression of the commitment of the services as much as the patients or consumers (Brophy & Ring, 2004; Geller, et al., 2006; Gibbs, et al., 2005; Swartz, et al., 2003). Similarly Canvin, Bartlett, et al. (2002) described how, like Peter, people can simultaneously resist and accept orders, hence the theme of neutrality and ambivalence.

As Churchill, et al.’s (2007) study found in general consideration of CTOs, there is an emphasis in implementation on achieving safety and stability, particularly through compliance with medication. What is also emphasised in this case is the importance of moving beyond medication to a more holistic approach, one that addresses the marginalisation many people with serious mental illness experience. This approach
addresses one of the common complaints and fears about CTOs; that they contribute to an increased medicalisation of treatment. It may be that in this case the protective or mediating factors are the role and function of an MST, and the particular influence of the team’s culture and leadership. However, even though emphasis on a holistic approach is evident, the central role of medication in treatment is still apparent.

An emphasis on risk was also identified and decision-making in this case appeared to be influenced by both acute and chronic risk factors in the context of complex needs. Thus maintaining the ‘insurance policy’ that a CTO can often represent (Churchill, et al., 2007).

Peter, as a member of the “chaotic” cluster confirms how CTOs have become important in trying to meet the needs of people with multiple and complex needs and Peter’s case demonstrates just how complex the needs of these people can be. He also demonstrates how difficult it can be to get off a CTO once a range of risk issues have been identified and there is an established history of non-compliance. The significant role of insight in decision-making is also identified. The sometimes disempowering impact of CTOs, and the negative effect they can have in relation to a person’s sense of personhood or self-efficacy, is also apparent in Peter’s case. Peter’s situation demonstrates how this negative impact can sit alongside generally agreed upon positive outcomes for the person.
Case Study Three

Introduction and brief case description.

Maria is a woman in her mid 30s who lives alone in a unit. She is the non-custodial parent of a 12 year old boy who stays with her at least one night per week. She continues to have regular contact with her child’s father. She is also in regular contact with her mother who lives nearby. Her brother lives with her mother and he also experiences serious mental illness, as did her father who is deceased. Both her parents migrated from Italy to Australia. Maria’s mother’s first language is Italian although she was able to be interviewed in English.

Maria thinks her principle diagnosis is currently bi-polar affective disorder although the members of her treatment team indicated that they are unsure about her diagnosis. She has been previously diagnosed with schizophrenia and schizoaffective disorder. Maria describes being on a CTO “on and off” for the last ten years. She first experienced serious mental illness when she was pregnant with her son. By the time the follow-up interview was held Maria had had an occasion of relapse when her CTO was revoked and she was re-admitted to hospital. Maria describes having at least ten hospital admissions since she was first diagnosed with serious mental illness. According to her case manager these episodes or relapses seem to follow a pattern of occurring around the end of summer. Maria is currently a client of the MST. The first interview was held at the clinic, the second was conducted in her home. Maria agreed to her consultant psychiatrist (Dr Howard) and case manager (Jill) being interviewed and she also agreed to her mother being interviewed. The consultant was interviewed rather than the psychiatric registrar (or treating doctor) because the registrars had recently

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9 Registrars are rotated through the various programs in Area Mental Health Services as part of their training program and they usually only stay in programs for six months, although some do have longer placements of up to one year. Many of these registrars are international medical graduates who are seeking registration with the Australian and New Zealand College of Psychiatrists.
been rotated and the case manager thought the consultant would have more knowledge about Maria’s situation than the new registrar. Maria’s mother, her nominated carer, provided a single interview because she declined a second interview at follow-up, citing fatigue and health problems.

Maria was identified by her case manager in the recruitment phase as representing cluster three “Chaotic”. This was particularly because of her recorded history of frequent and complex relapses that required readmission to acute inpatient facilities, vulnerability to self neglect and victimisation, and risk issues that included harm to herself and others. Like many of the people in cluster three she had had a diagnosis of Schizoaffective disorder and she had been on (and off) CTOs for a lengthy period. She also appeared to share some of the characteristics of people in cluster one because of her age, gender, family contact and ethnic background but she seems to have been more strongly identified as representing cluster three because of the level of risk involved. This is also confirmed by the involvement of the MSTT who tend to be limited to working with more complex people in the AMHS.

Key themes.

Using NVivo 7 nodes and tree nodes as a tool, the content of five interviews specific to Maria’s case were analysed in order to identify key themes.

Table 13: Maria (Cluster three: Chaotic) Nodes and Number of References

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/Carer interests</td>
<td>33</td>
</tr>
<tr>
<td>Thoughtful decision-making</td>
<td>28</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>23</td>
</tr>
<tr>
<td>Involving carers and family</td>
<td>21</td>
</tr>
</tbody>
</table>
In considering the purpose of the CTO, and in any discussion of positive outcomes, there was an emphasis on "Achieving compliance". "Lack of recognition of side effects" was added as a tree node under "poor practice" because this appeared, at least for Maria, to be a factor in problems around achieving compliance – in particular her problems with weight gain. Even so, the treating team described how her medication had been reduced, without her mother’s support, and she had subsequently
relapsed and required admission. This appeared to contribute to the often mentioned importance of “Thoughtful decision-making” in these interviews.

As with Joan in case study one, all the respondents, in one way or another, discussed the relevance of Maria’s relatives’ needs in relation to why she was placed on a CTO. This was particularly expressed in relation to decreasing “carer burden”. For example:

Well, so what she gets sick, sell everything for nothing. I bought her (a) fridg... It cost me $1,200. (Maria’s Carer)

In Maria’s case there appeared to be more tension around the use of the CTO than was apparent in case studies one and two. There were more references to issues such as “coercion and power” including the CTO enabling the workers to be more empowered, and references to the “use of authority”.

In Maria’s case there seemed to be added leverage into treatment attached to the risk that she may lose the contact with her son (even though this was already limited) and her experience of coercion was not confined to the behaviour of the treating team involved. She also appeared to have experienced coercion from her ex-partner, her mother and even her son. There are references in the interviews that imply that her ex-partner had at times expressed considerable anger towards her, that her son had been violent towards her and her mother had “stopped talking to her” over issues such as wanting a reduction in medication. The following quotes illustrate these multiple sources of power and coercion in relation to Maria:

One of the things that keeps her on the straight and narrow so to speak is Jason, because she is so fearful of losing her relationship with him. There’s a Court Order, a Family Court Order, which says that if she’s unwell we can say she’s not in any fit state to be looking after Jason and have him removed - stop her access So we have to work closely with Joe (her ex-partner) too, but he’s happy with that and so is mum. But she’s got that keeping her on the straight and narrow aside from the CTO. (Maria’s Case Manager)
I say you ‘Play with mum. You hurt mummy. So you nearly strangle her. You don’t understand because you think you’re playing, but you’re too strong. Your mummy scream, that’s not good. Why, you want mummy to go back into hospital?’ ‘No, no, no. I look after Mummy too’. But some time she ring me ‘Mum, Jason kick this, kick that’. ‘Maria, you ring me. What am I doing? I can’t see, me not have a car. What do you want me to do?’ When the father come to pick up, he is fright of him. She not want to say because she is scared of Joe bashing him, maybe after Jason …but I say Maria, all right, you don’t want to say everything, but the fact the thing you have to tell him because after it’s worse for you, when grow, more grows for you. She said ‘Ma, you are right. Jason quiet and watching TV from yesterday and today’… (Maria’s Carer)

Interviewee: And they can be more connected in with the mother and in this instance where I think the mother is more ‘oh don’t change the medication and don’t take her off the CTO’.
Researcher: Keep everything the same.
Interviewee: And ‘look what happened last time’ and you know. We actually had that discussion after the last relapse. We thought the mothers going to even more so say ‘don’t change anything now because last time something was changed and Maria became unwell and ‘I told you so’. (Maria’s Doctor)

Interviewee: At the moment my mum is upset with me.
Researcher: Oh is she?
Interviewee: Yes. I know it is more about work, but because I didn’t wash a couple of cups at her house she just freaked. She got in one of her moods she doesn’t want to see me. (Maria)

Whilst Maria thought that her mother was ‘in one of her moods’ because of poor attention to domestic duties, Jill, in her interview, anticipated Maria’s mother being upset about a recent reduction in medication.

Maria demonstrated considerable awareness that other people’s interests were being taken into account:

Maria: Well I know other people’s opinions count, but really I feel it should be my own opinion. It should be me because I know I’m doing well.
Providing “continuity of care” seemed a particularly important back drop to the purpose of Maria’s CTO as was the perceived need to “deal with complexity”. Again her mother sums this up:

So they’re helping her a lot, supervising her medication, getting her to go to groups, popping in and seeing her, having a bit of contact with people. They don’t go away when she’s sick. Even when she gets sick, Jill goes around. With other people it’s harder because they go away. (Maria’s Carer)

“Comparative liberty” was again relevant to Maria. She too disliked hospital. Establishing “mutual obligation” was discussed as follows:

I think that while she’s on a CTO she knows that she, while we’re obliged to treat her, she also has an obligation to accept that treatment and she doesn’t want to go back to hospital. (Maria’s Case Manager)

The negative impacts on Maria’s personhood, self-efficacy and empowerment were acknowledged. Maria expressed experiencing “stigma” as a result of being on a CTO. The following quote helps explain that this was worse early in her experience on CTOs:

Interviewee: Well when I first went on it years back I was like oh I am on a community treatment order, oh I must be bad this and that.
Researcher: What did you mean you thought you ‘must be bad’?
Interviewee: Like I must have been really ill I used to see it like that. Like people would say “you are on the community treatment order?” Yeah.

Overall being on a CTO was an equally negative and neutral or ambivalent experience for Maria, even though there were some positive comments about the CTO made in the interviews.

Good practice in Maria’s case was located around some key issues. As discussed above “thoughtful decision-making” was seen by the case manager and doctor to be important, especially because they seemed to be aware that they had made decisions in
the past that had led to relapse or criticism from Maria’s family. Another was “Involving carers and family”. “Flexibility and negotiation” also featured, as did “Authenticity”. But what seemed more important in this case was dealing with Maria’s “Loss of agency, personhood” through more emphasis on a “Focus on wellness and strengths” and on having a “Holistic recovery focus”:

Well when I look back I don’t like to say I was ill, but I was in the wrong; my opinions were wrong, the way I was acting was wrong because everyone goes against me and then I get more pressured into trying to prove them and it was because you’re sick, you’re sick, you’re sick. I don’t like hearing that, I don’t see myself as a sick person. (Maria)

She started recently going to a group called Looking Forward, a women’s group that is run by the Community Health Centre and it’s for women who have been in abusive relationships…. I think a lot have been in very physically abusive relationships. It’s a fairly small group…. She’s never been physically abused, but she has been emotionally abused, and Joe will verbally abuse her quite violently, and Jason picks up on that. So I was keen for her to go to learn some assertion, more assertive behaviour around stopping particularly Jason being verbally abusive towards her. (Maria’s Case Manager)

A new node was added when reading transcripts of the follow-up interviews – that of good practice featuring “Recognising patterns and good assessment”:

So again if she achieves a period of stability of where you know she’s reflective, she’s functioning well, she’s working with us around the medication, seems to understand the need for some ongoing treatment which is the same as last time really. It would be very similar. In other words I don’t think ‘oh that hasn’t worked one time. They failed, we failed, we won’t try it again’. In fact almost the converse. I would hope and expect that she’s learned something even more from the last time that will be a stronger platform for her in the future. Therefore you know I wouldn’t necessarily wait longer this time thinking ‘oh goodness you know it didn’t work last time’. It could make me think we’d try it even earlier this time. It depends on the individual again though. With some individuals where they don’t seem to have learned so much from say a relapse and coming off the CTO then I would wait longer. (Maria’s Doctor)

“Reduce vulnerability” appeared to relate to the main risk issue in this case:
I just want to do the best thing now. I was even dating guys and I had my partner, I was being really stupid and immature, sluttish, just ridiculous. (Maria)

Yes, that’s what made me lapse, because of it. I was doing quite well and then I ended up selling all my furniture, most of it for peanuts. It’s really bad for me. (Maria)

“Restoring functioning”, “building self esteem” and “talking and listening” were areas of good practice that emerged. Perhaps related to the issue of the importance of thoughtful decision-making was another factor “team approach and collaboration” as expressed in the following:

I don’t think it can be left to one person in this because it’s such an important area. I think the medics certainly have to hold the responsibility but I think everyone else plays a part and ought to whether we’re talking amongst us as practitioners but also the other stakeholders out there. (Maria’s Doctor)

In summary, a number of themes were evident in this case study although, with the assistance of coding, five interrelated key themes appear to predominate. They are:

1. Family/Carer interests and involving families
2. A team approach to difficult decision-making
3. Maintaining continuity of care and reducing vulnerability
4. Power, authority and the use of coercion
5. Stigma, loss of personhood and strategies to enable recovery.

These multiple themes appear to be a foundation to understanding the purpose of the CTO in this case. It also highlights the potential contradictions that the CTO represents in this case in particular. While there was awareness and concern about the negative impacts of the CTO on Maria’s sense of self, there was considerable commitment to the importance of using the CTO to ‘protect’ Maria and those who cared about her from the consequences of relapse. Maria’s situation also highlighted how people, and perhaps particularly women, can be subject to multiple sources of power and coercion, with more people having a ‘stake’ in how they conduct themselves and what risks they take.
Discussion of findings – Case Study Three.

Maria’s situation reflects in many ways the characteristics identified amongst those in the ‘chaotic’ cluster identified by the cluster analysis. For example, the difficulty those involved experienced in establishing clarity regarding her diagnosis. She also had had numerous admissions and experienced a high level of risk, particularly in terms of her vulnerability, when she was considered unwell.

These findings, in relation to Maria’s specific situation, provide strong evidence that gender and different ways of constructing risk when it comes to women, especially women with children, are important factors in the implementation of CTOs (Freckelton, 2003b). While Maria was not a member of the ‘connected’ cluster, where such a finding might be most expected, she represented, it could be argued, a more critical version of their story. CTOs may provide a different function depending on gender. This is particularly represented in the emphasis on acting in the interests of carers and in the involvement of carers. Maria’s Italian cultural background may also have some significance here as well. Some cultures, such as Whanau or Maori families in New Zealand, particularly emphasise maintaining connections between family members and highly value mutual caring in families (Gibbs, et al., 2005; Gibbs, Dawson, Forsyth, & Mullen, 2004). Similarly strong traditional bonds are often associated with the Italian community and so is stigma about mental illness (Queensland Health, no date).

Maria was also experiencing multiple sources of leverage, potentially increasing her experience of coercion, stigma and frustration (De Jong & Insoo-Berg, 2001; Swartz, et al., 2006).

Maria was fundamentally ‘persuadable’ by the CTO and there was considerable trust in the effectiveness of the CTO by the service providers involved. However, the negative impacts were also apparent. The service providers had taken risks to enable reductions in medication but they were challenged by the relapse that appeared to have been the consequence. Even so the consultant psychiatrist highlighted that these were
learning opportunities and her input confirmed the value of having continuity in staffing and thoughtful, collaborative decision-making. Maria’s situation perhaps reflects some of the potential problems that have been anticipated or speculated about in relation to CTOs, in particular the tendency towards conservative decision-making, especially when junior, inexperienced or short term staff are involved (Freckelton & Lesser, 2003; Jaworowski & Guneva, 2000). The case appears to demonstrate the value of consultant psychiatrists being actively involved in decision-making. This has been identified as being hard to achieve when consultant psychiatrists are difficult to recruit in some localities, carry large case loads and supervisory responsibilities (Freckelton, 2003b).

Maria’s experience of attempting to persistently ‘resist’ the CTO may be consistent with ideas expressed by (Thorne, 1990) in describing ‘constructive non-compliance’. Maria remains dissatisfied by the weight gain she experiences being on her medication and this has been found elsewhere to place people at increased risk of non-adherence to treatment (Pinikahana, Happell, Taylor, & Keks, 2002; Tham, Jones, Chamberlain, & Castle, 2007).

Maria’s experience of stigma is consistent with findings elsewhere about the experience of being on a CTO and perhaps being on a CTO compounds the common experience of lowered self esteem in people with mental illness (Brophy & Ring, 2004; Watson, Corrigan, Larson, & Sells, 2007). She is able to accept the need for treatment and, on reflection, appears to reluctantly acknowledge the value of some, if not all, interventions by the treating team. She is able to recognise occasions of good practice in relation to her situation. However, she is also able to express the negative impact of the CTO on her sense of self and her personal experience of disempowerment. Maria can relate this to how other family members treat her and her apparent loss of status in her family as expressed by the doubts they appear to express when she tries to exert some control over her treatment. Maria’s thoughts draw out the value of considering the links that have been made in the literature between self-efficacy and recovery (Mancini, 2007). Meehan, King, et al. (2008), in discussing the recovery literature, highlight the difficulties in situations such as Maria’s. Some recovery literature indicates that having
forced treatment and a recovery focus are actually incompatible (Minkowitz, 2006), but, as previously established and highlighted in this case, it is very difficult for service providers to move away from the pressure to manage risk through the use of CTOs. Indeed there is the possibility that through allowing greater risk taking the treating team are concerned that, should the outcome be a relapse or deterioration in functioning, this potentially allows in other forms of coercion – for example, in Maria’s case, the police and child welfare authorities. As discussed above Maria’s case provides valuable insight into the incongruity and ambiguities that surround well meaning and skilled service providers, who appear to be genuinely acting in the interests of the person and their potential recovery, relying on the use of coercion (Meehan, et al., 2008).
Case Study Four

Introduction and brief case description.

Joseph is a 30 year old man who lives with his mother and younger sister in his family’s home. His mother was born in Greece and is divorced. Joseph did not mention any contact with his father. Joseph has a child from a relationship he had in his late teenage years and his mother, at different times, described adopting the role of primary carer for Joseph’s daughter who is now 13 years old. At the first interview it had been many years since Joseph’s mother had had regular contact with her granddaughter, but by the time the second interview was conducted, approximately six months later, Joseph’s daughter was again living in the family home at the request of her mother, Joseph’s ex-partner.

Joseph was identified by his case manager as fitting into the profile of cluster three “Young males”. Like the majority of the people in cluster one, Joseph is male and has a diagnosis of paranoid schizophrenia. He also has a history of poly drug abuse but, according to his mother and the treating team (doctor and case manager), he now limits his drug use to smoking marijuana on a regular basis. He left school in year 9 and is currently on the disability support pension after never having achieved regular or sustained employment. He was very close to the average age of cluster two and although it was unusual for cluster two members to have been in a partnership (and presumably to have a child), it was not unusual for them to being living with family, like Joseph.

Joseph says he thinks he has been “sick” for about five years. His mother thinks it is longer and she is inclined to blame his drug use as a trigger for his illness. His treating team traces his illness back to his late teenage years. His mother expressed regret about the amount of time Joseph did not receive supervision when he was in his teenage years because of the demands of a family business. At the time the first interview was held,
Joseph had been on a CTO for approximately four, maybe five years. This was unclear because it seemed that Joseph was last on the inpatient unit approximately five years ago and both his case manager and doctor thought that his CTO followed an admission. Since this information gathering did not involve a file review and relied on the memory and observations of the interviewees it was difficult to be accurate about the length of the CTO. However, what distinguishes him from the other case studies is his relatively low level of service usage over those years.

Joseph was described as having a history of becoming verbally and physically aggressive at home when he was unwell. He continued to also have, according to his mother and treating team, a gambling problem. Joseph often plays on poker machines and has stolen items from his mother to pay for the gambling, for example, selling the lawn mower at a pawn broker. However there was no indication that Joseph had any serious forensic issues at the time of the interviews or in his background.

Joseph was a current client of the Continuing Care Team (CCT) and agreed to his case manager (Chris) and Doctor (Dr Patel – a consultant psychiatrist) being interviewed. According to the case manager, he recalled Joseph having five different psychiatric registrars before Dr Patel took over his care. Joseph also agreed to allow the researcher to interview his mother (Philomena) and she agreed to an initial and a follow-up interview. Joseph was relatively difficult to interview. He was reluctant to answer questions and tended to want to keep the interview quite short. Here is an example of our conversation:

Researcher: What do you understand about why you’re a community treatment order?
Joseph: I don’t know, really.
Researcher: What do you understand that it is?
Joseph: I’m not too sure.
Researcher: Did anybody ever give you any information about it or anything?
Joseph: Yes.
Researcher: What did they tell you about it? What does it mean for you?
Joseph: I don’t know.
The first interview was held at the clinic, the second was conducted in Joseph’s home where both he and his mother were interviewed separately.

At follow-up Dr Patel had very recently decided to discharge Joseph from his CTO. Joseph was described as being compliant with his depot medication although he continued to lack any engagement with psycho social rehabilitation. At that time, due to a staff shortage, he did not have a case manager actively involved in his care (the person contacted described herself as having a backup role only and did not know Joseph well enough to be interviewed) so no follow-up case manager interview was undertaken. Joseph had been discharged from the CTO a few days before our follow-up interview but he did not seem to be aware that this had happened.

**Key themes.**

Using NVivo 7 nodes and tree nodes as a tool, the content of five interviews specific to Joseph’s case were analysed in order to identify key themes.

**Table 14: Joseph (Cluster two: Young Males) Nodes and Number of References**

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involving carers and family work</td>
<td>19</td>
</tr>
<tr>
<td>Family/Carer interests</td>
<td>13</td>
</tr>
<tr>
<td>Carer burden</td>
<td>11</td>
</tr>
<tr>
<td>Achieving compliance</td>
<td>8</td>
</tr>
<tr>
<td>Lack of insight</td>
<td>8</td>
</tr>
<tr>
<td>Limited impact on substance abuse</td>
<td>8</td>
</tr>
<tr>
<td>Talking and Listening</td>
<td>7</td>
</tr>
<tr>
<td>Deal with substance abuse</td>
<td>7</td>
</tr>
<tr>
<td>Recovery focused and holistic</td>
<td>7</td>
</tr>
<tr>
<td>Maintaining regular contact and routine</td>
<td>6</td>
</tr>
<tr>
<td>Loss of agency or personhood</td>
<td>6</td>
</tr>
</tbody>
</table>
As with case study three, in considering the purpose of the CTO, and in any discussion of positive outcomes, there was an emphasis on “Achieving compliance”. For example:

Researcher: So why do you think he was on the CTO in the beginning again what was that about?
Interviewee: Because of his lack of compliance and because of his poor understanding about the need for treatment. That understanding hasn’t improved significantly, but he has become more compliant. (Joseph’s Doctor)

Reducing “Carer burden” and acting in “Family/Carer interests” represented important themes in this case study, particularly in relation to the purpose of the CTO and also in the identification of positive outcomes as the following describes:

That’s right. Actually, on what I was saying before, I think that knowing that the CTO is there for family members, I guess they don’t feel as anxious anymore and that affects the way that they interact in the family home. So I guess if they become more relaxed and reassured that there is something there and they can openly discuss things with the treating team, then I think, overall, within the family, it changes the dynamics, the way they relate to each other. (Joseph’s Case Manager)

This also relates to comments about managing risk, in particular maintaining safety and stability in the home:

I guess, the risk of when Joseph has become unwell, in the past, how it affects relationships in his family, as well as the risk that flows on to himself. (Joseph’s Case Manager)
Like Joan, Peter and Maria, despite Joseph tending to be frugal with words, there was no doubt that Joseph experienced the CTO as a version of “comparative liberty” and he was able to express his desire not to return to hospital as follows:

Facilitator: Would you prefer to be in hospital, rather than living at home?
Joseph: No. I’d hate it...hospital.

Addressing drug use and, to a certain extent, assessing the outcome of the CTO in relation to drug use was relevant. For example:

Interviewee: I’m not worried because I see Joseph and Joseph ask me for cigarettes, for money, for this and that, but he’s not violence, like to hit me, like he used to before, years ago..... this speed. Speed makes him crazy, makes him hit...jump up and down and I don’t know what to do. That’s really bad. ...drugs destroyed the world. (Joseph’s Carer)

However, respondents also made comments, such as the one below, about some of the limitations of the CTO in relation to drug use:

I have gone through the file review thing. One (reason he was on the CTO) was because of the risk of relapse and the second thing was relapse, not only because of the compliance related issues, but also because of the substance abuse. And still he is constantly using cannabis; he has stopped using the other illicit drugs. (Joseph’s Doctor)

There were also comments about the limitations of the CTO in relation to other psychosocial problems, suggesting outcomes that were hoped for beyond whether or not Joseph was compliant with medication and representing reduced risk. His mother attempts to explain this from her perspective below:

Yeah, good start. Every time he goes (to his appointments), two hours, three hours, good, Joseph just get out from my head. But not really enough. You know what I want for Joseph? To go out there and jog. To go and do some work. I know he’s not – but he can do some work, you know, just for a couple of hours. He can do that. If they (Centrelink?) tell him, “Oh no. We’re going to stop to pay you. You have to do the job.” Maybe, Joseph will do it.....
Not just let them hang around and pay you and that’s it. Finished. Not good, you know, for the parents and not good enough for them, too, because what they do? (Joseph’s Carer)

Providing an insurance policy against the risk related to “lack of insight” appeared to be a driving force in relation to Joseph’s CTO. Joseph represented particular challenges for the treating team because he seemed to not understand much about his illness and the CTO itself. As his mother described:

Researcher: What do you think it’s like for him to be on the community treatment order?
Joseph’s Carer: For him, it’s okay, because he has to take the tablets. Like a little boy, he doesn’t understand much. The doctor says you have to take it.

However during the second interview with the doctor some change was recognised:

Then we sat with him and talked to him about what has helped him in the past – referring to the CTO and things. He came up with some explanation that the medication has helped him so there was some – I won’t say significant improvement – but there was some level of insight. It might be due partly to the fact that he was on CTO so he could understand that he needs to take medication. (Joseph’s Doctor)

Another seemingly key issue in this case study was “Involving carers and family work” represented by the following comment:

Mum was very actively involved. ... Mum was quite stressed out with looking after Joseph, and we actually sorted out a separate meeting for her with the consultant as well. (Joseph’s Doctor)

“Talking and listening” remained an important theme although perhaps less so than other case studies. It seemed particularly important to Philomena and in her experience she was able to distinguish those who were outstanding in this regard. For example:
Joseph’s Carer: Dr J.’s (a previous doctor) a very nice person. I like Dr J.. He’s good talking, nice, lovely talking.

Researcher: I think that it sounds like that’s the kind of thing that really helps you, if people think about your financial situation or what it’s like for you to be caring for Joseph at home.

Joseph’s Carer: ...Chris B have to to

Researcher: Well, for you, that’s good, a good worker, listens to you.

Joseph’s Carer: Yeah, that’s right. A good worker. Not ignore everyone’s problem, because he’s got problems too. Because he has the same problems with the other peoples. But he’s paid to do that job.

However, for Joseph, “talking and listening” was more problematic:

Researcher: So coming and talking at the appointments, you don’t really like that part.

Joseph: No.

His case manager had some interesting thoughts about this:

I think what’s really helpful is that he feels comfortable, I guess, in inviting me to his house, to talk to his mum. So hopefully to have gotten to that stage,... hopefully, he would have felt that I have respected him, as an individual, and have, to a certain degree, set some boundaries. However – it’s hard to articulate, really. I think, from Joseph’s point of view, he quite enjoys the time when I actually do talk to his mum and he’s not just the centre of attention. So I think he feels that, in a way, that I may respect him and his family, that way, by ensuring that Mum’s looked after, as well, because he does get worried about Mum. He’s got a quite close relationship with her. (Joseph’s Case Manager)

Again “lack of agency or personhood” and “stigma” appeared to be part of Joseph’s experience:

He doesn’t express any sort of resistance towards it, as such. I think his whole life – well, not his whole life, but his life at the moment, in a way, is like a CTO – you know, what the CTO expects from people. But Mum always ensures that he’s safe and he’s set up for the day, like she’ll either give him some money or go through the same routine every day. So his life is quite structured and depends on, I guess, either what his friends want to do or what his mum wants to do, what mental health service wants him to do. He’ll go shopping only to the list that Mum gives him. He’ll pay bills that Mum tells him to pay. (Joseph’s Case Manager)
And, like “talking and listening”, “maintaining regular contact and routine” appeared to be an aspect of good practice despite what the above might suggest about the risk it attaches to “loss of agency and personhood”. Consider the following:

Researcher: So what’s it like to be on a CTO?
Joseph: Good.
Researcher: What’s good about it?
Joseph: ...just all the appointments and that.
Researcher: Why are they good?
Joseph: I don’t know, really.
Researcher: Do they fill up your day?
Joseph: Yes.
Researcher: Give you something to do?
Joseph: Yes.

In summary, a number of themes were evident in this case study although, with the assistance of coding, particular themes appear to predominate. They are:

1. Family/Carer interests and involving families.
2. Dealing with substance abuse.
3. Poor engagement

These three themes, in particular, appear to help understand Joseph’s experience whilst on a CTO and the issues that have been important in leading to his subsequent discharge. Joseph’s case appears to highlight the limitations of a CTO, especially in relation to trying to meet the needs of a relatively young person who seems cognitively impaired and maintains persistent, if not dangerous, substance abuse. His poor engagement is related to his limited capacity to demonstrate an understanding of the CTO, his reluctance to talk to service providers and his lack of community connection.

Discussion of findings – Case study Four.

As discussed by Munetz and Frese (2001) poor adherence is as a major contributing factor to relapse in schizophrenia and, as can be seen with Joseph’s case,
this is often a factor supporting the need for involuntary treatment. Also, Joseph’s case demonstrates the common treatment strategy of administration of medication via depot when people are on CTOs, rather than relying on the person to consistently take oral medication (Muirhead, et al., 2006).

Furthermore, Joseph’s case provides considerable evidence to support the idea that CTOs are often used as part of an attempt to maintain stability and safety in the home (Freckelton, 2003a) and therefore attempt to reduce the perceived burden placed on family/carers. Joseph’s situation suggests, in many ways, what has been colloquially described as a ‘failure to launch’ in that he has not been able to meet many of the usual challenges for someone at his life stage. Although he has a child there seemed to be no expectation that he would have any responsibility for her care. He is on a disability support pension and his mother’s comment that he is treated as though he is “finished” is a powerful summary of his circumstances. Even so, the CTO appears to have enabled some meaningful and useful intervention if indeed it can be held responsible for reducing his substance abuse and his risk of violence towards his mother. At follow-up, his doctor appeared to be more confident that he can be compliant with treatment, even though his insight into his illness and his capacity to consent to his treatment appears to remain limited. This appears to support a more contextual and less restrictive position in relation to whether involuntary treatment is necessary if the person is able to cooperate with their treatment plan but appears to be compromised in their capacity to fully understand their treatment and continues to lack insight into their mental illness or at least how their problems are understood by their family/carers and service providers.

This does raise the question of whether Joseph was able to give consent to this research. However, he did freely participate (even though he kept the interviews short) and was at home when I interviewed his mother and readily agreed to this more than once. Furthermore his case manager and his doctor (who was a consultant psychiatrist) thought he was able to consent and understood research. Therefore, it seems Joseph’s poor level of functioning varied and he was perhaps one of the people who Munetz and
Frese (2001) describe as having a lack of insight that can be a product of their mental illness. Alternatively it may be that Joseph’s communication difficulties had reduced the effectiveness of conversations about diagnosis and treatment. The treating team may have also underestimated the degree to which Joseph needed more specific help with communication about complex issues.

Meanwhile, Joseph’s behaviour and risk issues can be understood in the context of his age and gender. To a certain extent this may contribute to the presence and length of the CTO and why, as he ‘grows out’ of being a young male and all the inherent risks attached to that life stage, voluntary status can be considered.

Joseph’s problems with “talking and listening” are important, especially when so many of the implications of this overall study appears to suggest the value of “talking and listening” when it comes to CTOs. It appears that Joseph’s problems with “talking and listening” are in common with many other young men, although this is particularly discussed in literature relevant to male juvenile offenders (Snow & Powell, 2004, 2008). These articles discuss how language competence and academic achievement represent protective factors in relation to substance misuse, early school leaving and juvenile offending. Problems associated with interviewing and intervening in relation to young males with problems with their narrative language ability are apparent in my own experience with Joseph. Snow and Powell (2007) suggest that:

Language and social skill deficits…are likely to have pervasive detrimental effects on ability to negotiate the business of everyday life.(p. 11).

Joseph’s deficits are also likely to be the result of the illness itself as schizophrenia is linked with cognitive impairment (Munetz & Frese, 2001).

Hence, if this argument is accepted, Joseph requires specialised intervention, based on thorough cognitive assessment, to assist him to both engage with service providers in a way that is not asking too much of him and tends towards the development of realistic goals. It is difficult to see this happening in Joseph’s situation if the lack of continuity of care he has experienced so far is taken into account. That is not
to say that this analysis is critical of the work done by the treating team interviewed, in fact it is reinforced by the events that followed a doctor having a longer involvement (than had previously occurred) enabling his discharge from the CTO.

The limitations of CTOs in relation to persistent substance abuse and community engagement are apparent here. I have reflected considerably on Joseph’s mother’s request that Joseph be ‘made’ to go out and get even a small job – and this related back to comments made in case study one about the value of meaningful activity. It reinforces the degree to which, in the main, CTOs and compliance with CTOs is very much a representation of the “heavy emphasis on pharmacological management of serious mental illnesses” (Freckelton & Lesser, 2003 p.v.). However, the ethical quagmire that CTOs already represent (Geller, 2006) becomes even more muddy if attempting to force people into meaningful activity becomes part of the regime! What these findings indicate is the value of an integrated service system acknowledging the challenge of reluctance when it comes to recovery focused activities. This may be particularly important for Victoria’s psychosocial rehabilitation and support services that currently place a strong emphasis on consumer empowerment and self determination. These commitments may inadvertently create barriers for people who are reluctant, have difficulty expressing their needs and perhaps have a history of poor engagement with any kind of support and learning typesetting, dating back to their (relatively few) years at school.

**Summary: common and divergent themes**

In summary these four case studies represent common and divergent key themes about what was commonly understood about the purpose of the CTO in each case and what the case study suggested about good practice. These are tabulated in Table 15 in order to more clearly compare and contrast them.

**Table 15: Four Case Studies and Key Overall Themes**
<table>
<thead>
<tr>
<th>Case study</th>
<th>Key overall themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joan</td>
<td>• Comparative liberty</td>
</tr>
<tr>
<td>Case Study One</td>
<td>• Family/Carer interests</td>
</tr>
<tr>
<td>Cluster one: <em>Connected</em></td>
<td>• Flexibility and rapport</td>
</tr>
<tr>
<td>Peter</td>
<td>• Mutual Accountability</td>
</tr>
<tr>
<td>Case Study Two</td>
<td>• Achieving Compliance</td>
</tr>
<tr>
<td>Cluster three: <em>Chaotic</em></td>
<td>• Recovery focused or holistic approach to treatment</td>
</tr>
<tr>
<td>Maria</td>
<td>• The impact of the CTO on personhood</td>
</tr>
<tr>
<td>Case Study Three</td>
<td>• Family/Carer interests and involving families</td>
</tr>
<tr>
<td>Cluster three: <em>Chaotic</em></td>
<td>• A team approach to difficult decision-making</td>
</tr>
<tr>
<td>Joseph</td>
<td>• Maintaining continuity of care and reducing vulnerability</td>
</tr>
<tr>
<td>Case Study Four</td>
<td>• Power, authority and the use of coercion</td>
</tr>
<tr>
<td>Cluster two: <em>Young males</em></td>
<td>• Stigma, loss of personhood and strategies to enable recovery</td>
</tr>
<tr>
<td></td>
<td>• Family/Carer interests and involving families.</td>
</tr>
<tr>
<td></td>
<td>• Dealing with substance abuse.</td>
</tr>
<tr>
<td></td>
<td>• Poor engagement</td>
</tr>
</tbody>
</table>
The findings of the case studies indicate that the purpose of a CTO can vary depending on the CTO recipient. Common themes are particularly those related to the importance of families and carers, thoughtful decision-making and the impact of the CTO on the person. These themes will be considered again in later chapters as all the data sources are brought together to develop overarching themes. The divergent themes particularly refer to how the CTO is seen by the recipient. Joan is rather positive about her experience, Peter is generally ambivalent, Maria see the degree of coercion she experiences in her everyday life negatively and Joseph seems only vaguely aware of the implications of being on a CTO.

The case studies will be revisited in Chapter Eight after all the findings are presented, analysed and discussed and there is an opportunity to ‘test out’ the principles identified.
Chapter Six: Semi-Structured Group Interviews with Key Stakeholders: Findings and Analysis

Introduction

This chapter presents the findings of the semi-structured group interviews with four key stakeholder groups; consumers, carers, Mental Health Review Board (MHRB) members and managers and senior policy advisors. It was anticipated that each of these groups would provide a perspective on the implementation of CTOs and have their own ideas and observations about good practice from very different perspectives.

Key themes from each of the interviews are identified and are subsequently discussed. There are considerable similarities identified with the qualitative findings elsewhere, particularly for the consumer and carer groups. The opportunity is also taken to compare the findings of each interview. These comparisons enable the emergence of the common and divergent themes evident in the key stakeholder perspectives.

Consumer group

Introduction to the interview.

This interview was held at the mental health service and attendance was encouraged from the local consumer advisory group, the consumer consultants employed at the service and an invitation was extended to a mental health consumer advocacy organisation that was based in the local area but has a state-wide role. The interview was not confined to people who had been on CTO; it was also extended to those who thought they could provide a consumer perspective on CTOs. Six people who were current or past consumers of mental health services attended and one written
response was received from someone unable to attend but keen to address the questions.

Two people amongst the group had had direct experience of being on a CTO, two were consumer consultants and another two worked for the consumer advocacy organisation. Two of the participants were also involved in the local area mental health service’s consumer advisory group. All were confident that they could provide a consumer perspective because of their own experience and frequent contact with people on CTOs through both formal and informal support and advocacy roles. The written response was received from another consumer advocate. A summary of the raw data is provided in Table 16.

Table 16: Consumer Semi-Structured Group Interview: Nodes and Number of References

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td>System concerns</td>
<td>11</td>
</tr>
<tr>
<td>Disempowerment</td>
<td>9</td>
</tr>
<tr>
<td>Lazy psychiatry and part of the routine</td>
<td>8</td>
</tr>
<tr>
<td>Loss of agency or personhood</td>
<td>8</td>
</tr>
<tr>
<td>Flexibility and negotiation</td>
<td>8</td>
</tr>
<tr>
<td>Victim blaming</td>
<td>7</td>
</tr>
<tr>
<td>Overused resource management tool</td>
<td>6</td>
</tr>
<tr>
<td>Talking and Listening</td>
<td>6</td>
</tr>
<tr>
<td>Mask other problems</td>
<td>6</td>
</tr>
<tr>
<td>Therapeutic relationship</td>
<td>6</td>
</tr>
<tr>
<td>deskilling</td>
<td>5</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>5</td>
</tr>
<tr>
<td>Stigma</td>
<td>5</td>
</tr>
<tr>
<td>Reliance on depot and overmedicating</td>
<td>5</td>
</tr>
<tr>
<td>Coercion and power</td>
<td>4</td>
</tr>
<tr>
<td>Protection</td>
<td>4</td>
</tr>
</tbody>
</table>
In relation to the questions about the purpose of CTOs there was acknowledgement amongst the group that a CTO enabled a less restrictive option for many people, suggesting the relevance of the theme of “Comparative liberty”. As one participant suggested, with general agreement:

It is theoretically to get people out of hospital, but still receiving appropriate treatment.

There was also awareness that this extended beyond involuntary admission and into other potentially more restrictive situations, as illustrated below:

I also remember speaking to one person who felt there was a strong benefit being on a CTO, it worked for him in that he lived in a small community, you tended to relate better with police. You didn’t get entangled with the police. They automatically thought, right, CTO - and got him back in touch with the area mental health service. So he thought it was a benefit to him. He wanted to keep the CTO, because it helped him relate to the police, because it’s related to mental illness. Proof that it is related to mental illness rather than naughty behaviour.

This interview led to the identification of the new node labelled “lazy psychiatry and part of the routine” which appears to relate to the idea of CTOs being a product of psychiatric services being “overcommitted” to the use of CTO and increasingly demonstrating “reliance” on CTOs to ensure follow up of treatment in the community. It also represented either the lack of skill or gradual “deskilling” of staff as they increasingly rely on “coercion and power”. This group saw a lack of preparedness by
services to acknowledge and deal with how unattractive many of the treatments imposed on potential CTO recipients are. The following comment is typical:

It seems that often CTOs are used as a fast track way, rather than spending the time sitting down talking with the person, working out what treatment the person may be willing to agree to. Doing thorough assessments and really building up that knowledge. It certainly seems to me that a lot of people placed on CTOs, it’s not that they’re refusing consent to treatment, but that they believe that side effects of the medication that they are on is just not liveable with and that is just not heard. Sometimes it’s a sort of lazy psychiatry that puts people on CTOs.

And in summing up the issue of “lazy psychiatry and routine”:  

Some services they do become just become routine. You’ve been to hospital now its housing, given medication, a CTO, off you go. It can become too easy. 

This group of consumers was critically aware of the powerlessness of many CTO recipients (they frequently referred to “disempowerment”). They were also concerned about the degree to which, not only lack of skill contributed to the use of CTOs, but also resource limitations. They tended to see CTOs as an “overused resource management tool” as described in this quote:

Also my understanding of why people are placed on CTOs also has to do with the whole pressure that’s placed on mental health services generally at the moment. 

There was also a contradictory perspective offered in this context about “comparative liberty” with one participant wondering if facilitated discharge was actually in the best interests of people:

It’s very well known that there are people who are discharged on CTOs that aren’t ready to go yet - but Joe over here needs a bed more than this person. So we do that, and the CTO then becomes something it was never designed to be. It becomes a hospital outside a hospital...that is not good practice. If someone needs to be in hospital that’s where they should be – it should not be about bedscape.
Despite what may be beginning to appear to be a very critical stance, the participants, in the main, appeared to accept that CTOs were sometimes required to protect people. For example:

Whether that’s for their own care and protection, or the protection of the society. People could be a risk to themselves or others in the community if they didn’t receive treatment.

It was the process of how and why the CTO was implemented that tended to be of greater focus rather than the contested or opposing issues of whether people should or should not be placed on CTOs. They recognised the potential value of a CTO in establishing “mutual obligation” although it was suggested at one stage that “maybe the service should be placed on a CTO” in order to deal with the many “insurance policy” associations that were made about CTOs, including comments about ensuring that people in rural communities get access to services.

The reference to a number of “system concerns”, which also related to concerns about “lack of resources”, that this group raised is noteworthy. Many have already been mentioned above but participants also went on to discuss difficulties attached to having only 9.00 to 5.00pm services that were very problematic for any person on a CTO who was in the workforce. For example:

I get the feeling that this is quite a common problem because the service won’t budge, and it’s going to close at five o’clock. So after a while it’s the expectation that people who are on a CTO don’t work, and that’s the way it goes. People who are on a CTO must make themselves available for working people. The clash happens quite frequently.

The quote above relates to the common theme in this interview about the “stigma” and “loss of agency or personhood” associated with being on a CTO that this group had either experienced themselves or observed. They were also frustrated by the degree to which processes around the implementation of CTOs often suggested “victim
blaming”, that is, tending to place more responsibility for compliance with the CTO recipient:

And you don’t like the service; you think we’re damaging your life. Obviously doctors only do good things, so therefore you must be crazy.

When discussing what might represent good practice with people on CTOs it wasn’t surprising, on the basis of the above, that the consumer stakeholder group emphasised “flexibility and negotiation”:

Good practice would be real negotiation, even if you don’t have to, even if it’s ineffective. Good doctors try to get consent, even if they don’t legally need to. They still try hard to get consent. They don’t just say - well you’re doing this, you’re having an injection now... once I heard about five hours being spent (trying to convince someone to have their medication). One nurse in the training group felt empowered to say; well that was a waste of time. You should have just given it to him; it was a waste of five hours. But if you build a relationship, the nurse will never know, you find out things you’d never know.

The value of “talking and listening” was consistently identified:

Listening is such a simple thing. The number of times people ring up (our organisation) because they feel they’re not being listened to is incredible.

There was considerable agreement in the group with the person who said: “We are losing the therapeutic value of conversation...”.

There was concern amongst the participants about people “languishing” on CTOs so they were keen to suggest the value of having a “focus on discharge” as part of good practice as described below:

I believe it is possible for clinicians to adopt an attitude of health promotion. A manifestation of this would be that all therapeutic practice would be directed at achieving “non” Order status for each individual. This means all therapeutic interactions are framed by the five criteria for Orders, with a view to planning what needs to be done in order to come off them. It may be that the person is never able to demonstrate that they no longer fit the criteria and will remain on
an Order. But at least the clinician provides each and every opportunity to have the consumers’ preferences upheld and resources the consumer to regain control. Equally it becomes very transparent to both consumer and clinician on what grounds judgments are being made to keep someone on Orders, since their relationship is based on moving off them.

Other concerns in this group included the potential for a CTO to “mask other problems” and the problem as they saw it of “reliance on depot and over medicating”. They also discussed the potential of a CTO having a negative impact on the “therapeutic relationship” between the CTO recipient and the service providers.

In summary of the above and other responses made throughout the interview, according to this group of consumer stakeholders, a CTO is not a substitute for assessment, conversation and connection. They suggest that there should be an authentic process that is honest and does not attempt to mask other issues or problems. They recommend that people continue to have choices within the boundary of the CTO to enable some ongoing self determination. They are concerned about the lack of advocacy many people on CTOs experience and the degree to which there is a lack of genuine legal protection of people’s rights.

Four themes appear to predominate. They are:

1. Concerns that CTOs are too easily relied on and have become part of the routine
2. Criticism of the lack of flexibility of services
3. Concerns about CTOs being stigmatising and disempowering
4. Emphasis on medication and lack of reciprocity

Discussion of findings:

The above findings relate well to the following observation in the MacArthur Coercion Study (MacArthur Research Network on Mental Health and the Law, 2001):

The amount of coercion experienced is strongly related to a patient’s belief about the justice of the process by which he or she was admitted. That is, a
patient’s beliefs that others acted out of genuine concern, treated the patient respectfully and in good faith, and afforded the chance to tell his or her side of the story, are associated with low levels of experienced coercion (p.1).

It also supports the earlier findings of McDonnell and Bartholomew (1997) in Victoria that consumers complained that “nobody talks to you (p.31)” and “there is not much I can do to get out of psychiatric services (p.32)”.

Consumer stakeholders appreciated CTOs being a less restrictive option than hospital, but expressed frustration with the discharge process which appeared to lack consistency and transparency. They described a lack of reciprocity – that is, the onus was on the CTO recipient to “do the right thing” while the service did not have to do very much at all such as, for example, have after hours appointments or better medications with less side effects or staff more skilled at listening.

Dawson (2007) has discussed patient’s perceptions of ‘comparative’ liberty – the impact on negative liberty compensated for by positive liberty. But how can the right balance be achieved? As Dawson and his colleagues found in the comprehensive Otago CTO study conducted in New Zealand (Faculty of Law University of Otago, http://www.otago.ac.nz/law/otagoCTO/index.html) there were some subjects who were ambivalent about their experience, because they felt both coerced and supported by the order at the same time, acknowledging the capacity of the order to restrict and to advance their liberty, albeit in different ways, or at different times in their lives.

The findings above are also consistent with Brophy and Ring (2004) who reported that many consumers were poorly informed about their legal rights and that compliance with medication formed the primary basis to any decision about discharge. As with Brophy and Ring (2004) there is some recognition that consumers may see CTOs as a method of ‘fast tracking’ themselves into hospital if required in a crisis, or perhaps gaining access to resources. But the price of a CTO is that it had the propensity to be stigmatising and disempowering.

Consumers seem to consistently express concerns about the way CTOs are administered. Similarly there is also a general concern about the emphasis placed on medication as the primary, and sometimes only, treatment offered.
**Carer group**

**Introduction to the interview.**

This interview was held at the mental health service and attendance was encouraged from the local carer support group and the carer consultants employed at the service. The interview was not confined to people who were directly caring for someone on a CTO; it was also extended to those who thought they could provide a carer perspective on CTOs. Nine people who were current carers of a person with a serious mental illness attended.

For some of the people in the group, English was their second language and this contributed to some communication difficulties. In particular it was difficult to establish who had had direct experience with a CTO, partly because of the language barrier and it also appeared that some of the participants were unsure about the terminology and were generally unsure about whether their relative had ever been placed on a CTO. However, everyone in the group appeared to have had an experience where authority and compulsion had been used by mental health services in relation to their relative (usually in the form of an involuntary admission to hospital). At least two participants were able to clearly describe direct experience with a CTO.

**Themes in responses:**

A summary of the raw data is provided in Table 17.

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involving carers and family work</td>
<td>13</td>
</tr>
<tr>
<td>Carer Burden</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 17: Consumer Semi-structured group interview: Nodes and Number of References
<table>
<thead>
<tr>
<th>Topic</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery focused holistic approach</td>
<td>5</td>
</tr>
<tr>
<td>Emphasis on medication</td>
<td>4</td>
</tr>
<tr>
<td>Medication side effects</td>
<td>4</td>
</tr>
<tr>
<td>Good practice is good practice (warmth, genuineness and care)</td>
<td>4</td>
</tr>
<tr>
<td>Lack of skill</td>
<td>4</td>
</tr>
<tr>
<td>Team approach and collaboration</td>
<td>4</td>
</tr>
<tr>
<td>Talking and listening</td>
<td>4</td>
</tr>
<tr>
<td>Family/Carer interests</td>
<td>3</td>
</tr>
<tr>
<td>Keeping carers informed</td>
<td>3</td>
</tr>
<tr>
<td>Surveillance</td>
<td>3</td>
</tr>
<tr>
<td>Deal with or reduce substance abuse</td>
<td>3</td>
</tr>
<tr>
<td>Manage risk</td>
<td>2</td>
</tr>
<tr>
<td>Use of authority</td>
<td>2</td>
</tr>
<tr>
<td>Stigma</td>
<td>2</td>
</tr>
<tr>
<td>Relief</td>
<td>1</td>
</tr>
</tbody>
</table>

This group of carers identified acting in “family/carer interests” and relieving “carer burden” as key issues in considering the purpose of CTOs. This group also added a new node to the analysis entitled “relief”. The following quotation sums up this aspect of their perspective and also, in the context of the interview, received considerable support and agreement from other participants:

My boy was on a CTO for 3 years but going back about 7 years ago– I was really very relieved that he was on a CTO. He was acting out his delusions …He was really very ill, he was admitted involuntary, he was ill for 10 years before that without being in hospital; the medication had not been helping him. From his angle and the families angle it was a safety valve to be put on a CTO and it was a great relief to us and through that .. I was able to have a little more contact with his doctor because we are now going back a few years when there wasn’t much family involvement and my boy eventually learned to trust his doctor and there
was a trust between him and his case manager who really explained to him why it was he had to be on the order and how it protected him and his family and I saw it as a real benefit – not a government body forcing my son to take medication – I knew that without the medication he would be ill ..trust was built up with the case manager particularly and my boy..it led the way forward for newer medication.

Another carer in the group saw CTOs as connected with maintaining the safety and well being of their relative, even if this was very painful to see happening:

It is a most grievous thing. Our heart is broken, we just feel so disorientated. My conviction is that there must be the saving of a life because the life is of value and often it is taking it out of our home, our guardianship.

Generally the group tended to favour the use of CTOs and actually found the use of authority by the staff helpful. This appeared to be because it shifted the burden of having to coerce their relative into treatment from themselves to the doctor and case manager. However, there were concerns about both the “emphasis on medication” and “medication side effects”. The following illustrates one carer’s concerns:

My daughter had a ...situation with the psychiatrist pumping the girl with anti depressant – and the girl reached 140 kilos and he was still giving – the girl was not depressed. I have common sense, you don’t have to have fluent English – to have commonsense. So I thought the doctor was doing wrong ... they lost trust.

This carer went on to say:

I don’t expect doctors and Case Managers to be emotionally involved with our problems, but I expect them to show compassion, to show understanding and respect to my problems, to our problems and when I don’t see that then I become so angry.

The above supports the idea that good practice with people on CTOs needs to incorporate all the things that these carers associated with any “good” helping relationship. That is, that the staff should demonstrate “warmth”, “genuineness” and
“care”. Consistent with this, the group added another new node to the analysis, “lack of skill” and this was discussed in the context of the carer’s observations, and their frustration, when they came across staff who either didn’t seem to care or have the skill to properly assess the situation. For example:

Something came up, a question from the doctor, the case manager made a remark and a joke; about a serious problem we mentioned in a previous conversation, that shouldn’t have happened, you don’t use what you heard from these people to crack jokes. That’s terrible.

Carers in the group supported “involving carers and family work” as a key component of good practice and that is implied in many of the quotations above. They also referred to the value of “keeping carers informed”.

Carers generally expected treating teams to take a “recovery focused holistic approach”:

With the CTO, I see medication as step one, whether on a CTO or not, but then the recovery focus. The case manager or whatever, to expect the person to make progress then we have to work together.

As suggested in this quotation a “team approach and collaboration” was favoured by many of the carers and they also supported “talking and listening”.

A new node, introduced when analysing this interview, was “surveillance”. There seemed to be a common understanding amongst the group of the need to engage in surveillance of their relatives, when there was the possibility of non-compliance with treatment. The group was aware of problems engaging in “surveillance” created for family relationships:

But we tried to trust him. One day he goes to his bedroom he take his medicine, he don’t turn the light on, we see some under the bed—last night maybe he took but every night I check. We tried to trust him.
Another carer described the problems in trying to supervise medication or make sure their relative takes medication as “kind of like playing a policewoman”.

Carers tended to be concerned about substance abuse and had expectations that the CTO would “deal with or reduce substance abuse” and they also supported the CTO enabling the “use of authority” by the service providers involved. For example:

In my opinion, the doctors have got to control this matter.

Perhaps this also related to their own sense of powerlessness at times in the situation as described by another participant:

We have to be very careful when we speak to doctors. They have the authority. We cannot tell them what they can and can’t do.

This group of carers also described experiencing “stigma”, not necessarily related to CTOs as such, more in response to what was for some many years of supporting their relative with very little support from others:

Why are they doing this to my person with a feeling of shame that this happens? There is a sense of shame.

And:

My friends I have known them 20 years – I just say I’m fine, he’s fine.

In summary, a number of themes were evident in this semi-structured group interview although, with the assistance of coding, four themes appear to predominate. They are:

1. General support for CTOs, especially in enabling treatment and reducing family/carer burden,

2. High expectations about the use of authority and advanced interpersonal skills,
3. Poor quality of treatment and care and level of skill of service providers, and
4. Support for involvement of family/carers and keeping them informed.

Discussion of findings:

This semi-structured group interview suggests that carers of people with serious mental illness who may be the subject of involuntary treatment experience considerable contradictions. They give an impression of wanting treating staff to use authority in relation to their relative and generally support the use of CTOs. They appear to see a CTO as enabling clinicians to share some of the burden they experience in trying to get their relative to comply with treatment and reduce the risk that non-compliance with treatment represents to them. A general statement might be that they tend to weigh the best interests of their relative as of greater value than individualistic negative rights. But they appear to be troubled by the general lack of involvement of carers in decision-making and treatment planning, the lack of skill and sensitivity they observed amongst the service providers, the side effects and limitations of treatment and, at times, poor quality care.

Skegg’s (2002) Victorian based, qualitative research, had some very similar findings. She found that family/carers tended to support involuntary admission although reluctantly, especially if they saw the treatment as inadequate. This was especially related to issues around medication and unpleasant treatment environments. Another consistent finding is that, of the people Skegg (2002) interviewed, many tended not to understand the mental health legislation. One of Skegg’s (2002) findings was an appreciation that involuntary admission can be traumatic for carers and that they were relying on the skills of staff and an appropriate level of care to mediate this potential trauma, but this was subsequently not their experience. They found that often their relative was not experiencing the standard of care they expected and there was minimal assessment. This is also consistent with Hallam (2007)’s study of carers in Queensland. It appears that the above analysis adds some support to these findings. Carers may see
the necessity for control and containment and may engage in some of this themselves, particularly through the use of surveillance, but they experience ambivalence about this when the quality and standard of treatment does not fulfil their expectations.

Carers in this group also supported the need for a more holistic approach to treatment and bemoaned the emphasis on medication. My understanding of a holistic approach, as discussed by the carers and others in this study, is the notion that people on CTOs will be recognised as a whole person in their environment with a range of strengths, limitations and needs. A holistic approach suggests the need for intervention goals that relate not only to the person’s symptoms and mental illness but also their relationships, activities, accommodation, employment and so on (Bland & Renouf, 2006).

Carers also wanted to be respected, involved and listened to and this is consistent with findings by Gibbs, et al. (2004) amongst Whanau (Maori Family/Carers) in New Zealand, Hallam (2007) and others summarised by Churchill, et al. (2007). They were greatly relying on the skills and experience of service providers and seemed to be often disappointed at the standards of practice they experienced. Even so, they were also able to provide examples of what they saw as very good practice which appeared to relate to the building of positive relationships and trust.

There were some limitations to the interview, particularly the language barrier at times and the lack of many participants having clarity about CTOs. However, the group was very enthusiastically attended and there was considerable discussion that had to be closed after over 60 minutes and could well have gone on for longer. As the interview progressed and personal stories were shared, the participants were able to relate well to the concept of a CTO and, even those without direct experience (at least that they could recall) could readily contribute to the discussion.

The new nodes that this interview introduced, particularly those around the CTO providing these carers with relief, sharing the burden and reducing their need to engage in surveillance of their relative, are of interest. This interview confirmed what was previously discussed, particularly in Maria’s case, about how carers can also be a source
of authority and/or coercion in relation to trying to provide leverage into treatment (Groff, et al., 2004). This appears to also link back to CTOs being in the interests of carer/families in that they can sometimes help with, if not relieve, the burden of having to care for someone who would otherwise refuse treatment and also the burden of trying to ‘police’ this situation (Groff, et al., 2004; Hallam, 2007).
Mental Health Review Board Members

Introduction to the interview.

This interview was held at the offices of the Mental Health Review Board (MHRB) and attendance was encouraged from any interested Board members. The MHRB is made up of legal, psychiatrist and community members. Eight members of the Board attended: three legal members, four community members and one psychiatrist member.

All participants in this group had direct experience in hearing reviews or appeals in relation to CTOs and they ranged in experience on the Board from fifteen years to two and a half years. The interview was held for approximately 90 minutes. Like all the key stakeholder interviews, it could easily have gone for much longer with considerable ease in generating discussion and interest in the topic in general.

Themes in responses

A summary of the raw data is provided in Table 18.

Table 18: MHRB Semi-structured group interview: Nodes and Number of References

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good practice is good practice (warmth, genuineness, respect, rapport and care)</td>
<td>9</td>
</tr>
<tr>
<td>Languishing</td>
<td>7</td>
</tr>
<tr>
<td>Managing resources</td>
<td>6</td>
</tr>
<tr>
<td>Research evidence or information</td>
<td>6 (new node)</td>
</tr>
<tr>
<td>Lack of continuity of care</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>--------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Volunteers for compulsion</td>
<td>4</td>
</tr>
<tr>
<td>Lack of skill</td>
<td>4</td>
</tr>
<tr>
<td>Lack of communication</td>
<td>4</td>
</tr>
<tr>
<td>Lack of adequate review</td>
<td>4</td>
</tr>
<tr>
<td>Procedural fairness</td>
<td>4</td>
</tr>
<tr>
<td>Least Restrictive Option</td>
<td>3</td>
</tr>
<tr>
<td>Acknowledging complexity and individual difference</td>
<td>3 (new node)</td>
</tr>
<tr>
<td>Emphasis placed on risk</td>
<td>3</td>
</tr>
<tr>
<td>CTO and receiving help</td>
<td>3</td>
</tr>
<tr>
<td>Relentless</td>
<td>3</td>
</tr>
<tr>
<td>Thoughtful decision-making</td>
<td>3</td>
</tr>
<tr>
<td>Focus on discharge</td>
<td>3</td>
</tr>
<tr>
<td>Defensive practice</td>
<td>2 (new node)</td>
</tr>
<tr>
<td>De-skilling</td>
<td>2</td>
</tr>
<tr>
<td>A difficult job/dedicated staff</td>
<td>2</td>
</tr>
<tr>
<td>Involvement of carers and family</td>
<td>3</td>
</tr>
<tr>
<td>The role of case managers</td>
<td>1</td>
</tr>
</tbody>
</table>

This group of Board members appeared to generally see the use of CTOs as providing a “less restrictive option” for involuntary treatment. This was described by one participant as follows:

So the CTO as I see it and I think as it’s practiced most commonly, besides those extra situations, is that you’ve got people who are ill, they need the treatment, they don’t have the sufficient insight to be able to agree to have the treatment as they require it and sending them out on a CTO is the least restrictive way of treating them.
The participants tended to agree that they came across a wide variety of consumer experience with CTOs. This ranged from people who seemed to actually want to be on a CTO (what has been described as “volunteers for compulsion”) thus appreciating the safety net it provided for them, through to those who found CTOs to be a very negative experience. The topic of “acknowledging complexity and individual difference” was apparent throughout the interview and represented a new node for this group. The following quote helps to illustrate this:

There are so many different things that can happen in a case study or a person’s journey so there’s so many variables. Some people like being on CTOs and their carers like having them there and some people don’t have any carers and are very angry and upset about being on a CTO. So it’s just a wide spectrum. Some people it suits to be on a CTO for a length of time and their degree of insight is such that they know that they need to have another motivation other than just themselves and other people, like I say, are so upset and angry at the whole time. There’s a lot of variables.

In relation to the purpose of CTOs another new node was introduced by this MHRB interview, that of “Defensive practice”, a node that seemed linked to the “Emphasis placed on risk”:

And this all kind of relates back to J.’s point which is the idea that not letting risk become an overarching decision-making factor, but actually using risk to guide maybe getting information but not necessarily being a factor that becomes so huge in your thinking that other potential kind of avenues are ignored.

The MHRB members were concerned about the degree to which the use of CTOs related to “managing resources” and this appeared to be in two different ways. Firstly to manage scarce inpatient beds:

To enable people to come in to the hospital because there’s always bed shortages. So the fact that people go out sometimes too early on a CTO is because of the stress of the need to find beds for those people to come in to hospital.
And secondly to ensure a pathway back into hospital if required:

The justification that’s sometimes presented by the mental health services is that if somebody is on a CTO they say it’s easier for them to have the patient readmitted if the need arises. It’s never clear to me why exactly that is so; as far as legislation is concerned it shouldn’t really make any difference.

These comments relate to the common issue raised in this semi-structured group interview about the link being made, or observed by MHRB members, between being on a “CTO and receiving help” and participants expressed concern that perhaps this was an inappropriate purpose or reason for use of CTOs:

And the reality is that it does worry us sometimes that we frequently ask “now if that person is not on a CTO will they get all the things you’ve said in the treatment plan?”.

In regard to the questions that asked MHRB members to consider their observations about what it was like for people to be on a CTO, they again emphasised the diversity in both experience and outcomes. However, two issues emerged as common concerns. The first was frequent reference to seeing some people “languishing” on CTOs and the other recognised how seemingly “relentless” CTOs could be. For example:

Those that I find hardest to deal with are those that are sort of some years out and it just sort of ... it’s really hard to know what you’re looking at. There seem to be some where it’s just ... it’s being rolled over and over in the system. There’s been so ... huge number of changes in the personnel in the psychiatric service over that period of time and somebody has a view that it’s really safer for this person to remain on a community treatment order, although there hasn’t been any sort of major upsets or renewal of their very florid symptoms.

Participants related these concerns to the current length of CTOs in Victoria:
The other thing to consider is that the CTOs in Victoria are, as I understand, comparatively long, I mean, they’re generally 12 months and that compared to some other jurisdictions is very long. So it’s interesting in terms of looking at less restrictive options how people come out with the expectation that kind of a 12 month period which is pretty long.

And the fact that the maximum is 12 months under the legislation, Victorian legislation probably does kind of set up this thinking we’ll do it for 12 months, you know, the fact the legislation says the maximum period is 12 months.

Although one member was inclined to think that shortening the length of CTOs may not be helpful in changing the problem of lengthy and possibly inappropriate use:

On the other hand, we’re nearly always extending them and extending them and extending them, so making them shorter isn’t really going to have any difference.

Why people remained on CTOs for very long periods and were frequently having their CTOs extended was a source of concern to the participants and they appeared frustrated by this phenomenon and at times unconvinced it was solely about the characteristics of people on CTOs, instead relating the problem to process, treatment and systemic issues:

Obviously sometimes there are answers to that (people needing to stay on CTO) but sometimes you just get the feeling that the CTO is being used for passive treatment rather than active treatment.

“Lack of skill” or staff apparently being “de-skilled by CTOs” relates to these frustrations:

You get the impression that again that continuing the CTO is with some services has got something to do with resources. That if a bit of effort was put in with this particular person it might be possible to persuade them of the need to continue their treatment without being on a Community Treatment Order.
Participants saw poor practice demonstrated in an emphasis on medication, inconsistency and sometimes “lack of communication” and the following two quotations summarise these concerns:

In relation to CTOs I’d be telling treatment teams that ostensibly they’re meant to be temporary things until the person can wrench back that control over their treatment and to not underestimate the value of the experience of the consumers and the carers and, you know, they are an expert in how their illness affects them, how the drugs, how they react to certain medications and if that’s not listened to, if you have an arrogant psychiatrist, which there are a few, if you have that sort of attitude that I’m the psychiatrist you will do this and this is the drug you’re going to take and I don’t care about the side effects that you’re talking about.

That would be one of my two points that I would make. I mean, the thing I hear most often is the patient hating the medication they’re put on. Sometimes they don’t want any, sometimes they want to try something different that they know about and that can be used or that has in the past been used. And it is very rare to see that mentioned in the treatment plan even though the act says that the treatment plan must make apparent that the patient’s wishes have been taken in to account. So I have a few times sort of sent the treatment plan … said it was not satisfactory. They really don’t seem to hear that quite often.

Participants in this interview generally agreed that it would be useful for them to have increased knowledge about “research evidence or information” about the use of CTOs. They tended to identify a number of gaps in their knowledge about the impact of their decisions and the implementation of CTOs such as follows:

That would be a very interesting statistic if you’re considering the question of whether CTOs should be shorter and you were to find out that 80% are renewed after … extended after 12 months well that would rather take away the grunt for arguing that they should be shorter in the first place, wouldn’t it?

But they did notice a lack of consistency in the implementation of CTOs:

It depends on the particular region, where the clinics are as to how those treatment plans are being used.
And at times a “lack of continuity of care”:

And that lack of continuity of the treating team and sometimes in the reports you’ll see someone will say well there was an incident with a knife or something and you ask about it and it was 20 years ago. That sort of thing because sometimes ... I mean, often the case managers are really good and they can give you ... they do know the patients but so often the doctor won’t and so they’re just picking up bits of history from the file. And I think sometimes we get fairly poor evidence, it’s just bits and pieces that suit their case that are perhaps pulled out and not other things that might be relevant.

And their own practice in relation to providing an “adequate review”:

About 97% of the time we confirm it. And I worry sometimes that I become more conservative in my decision-making the longer I’m on the board.

In terms of good practice, what MHRB members appeared to appreciate most was when they observed “thoughtful decision-making” and a “focus on discharge”:

Well, that’s what J. L. (the MHRB president) always says, some of our best work is done when we’re not there because we’re focusing the treatment teams’ minds on the criteria.

And I think the culture, you know, the culture of the place that can vary and in some ... you know, you can be surprised some days to see there’s quite a few CTOs that are only six months for example and sometimes doctors ... you know, it’s clear that sort of doctors are thinking occasionally when representing they will very much look to getting someone off the CTO. So perhaps the culture can vary a bit from place to place I wonder also.

In this interview MHRB members were at times critical of mental health staff but they were also aware of how difficult their job often was. This represented only one coding reference but achieved considerable agreement from the other participants:

There’s also the opposite side of all of this and I’m often impressed by the fact that services persist with particularly difficult patients. You know, people get threatened, staff get threatened, they get bashed, they get reported here, there
and everywhere and I am often really impressed. The easiest way of dealing with this would be to discharge them.

And:

Particularly where there’s a lot or risk, you know, where there’s a risk factor I think, where there’s a possibility of litigation if they discharge people, but when the patient is antagonistic and difficult and they do their best and often we shouldn’t be too critical of the service.

Ideas about good practice were consistent with what have been identified by the researcher as established ideas about the helping relationship and good practice, that is, being “caring”, “genuine”, developing “rapport” and attending to “relationship” issues and also displaying “respect”.

MHRB members also supported the “involvement of carers and family” as discussed below:

And services differ in that some services are very prescriptive, you must do this, you must do that, and others are more caring in their attitude and they bring people in, they’ve involved the carers and they involve the client themselves in making up the treatment plan.

They also discussed the value of “procedural fairness”:

Like B. said before, it’s good to remind the treatment team in front of everybody at the hearing that they can be taken off it at any time by the treatment team prior to that 12 months too. When that’s said, you know, raised a bit of hope for the person that they’re not going to be on it for the full 12 months and it reminds the treatment team that yes we do have that power and that we can exercise it.

Another comment which received support from other participants was made about the role of case managers:

Actually the case managers are a very impressive group of people I think and increasingly so.
In summary, a number of themes were evident in this semi-structured group interview although, with the assistance of coding, four themes appear to predominate. They are:

1. Concerns about a lack of resources and CTOs being used to deal with systemic problems.
2. Recognition of the need for advanced skills and compassion.
3. Frustration at the lack of consistency in standard of care, access to procedural fairness and treatment planning.
4. Request for guidelines, feedback and research evidence to improve decision-making.

Discussion of findings:

This group of MHRB members appears to be experiencing considerable dilemmas when it comes to the administrative review of CTOs. Perhaps their position sums up a key tension in relation to CTOs. This tension is represented by, on the one hand, supporting CTOs because they enable continuity of care in a least restrictive environment that does not exclude people who are perceived as difficult and/or risky, juxtaposed with a CTO acting as deskilling instrument that threatens people’s rights and potentially their well being.

Board members appear frustrated with their lack of ability to effect real change in standards of care, even though they provide strong evidence in this interview for having a keen eye for both the strengths and weaknesses in the mental health system when it comes to the experience of people on CTOs who come before them and their treating teams. They were able to identify cultural differences between services and varying standards of practice across the state.

The support for the role of case managers and increased communication between service providers and recipients is consistent with Brophy, Campbell and
Healy’s (2003) findings that case managers, although they may experience some dilemmas in their role, can make an important contribution to MHRB hearings. The concerns about people “languishing” on CTOs appear to be consistent with findings elsewhere in the literature, discussed in earlier chapters, that suggest the length of a CTO is important (Dawson, 2005).

The MHRB members consistently expressed their concern about systemic and structural issues impacting of whether a person was placed on a CTO and whether they remain on one. Again this has been highlighted elsewhere (see Chapter’s one and two) and concerns have been expressed that CTOs are being over used in Victoria (Dawson, 2005).

These findings suggest that it is very difficult for MHRB members to generalise about their experience with CTOs in relation to what impact they have on consumers and how they are being implemented. However, it was this very complexity and variation that they were able to agree upon. This appears to support the findings of this studies’ cluster analysis that gave recognition to the idea that CTO recipients in Victoria appear to be a diverse group who are on CTOs for a variety of purposes. However, as the responses in this interview suggest, the variation in the characteristics of CTO participants only partially explains differences in implementation. It appears that systemic factors are important. Mullen, Dawson and Gibbs (2006) note that some clinicians have concerns that:

CTOs will not be used primarily to advance the interests of patients, but to reduce family or public concern about deinstitutionalisation, or concerns about the risk of violence, or that they may constitute a form of defensive medical practice (p.537).
Senior Managers, Executive and Policy Advisors

Introduction to the interview.

This interview was held at the offices of North West Area Mental Health Service (NWAMHS). Attendance was encouraged from any interested senior managers, area executive members (such as discipline seniors and senior medical staff) and policy advisors from the Mental Health and Drugs Division of the Victorian Department of Human Services. Twenty four people were sent invitations to the interview and ten people were able to attend. Two were from the Mental Health and Drugs Division; two were discipline seniors (one nursing and one social work), three program managers plus the area manager and a senior consultant psychiatrist who was the deputy director of clinical services.

This entire group had direct experience in reviewing the quality of services provided to people on CTOs. All were senior staff with considerable experience in mental health services in a range of professions including psychiatry, nursing, social work and psychology. The interview with this group was held for approximately 70 minutes. Again, like all the key stakeholder interviews, it could easily have gone for much longer with considerable ease in generating discussion and interest in the topic in general and these questions in particular. At the end of the interview a short presentation of my preliminary findings was undertaken and considerable interest and engagement was apparent amongst the participants.

Themes in responses:

A summary of the raw data is provided in Table 19.

Abbreviation will be “senior managers”
Table 19: Senior Managers, Executive and Policy Advisors Semi-structured group interview: Nodes and Number of References

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of references</th>
</tr>
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<tbody>
<tr>
<td>Continuity</td>
<td>15</td>
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<tr>
<td>Carer/family interests and reduce carer burden</td>
<td>8</td>
</tr>
<tr>
<td>Maintaining regular contact and routine</td>
<td>7</td>
</tr>
<tr>
<td>Good practice is good practice (warmth, genuineness, respect, rapport and care)</td>
<td>7</td>
</tr>
<tr>
<td>Mutual obligation/mutual accountability</td>
<td>6</td>
</tr>
<tr>
<td>Thoughtful decision-making</td>
<td>5</td>
</tr>
<tr>
<td>Use of authority</td>
<td>5</td>
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<tr>
<td>Case Managers role</td>
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</tr>
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<td>Less restrictive option</td>
<td>4</td>
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<tr>
<td>Containment and Structure</td>
<td>4</td>
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<tr>
<td>Achieving compliance</td>
<td>3</td>
</tr>
<tr>
<td>Minimising the use of coercion</td>
<td>3</td>
</tr>
<tr>
<td>Procedural fairness</td>
<td>3</td>
</tr>
<tr>
<td>Authenticity and transparency</td>
<td>3</td>
</tr>
<tr>
<td>Talking and listening</td>
<td>3</td>
</tr>
<tr>
<td>Worker empowerment</td>
<td>3</td>
</tr>
<tr>
<td>Flexibility and negotiation</td>
<td>2</td>
</tr>
<tr>
<td>Harm minimisation</td>
<td>2 (new node)</td>
</tr>
<tr>
<td>Recognise patterns and undertake good assessments</td>
<td>2</td>
</tr>
<tr>
<td>Set limits</td>
<td>2</td>
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<tr>
<td>System concerns</td>
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This group acknowledged that CTOs provide a “less restrictive option” for involuntary treatment and the following comment provides a simple summary of this:

Well that’s the legal framework is providing involuntary treatment in the least restrictive environment really. I guess that’s the legal purpose of it.

Another related response goes beyond the legal framework and addresses more about the reality of practice and what being in a less restrictive environment might mean:

That seemed to be a very powerful message to consumers about, you are sick so we do need to see you, and you haven’t been really that great in coming in. We’ve made you come. This is a way of us getting our needs met but also respecting the fact that you are a person, who has a family, who has a home, and who actually might be doing some other activities that are quite meaningful that keeps you well. There’s that sort of balance.

This participant’s reference to “getting our needs met” relates also to the emphasis and recognition this group generally gave to “mutual obligation” or “mutual accountability”:

Also it puts an obligation back on the services to make sure that the treatment and the care is provided in a timely manner. And followed up. The onus not only on the client but also on the service to put in.

Like many other respondents, this group of senior managers identified “achieving compliance” as an important justification for CTOs:

It’s fairly explicitly about trying to enhance adherence to treatment plan, adherence to medication.

They also added support for CTOs being implemented in the “Family/Carer’s Interests” and/or reducing “Carer burden”:
Over a number of months the level of distress for the families was significantly reduced because they’d had months and months trying to care for someone in the community, and they were quite disturbed in their behaviour. So you give the family a break, you give them some respite, you give them some support. Their experience is a bit better. You’re giving the person six or seven month’s worth of treatment and generally some sort of level of insight or understanding.

“Containment and Structure” was a topic that was discussed at length by this group and achieved considerable support as a valid purpose for CTOs:

I think I’d say a framework for the person to provide treatment. I know it’s got a legislative framework but the order itself from my experience provides a framework for the person who’s on the order, the client or the patient that’s on the order to provide treatment. And sometimes the order has been enough actually even on its own. I can think of certain individuals that that actually holds a whole lot of things together like a relationship or the service prevention of relapse, all that sort of thing. And a ready mechanism to get back into acute treatment if that becomes necessary. Sometimes without that frame around the person then they’re more likely to disintegrate clinically. It’s sort of the non-legal context.

But one participant recognised that it was a potential source of criticism of CTOs in the context of concerns about the amount of pressure on the system and potential to rely on CTOs:

It’s the earlier point about if you don’t have the legal compulsion, then what you’ve got to do is go out and engage people who are not compliant or have no insight or whatever. You’ve got to spend a lot more effort because to some small part, the CTO is a tool to engage people. So if you don’t have the tool doing that, you’ve got to put a whole lot of effort into doing that. And ideally you should do that anyway, but...

Another participant:

It will cost more.

Achieving “Continuity” was seen as valuable to this group both in relation to the purpose of the CTO and in relation to what represents good practice with people on
CTOs and this was an almost equally common factor in responses about what might represent poor practice:

I think it’s a way of just stopping people slipping through the cracks. There are more firm arrangements.

And:

You stick with it. You stick with them, you don’t disengage from them, you take some of the nonsense, you take some of the bad behaviour. You put it back to them. You put it in a framework of there’s not a lot I can do about it, but let’s work with it and let’s make the best use of it. Let’s stick with it. I believe as a nurse that’s how I would work with somebody.

“Continuity in practice” and “maintaining regular contact and routine” were discussed in some detail when it came to the question of whether there was a particular standard expected about how often someone on a CTO should be seen. There was general agreement with the following response:

The thing is that the relationship can replace that and it’s not necessarily about how often they’re being seen. Continuity is arguably more important than frequency.

There was a related discussion about the problems attached to both being able to retain staff and also the problems of the six month rotation of psychiatric registrars (who are usually the treating doctors):

I think if we had mental health services where all of our doctors were permanent and didn’t rotate every six to 12 months, there would be a section of people currently on CTOs who over the process of a couple of years build up relationships with their doctor that would be sustained because the doctor is sustained and they’d be able to come off the CTO. The group then highlighted the value of both the case manager and the authorised (or consultant) psychiatrist’s involvement acting as a potential antidote to this problem:
But that’s not solely a registrar’s decision to take somebody off. The registrar will work along with the case manager and take advice from the case manager about how things are going and the case manager’s perspective. It is about that team approach. It’s not just down to the registrar whether somebody comes off. Ultimately they make the representation, but that’s based on all the information and all the support from the team.

And:

It could be argued that that’s where you do need some sort of minimum frequency of contact built into it. It’s not about how often the case manager or the treating doctor sees them, but there would be an argument about how often the psychiatrist who’s monitoring the treatment sees the person. Because that’s the person who actually needs the continuity to be able to make those decisions.

The emphasis on “containment and structure” and “continuity of care” also related to the group’s acknowledgement that CTOs can be “protective” and this group introduced a new node, that of “harm minimisation”:

I hope I’m being clear here, what I’m saying is I’ve had this experience with a couple of people. They haven’t been on CTOs and have slipped through the cracks and ended up in hospital for three to six months or longer because they’ve deteriorated so rapidly. But then following that they’ve been on a CTO and as (another participant) was saying before, their illness has been detected or their relapse has been detected earlier, and they might only spend a week in hospital, or two weeks to get back on track or back on medication.

“Flexibility and negotiation” were recognised as important aspects of good practice and this related to a potential list of other goals for good practice, particularly the importance of “minimising the use of coercion”, “procedural fairness”, “authenticity and transparency”, “talking and listening” and “thoughtful decision-making”. What was highlighted and new for this group, especially when it came to the need for “thoughtful decision-making”, was an expectation that the CTO would be implemented assertively. For example:

It’s about necessary treatment. That’s sort of the crux of it, one of the risks that I see, the poor practice things is you see that dilemma that clinicians are faced with every day. They want to operate within the least restrictive framework, but
they’ve got someone who wants to come off an order, who wants to have their medication reduced, who wants to come off depot onto oral, and they’re in this bind the whole time and it’s a daily struggle and a constant pressure. From where we sit we see that sometimes people succumb to that, and so one of the less effective things is when there’s not enough assertion in the treatment. So when people aren’t clear about this, I have to do this, this is my responsibility for this patient. So the threshold for risk and taking risk goes up all the time.

Another topic this linked with was “use of authority” and “worker empowerment”:

I think even those clients who don’t have insight into mental illness occasionally get to understand it if they are on a CTO and don’t do what’s expected of them and comply, then they’re back into hospital. So even though they don’t gain insight, there’s almost a behavioural component to a CTO which they learn reasonably quickly that if they don’t take medication, if they don’t see a case manager, they don’t come back and see a doctor. Then at some point they return to hospital. In some cases, that’s actually not a bad thing, even if they don’t get an insight, but at least they’re treated and not causing distress and not at a risk to themselves or their family.

At one stage, this group was prompted to consider the impact of being on a CTO with the question “What do you think it would be like to be on a CTO?” and this generated a lively response in the context of the interview when at least one participant admitted that they would find it distressing. It provoked the following comment:

That’s where if you don’t walk in their shoes, and we all talk about what are they losing and what’s the impact of putting this legislation on them? If we don’t walk that line there, there’s a real huge percentage of people resisting, pushing back, being traumatised by the whole experience. Ending up in hospital eventually with their backs to the wall basically and feeling against the service, because it’s all been done to them.

The group strongly supported case managers in what they saw as the important work they do with people on CTOs, as described earlier in relation to continuity of care. This was extended also to recognition of their role in engagement, enabling a holistic approach and attending and contributing to MHRB hearings. They discussed the
problems attached to the potential for different ideas about what the role of the case manager was at a hearing and they generally concluded that it was not appropriate for case managers to be advocates at hearings. However, they all agreed that a case manager can assist in ensuring that the voice of the person on a CTO is heard through providing support and assisting the CTO recipient to gain some form of advocacy:

P1: They do have a role in advocating for the client. I would argue, I mean I don’t think clients are particularly well represented in these hearings.

P2: No.

P3: They don’t have enough advocacy. I think that the case manager involvement may help to ameliorate part of that. That’s not really the case.

P4: I don’t think the case manager’s there to advocate for the person. That’s a conflicted role then. They’re part of the treating team, and if the person needs advocacy then there are other ways of doing that.

P5: Maybe the case manager’s in a better position to organise advocacy for someone.

P4: Yes absolutely. I think that in fact is clearly their role. Not to necessarily organise it, but raise it as an issue and point the person in the right direction. Help them move along in the right direction if they need to. I think there’s a difference though between advocacy and support so they could be at the hearing providing some moral support to the person, but I don’t think that’s advocacy, I think that’s something else.

A number of factors were recognised as part of good practice and many of these are already mentioned. These include being able to maintain “rapport” and a good “relationship” with the CTO recipient while also being able to “recognise patterns and undertake good assessments” and “set limits”. These were all integrated into this group’s perception of good practice and the quote below helps illustrate this:

I have found with some consumers that that’s actually helpful (setting limits). To be able to give the message, just actually demonstrates a caring and a response to a person’s needs, whether they see it or not. The fact is they do have an illness, their insight is scarce and that you’re able to just talk through it. That’s just our bread and butter. That’s why people are on involuntary treatment orders. Whether they are in the community or they’re in the inpatient unit. So even though there’s a difference of opinion between the client and the service,
the service is demonstrating its commitment and willing us to work with a person and to support them ..to stop them getting sick again.

Finally one group member in particular raised concerns about whether too much focus was placed on the value or problems attached to CTOs when actually these were systemic issues that were not necessarily related to CTOs:

For me, and I’m sorry, this is a bit of a distraction, but for me the CTO itself is this thing. It’s like a skeleton or a framework. A very simplistic thing. When you read it in the Act it’s only a couple of pages. And then all the things you’re talking about which you’re hanging on the hook of CTO about turnover and engagement teams and treatment plans and all these sort of things. They’re all issues that aren’t particularly related to the CTO. We’ve got this consumer who we want to provide treatment to and the CTO is this little tool, but all the problems of rotation would be the same if the person was not on a CTO.

In summary, a number of themes were evident in this semi-structured group interview although, with the assistance of coding, the following themes appear to predominate. They are:

1. Support for continuity of care and reducing risks
2. The value of case managers and consultant psychiatrists in thoughtful decision-making
3. Good practice is building rapport and taking a holistic approach, plus worker empowerment and use of authority
4. Awareness of resource or system issues including lack of advocacy.

Discussion of findings:

This group of stakeholders, who generally had an overview in terms of their perspective on CTOs, seemed critically aware of many systemic issues and problems in their implementation. It could be argued, on the basis on the findings of the above analysis, that it is primarily systemic issues that drive their support for CTOs as reflected by the emphasis placed on continuity of care and mutual obligation. So what does
continuity of care actually mean? And why is it so important to this group? One formulation is that providing continuity is a manifestation of risk management and its emphasis in the interview is consistent with what Green (2007) has described as “the rise of risk” (p. 397). In this case the risk appears to have arisen in the context of a potentially fragmented and programmatic service structure where consumers can become lost or can easily chose to “drop out” even when this is not seen as in their best interests and where this might represent a risk to themselves or others. Therefore, to prevent the potential for deterioration in functioning and even dangerousness that can result from lack of treatment (Fuller Torrey & Chamberlin, 1999), CTOs form part of a package of risk management strategies aimed at ensuring continuity of care. The concern is more evident for this group because, as they indicated, they have responsibility for ensuring appropriate use of resources and maintaining standards of practice that are reflected in continuity of care and reduced acute service usage.

This group added a new dimension in many ways to the question of good practice in emphasising authority and worker empowerment. Again, Green (2007) helps to understand this in broader terms through identifying how the rise of risk increases the emphasis on responsibility and obligation. Green (2007) suggests:

Not surprisingly this experience increasingly defines the practice context for social workers, now having to resolve competing professional, administrative, ethical, and political interpretations of their client’s freedom and choice while managing objective dangers and identified risks in complex community settings. (p. 178).

The discussion about case manager involvement in MHRB hearings, which has been considered elsewhere (Brophy, et al., 2003), again appears related to this important issue of continuity of care, ensuring that the MHRB has the correct information from the person who has potentially the closest clinical relationship with the person appearing before the Board and is therefore able to provide an informed opinion about the appropriateness of the CTO. The discussion about the potential of ‘muddying the waters’ by also acting as an advocate for the client has also been
considered by Healy and Brophy (2001) who predicted that social workers may sometimes be at risk of being caught up in an advocacy role through both other advocacy not being available and the consequences of not being open, transparent or authentic with the person on CTO about their contribution to the decision-making. As a participant in this interview described, there is the potential to have a ‘good cop, bad cop’ situation that is potentially detrimental to the development of collaborative relationships for all involved. As suggested in the interview, and by the others (Carney, et al., 2008) it seems that an important strategy here is for the treating team, and particularly the case manager, to ensure that advocacy is available.

However, as the recent review of the Mental Health Act 1986 has described, there are deficiencies in the availability of advocacy in Victoria as well as concern that patients under involuntary treatment orders are not necessarily fully aware of their rights, a factor that may contribute to a lower uptake of advocacy options (Department of Human Services, 2008b).

The findings here about CTOs being an expression of the commitment of the service as much as the CTO recipient, are consistent with findings elsewhere (Brophy & Ring, 2004; Geller, et al., 2006; Gibbs, et al., 2006; Swartz, et al., 2006; Swartz, et al., 2003).

The findings about encouraging engagement and using the CTO as a tool for compliance appears very similar to the discussion of CTOs being effective for those who are able to be persuaded by them (Power, 1999). Similarly, the idea of a CTO providing a ‘structure’ to enable treatment and care is similar to comments made by a group of psychiatrists and other mental health clinicians surveyed in New Zealand (Romans, Dawson, Mullen, & Gibbs, 2004).

The concerns expressed here about whether CTOs would be necessary if the service system were better developed and more responsive to the needs of consumers is discussed by Dawson and Mullen (2008). They argue that the common problem of lack of insight may account for ongoing non-compliance and lack of cooperation with services even if this is offered assertively and intensively. Hence the argument is made
that a CTO may actually assist in gaining insight although this is not strongly established in research (Dawson & Mullen, 2008).
Comparisons of findings from four key stakeholder semi-structured group interviews

All groups appear to have been supportive of the use of CTOs in offering a form of “comparative liberty” (Gibbs, et al., 2005) or an opportunity for less restrictive treatment. The theme of relieving family/carer burden or generally seeing CTOs as in the interests of family/carers also seems to be a common thread. As detailed below in Table 20, a comparison of each of these group interviews suggests that there are common and divergent themes.

Table 20: Comparison of key themes from Four Key Stakeholder Semi-Structured Group Interviews

<table>
<thead>
<tr>
<th>Consumers</th>
<th>Carers</th>
<th>MHRB</th>
<th>Senior staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Concerns that CTOs are too easily relied on and have become part of the routine</td>
<td>- General support for CTOs, especially in enabling treatment and reducing family/carer burden, - High expectations about use of authority and advanced interpersonal skills, - Poor quality of treatment and care and level of skill of service providers</td>
<td>- Concerns about a lack of resources and CTOs being used to deal with systemic problems. - Recognition of the need for advanced skills and compassion</td>
<td>- Support for continuity of care and reducing risks</td>
</tr>
<tr>
<td>- Criticism of the lack of flexibility of services, lack of advocacy and information about rights</td>
<td>- Concerns about CTOs being stigmatising and disempowering</td>
<td>- Frustration at the lack of consistency in standard of care, access to procedural fairness and treatment planning.</td>
<td>- The value of case managers and consultant psychiatrists in thoughtful decision-making.</td>
</tr>
<tr>
<td>- Emphasis on</td>
<td></td>
<td></td>
<td>- Good practice is building rapport and taking a holistic approach adding worker empowerment and use of authority.</td>
</tr>
<tr>
<td>medication and lack of reciprocity</td>
<td>- Support for involvement of family/carers and keeping them informed.</td>
<td>- Request for guidelines, feedback and research evidence to improve decision-making.</td>
<td>- Awareness of resource or system issues including lack of advocacy.</td>
</tr>
</tbody>
</table>

Both the consumer and carer groups expressed concerns about CTOs related to increasing stigma about people with mental illness. They also expressed concern about an over emphasis on medication that had too many significant side effects and psychiatrists not spending enough time with their patients to fully understand what is happening. Both groups had general concerns about the quality of service they received. The carer and consumer groups also tended to think of CTOs as a safety net that potentially reduced risk to self and others and helped family relationships. Families and carers described less pressure to ‘police’ the situation and felt that the service was sharing more responsibility for the CTO recipient. However, they were frustrated about how little a CTO could help regarding substance abuse. Consumers and carers both thought that CTOs helped ensure access to services.

There was minimal discussion about human rights in the carer and consumer group interviews. They seldom mentioned the legislation and whether CTOs should exist in the first place. The participants tended to focus on issues related to the process and quality of care and treatment. Information sharing – particularly the ‘hidden story’ or the lack of opportunity for the ‘real story’ to be heard - was important. Some carers thought the CTO helped increase the sharing of information while consumers tended to be less satisfied that they were being heard when on a CTO.

Like participants in the consumer and carer group interviews, MHRB members appeared concerned that mental health staff were not as skilled as they expected and possibly this could contribute to more use of coercion. However, they also appreciated that many were demonstrating good practice through being mindful of developing an
engagement with the CTO recipient and being focused on that persons discharge from
the CTO.

All of the group interviews expressed concerns about CTOs in relation to the
quality of service delivery. MHRB members shared the concerns of consumers and
carers about the poor quality of service offered to many of the people on CTOs both in
relation to level of skill and availability of resources.

All the groups tended to think of CTOs as a safety net that potentially reduced
risk to self and others and helped family relationships. They all seemed to think that
CTOs helped ensure access to services.

The MHRB group raised more concerns about individual rights, particularly in
relation to procedural fairness. They also added a new perspective around what it is like
to ‘visit’ someone’s situation and then make a decision. They were aware that they get
very little information about the impact of that decision. They saw value in getting
feedback and research evidence about their work and how this could enhance their
practice. Therefore, the interview was able to highlight an area of their practice that the
Board members thought could be improved, in order to improve the implementation of
CTOs as a whole.

MHRB members and the consumers seemed to have the most in common when
it came to displaying compassion and respect. Perhaps this reflects an ongoing
commitment to humanism, libertarianism and a Kantian value base amongst consumers
and MHRB members, while family/carers and senior managers seem to reflect a
stronger commitment to a paternalistic, utilitarian position (Banks, 2001). This is an
important and common tension in mental health service delivery (Radden, 2003). Even
so, there is some common ground in ideas that appear to be in line with what Radden
(2003) describes as ‘relational individualism’ (p.9) which places values, ethics and
decision-making in the social context, in particular providing due consideration to the
person’s relationships with others.

Systemic problems, particularly the strain on resources in public mental health
services in Victoria, appear to be maintained as a common thread across the key
stakeholder interviews. There also appeared to be some shared, and what might be considered foundational, ideas about what represents good practice. The overall theme emerging is that, when it comes to working with CTOs, normative ideas about the key components of a good therapeutic relationship were shared across all four groups. This was represented in their support for service providers being, for example, respectful, compassionate and able to demonstrate advanced interpersonal skills. Although what appeared to differ for the Senior Management, executive and policy advisor group, and to a lesser extent the carer group, was the higher value they placed on the use of authority and containment. Another common issue discussed by key stakeholders seems to be that of CTOs acting as a kind of ‘insurance policy’, protecting CTO recipients, their family/carers, clinicians and the service system from various risks. The following are some of the factors that emerged in these interviews that appear to be the particularly important risks that this safety net is attempting to prevent:

- non adherence or poor compliance,
- harm to self or others,
- lack of continuity of care,
- poor crisis management and therefore difficulty in getting people back into acute care when they need it if not on a CTO, and
- people being “given up on” or “falling through the cracks” in a complex and sometimes poorly accountable service system.

The following chapter will develop these themes enabling a further comparison of all the findings and return to the original question of “What processes and principles represents good practice with people on CTOs?”
Chapter Seven: Bringing the Data Together: What Processes and Principles Represent Good Practice with People on CTOs?

Introduction

This chapter addresses the important task of deciding the degree to which this research has contributed to an expanded understanding of the central and primary question of this thesis- what processes and principles represent good practice with people on CTOs? The following builds a case for the five principles, and the inherent processes they rely on to be implemented, that have emerged from the data. To begin, the findings regarding how CTOs are experienced by CTO recipients and those caring for them are presented as well as exploring the findings about the purpose of CTOs. The concept of CTOs being like an ‘insurance policy’ in a risk averse service environment is presented to help understand and explain the potentially multiple and complex purposes of CTOs identified in this research. All the interviewees were invited to offer their ideas about good practice. This data was then synthesised into five principles that are in turn discussed.

The pros and cons of CTOs

As indicated by the questions in the semi-structured interviews, this research was interested in exploring ideas from multiple perspectives about the experience of being on a CTO. The findings suggested that CTOs, as experienced by some and observed by others, resulted in a range of issues or understandings emerging, including positive, neutral and negative perspectives.

Many respondents made positive comments about what they had observed, or experienced themselves, about being on a CTO and positive comments were grouped around three themes which are discussed below:
**CTOs enable a less restrictive option**

As with other findings in the literature, this research indicates that key stakeholders, including consumers, generally rank avoiding inpatient admission higher in terms of subjective value than the restrictions attached to a CTO (Gibbs, et al., 2006; Swartz, et al., 2003). Consumers found hospital repellent for all sorts of reasons. For example:

I wanted to get out of hospital quickly and come home to help my daughter with the household. (Consumer)

**CTOs provide structure and security**

Again this positive theme is very much in line with the findings in other studies and is expressed in the following:

I think the purpose of the CTO is just to get that stability and once they have that and can be empowered to take over their own treatment. (MHRB member)

**CTOs increase continuity of care**

There was considerable support for CTOs when they enable continuity of care and this important theme will be returned to later in this chapter when good practice is considered in more detail. As expressed by one stakeholder:

I think it’s a way of just stopping people slipping through the cracks. (Senior manager)

Respondents also provided *neutral or ambivalent opinions* about the experience of being on a CTO and six themes emerged and these are briefly described below:
People on CTOs have difficulty being heard

People on CTOs say that they have to work hard to get concerns, such as those about medication, heard and achieve change:

Finally I have got on to the tablets and I am happy about that. I prefer tablets more than injections. (Consumer)

People on CTOs experience being “Half in/ half out” (Consumer)

This theme is about being able to maintain an identity beyond mental illness and CTO. This seems related to what has been described as feeling both coerced and supported by the CTO at the same time (Dawson, et al., 2003; McKenna, Simpson, & Coverdale, 2006). The full quote from the consumer who discussed this is repeated below:

Researcher: So what’s it like to be on a CTO?
Peter: You have to live sort of half in, half out, so the people could do work and help and that and reiterate or whatever, you know, and sort of try to manage around this mental illness business.
Researcher: What do you mean by half in, half out?
Peter: Like you know keep your open mind to people who want to help and accept help and it’s a leeway sort of thing, you come half the distance between and all that, because if there is no mutual - that’s the big paranoia that gets a lot of people, common sense and the obligation of an expectation of mutual respect.

Indifference

As with the qualitative findings in New Zealand (Gibbs, et al., 2006), indifference about being on a CTO was a theme in these findings. That is, the CTO itself was not an issue of great concern. What tended to be important were relationships and treatment issues rather than the order itself. For example:
Like when I talk to these people I got the message one time – they can’t make up my mind for me. Ultimately it is up to me. (Consumer)

A resource management tool

As one consumer in the semi-structured group interview suggested:

Maybe the service should be placed on a CTO. (Consumer Group)

Her comment suggests that CTOs puts an obligation back on the services to make sure that the treatment and the care is provided in a timely manner and that people with serious mental illness and concurrent reluctance to comply with treatment are not ignored or seen to be too difficult to follow-up.

Lack of reciprocity

In observing that CTOs placed significant obligations for compliance and cooperation on the consumer, there was frustration expressed that minimal service was received in return. It was described as follows:

It is all one way – the onus is on the person. (Consumer)

Three out of four case study consumers tended to make neutral comments – especially at the follow-up interview. The CTO tended to be discussed in terms of the relationships with the treatment team rather than the order itself.

Negative comments about being on a CTO were made by a range of key stakeholders and they were grouped into three themes that are discussed below:

Minimal choice regarding treatment

Considerable concern was expressed that CTOs were associated with treatment being limited to medication, and this was often depot or injectable forms of medication. Apparently this occurred without enough attention being given to other interventions, such as counselling and social support. There was particular concern that the
preferences of consumers about treatment were not given enough consideration. As one consumer described:

Sometimes I get the impression that treatment equals medication. So if the treatment option is not medication you are at risk of being seen to be non-compliant. But you are actually looking for something different. (Consumer group)

This was also summarised by a MHRB member:

I mean, the thing I hear most often is the patient hating the medication they’re put on. Sometimes they don’t want any, sometimes they want to try something different that they know about and that can be used or that has in the past been used. And it is very rare to see that mentioned in the treatment plan even though the Act says that the treatment plan must make apparent that the patient’s wishes have been taken in to account. (MHRB group member)

These findings are consistent with those summarised by Dawson (2005), and found by Muirhead, et al. (2006), that people on CTOs were often on depot medication, even though this was usually found to be invasive and have more side effects than oral medication. This is also related to other neutral comments about concerns that CTOs did little to ensure that people got access to other helpful interventions such as engaging in meaningful activity and even returning to work, a finding consistent with a Western Australian study (Davidson & Rolfe, 2003).

Stigma

Like I must have been really ill I used to see it like that. Like people would say “you are on the community treatment order?”. (Consumer)

Consistent with previous findings in New Zealand, Western Australia and Victoria (Brophy & Ring, 2004), some consumers in this study felt stigmatised about being on a CTO. Carers and service providers also observed, and were concerned about, stigma.
Loss of agency or personhood

Yeah and what does that do, you know the thing to be human is to have your own locus of control to live your life in an authentic manner for yourself. So that’s what I sort of imagine is the worst side of things. (Doctor)

This was a common concern about CTOs expressed by respondents, including many of the consumers. It was conveyed by some as being such a negative aspect of being on a CTO that it was interfering with the CTO recipient’s capacity to recover and engage with services. This type of response was anticipated by Minkowitz (2006) in a New Zealand report by the Mental Health Commission that links the potential harm of compulsion to interference in the person’s recovery.

In summary, there appear to be strong links between the findings in this study and other qualitative research findings in the observations made by key stakeholders about the experience of being on a CTO. Key stakeholders consistently provide neutral, positive and negative perspectives on CTOs. This was also found by Churchill, et al. (2007) who commented in their comprehensive review that:

There is a surprising consistency between some of the findings from different studies involving different groups....all stakeholder groups expressed both positive and negative views (p. 88).

What might explain this consistency when, as Dawson (2005) discusses, CTOs are very difficult to generalise about in other ways because of differences in legislation, jurisdiction and the enthusiasm by service providers who use them? Perhaps it relates to another aspect of consistency about CTOs. This could be the issue of CTOs being fundamentally based on a relationship between service provider and recipient. The consistency in responses, therefore, reflects a related, shared set of beliefs or ideas about what people expect in good relationships. The consistency may also relate to the profound impact of stigma when it comes to having a mental illness, which seems to again be persistent across jurisdictions. It may also be related to the widespread dislike and preference for avoidance of psychiatric inpatient admissions. It is also possible that in many different jurisdictions, CTOs are addressing a similar and enduring set of
problems, such as the pressure to manage risk, provide security for families and carers, and deal with resource limitations. Therefore, there may be a reluctance to be too challenging about CTOs, and a wish to maintain the status quo as there is considerable powerlessness about how to deal with these problems in other ways.

**Other problems, issues and concurrent findings**

As discussed in Chapter One, this research is partly based on the contention that CTOs result in unintended consequences and below is discussion of the examples of this in the themes identified in this research.

**An (overused) risk management tool**

We tend to use CTOs for anyone who has been non compliant ...irrespective of the nature of risk and the seriousness. (Doctor)

The issue of risk and the degree to which it negatively impacts on thoughtful decision-making in relation to CTOs was apparent and consistent across the interviews.

**Difficult decision-making, especially in the context of the pressure to manage a wide interpretation of risk.**

Decision-making regarding who is admitted on to a CTO, how long they should stay on one and what represents an appropriate treatment plan have been presented in the literature (Geller, 1990; Jaworowski & Guneva, 2002; Muirhead, et al., 2006) and confirmed in the research as being difficult tasks:

It’s about necessary treatment. That’s sort of the crux of it, one of the risks that I see, the poor practice things is you saw that dilemma that clinicians are faced with every day. They want to operate within the least restrictive framework, but they’ve got someone who wants to come off an order, who wants to have their medication reduced. Who wants to come off depot onto oral, and they’re in this
bind the whole time and it’s a daily struggle and a constant pressure. (Senior manager)

Managing transition and continuity of care

Stability of treating team in this study appears to be strongly linked with the possibility of clarity regarding medication management, discharge and carer involvement. All the key stakeholders in this study, particularly the medical staff, were aware of the problems attached to staff transitions and lack of continuity and how this seemed to encourage conservative decision-making. This conservatism is reflected in discharge from inpatient units to the community, whereby a CTO might ensure continuity of care, and then difficulties in discharge from CTO once the person has entered community based care.

Importance of case managers

As expected, despite the very limited formal recognition of their role in the legislation, case managers have been identified as important both in supporting people on CTOs and contributing to improving MHRB hearings.

Not only do they know a lot but they’re clearly ... the majority of them are very caring people (MHRB)
And to add to this .....I think it is very important to have someone to talk to. (Consumer)

Dissatisfaction with administrative review processes

They just put me on it and I didn’t even go to the meeting because I knew I was going to have to be on it because it’s been happening for several years. (Consumer).

This finding is consistent with themes identified in a report by the Mental Health Legal Centre, Victoria (Topp, et al., 2008). This report was critical of MHRB processes as
a result of qualitative research focused on consumers who had experienced MHRB hearings. According to the report, one of the informants described MHRB hearings as:

The most dehumanising and degrading experience apart from seclusion (p.4).

This finding is perhaps not unexpected when thinking about the membership of the Board being dominated by professionals and its operation being limited in relation to its informality. However, it is unintended from the perspective of the legislation. The purpose of the MHRB is to protect and promote the rights of people on CTOs and ensure procedural justice. So it is essentially problematic when consumers do not recognise the Board as essentially ‘on their side’. Winick (2003) suggests that to:

Achieve the benefits of the psychology of procedural justice ...the hearing examiner should treat the individual fairly, with dignity and respect, and in good faith...respect the need for voice and validation, seek to impress the individual with the genuineness of the government’s motives, and engage in a dialogic process designed to educate, persuade and motivate him or her to accept needed treatment (p. 132).

It appears the MHRB is being accused of falling short of these aspirations.

**Concerns about the length of CTO**

Not unexpectedly people interviewed were concerned that CTOs may be too long and this is consistent with proposals in the recent review of the Victorian *Mental health Act, 1986* that has suggested that consideration be given to changing the current length of Victorian CTOs or decreasing the administrative review periods. These findings offer some support to the idea that CTOs in Victoria are too long and highlights the inconsistency with other states in Australia and with CTOs internationally (Department of Human Services, 2008b, 2009).
“Lazy psychiatry” (Consumer group)

This theme represents the idea that CTOs are just an easy response to the problem of someone’s reluctance and not thought through very much, a kind of ‘quick fix’. It is related to the observation that CTOs have the potential to be deskilling because it may be considered ‘easier’ to coerce someone into treatment rather than look at the potentially complex set of issues that may account for someone’s reluctance and attempt to encourage compliance. Wales and Hiday (2006) have described this as TLC (tender loving care), a potential alternative to PLC (persuade, leverage or coerce). TLC would involve improved patient centred treatment, entitlements and service delivery and include assertive outreach. However, Wales and Hiday (2006) discuss this problem as located not only with the capacity of service providers but also driven by government funding and resource availability.

Net widening

One of the consumers appeared to see herself as potentially a ‘false positive’ candidate for a CTO when she said:

I think I would have gone anyway (Consumer).

However, this comment’s context (available in the discussion of case study one in Chapter Five) was of this person remaining unsure and expressing ambivalence about whether she required a CTO to be compliant with treatment. Such is the complexity of the issue of CTOs and whether they are being overused, with too many people being included in an ever widening net. This theme is related to both overuse of CTOs and also concerns about the length of time people are staying on potentially unnecessary orders. Concerns about the potential net widening effects of CTOs have been expressed elsewhere (Geller, et al., 2006).
**The Purpose of CTOs – an Insurance Policy**

In undertaking an international comparison of CTOs, Churchill, et al. (2007) identify Victoria as amongst the jurisdictions that have both ‘least restrictive’ and ‘preventative’ features in the way CTOs have been designed. As such, they aim to provide both an alternative to admission to an inpatient unit as an involuntary patient and prevention of predictable deterioration that may lead to the person being at risk to themselves or others. Thus, in Victoria, CTOs may be seen to be able to meet different needs in relation to the CTO recipient and possibly the service provider. However, making a binary distinction between least restrictive and preventative is insufficient to explain the multiple and complex issues raised about the purpose of CTOs in this research. In compiling the data, I have found the concept of CTOs being like an ‘insurance policy’ has been a useful analogy. Thinking about the purpose of CTOs as an insurance policy appears to be meaningful to many of the interviewees and this has also been described as a theme in New Zealand (Mullen, et al., 2006). Taking this analogy further, what is the fine print when it comes to this so called ‘insurance policy’? What is being insured against and how? The following provides further insights into these questions.

**Risk of poor compliance or non adherence**

There is considerable support from all stakeholders that this is a central factor driving the purpose of a CTO. Interviewees in all four case studies referred to the possibility or risk of non compliance as being important in understanding why the person was on a CTO. This was seen to be demonstrated by past history, current ambivalence or lack of insight – particularly in the context of limited cognitive capacity. However, it seems important to note at this point that none of the consumers were currently seen to be non-compliant with medication and/or attendance in any of the case studies.
Harm to self and others

It seems appropriate to conclude that there was a very low tolerance amongst the service providers for any potential for harm to self or others and there seemed to be a strong belief that a CTO would help to prevent this risk as illustrated in the justification for a CTO provided below:

Aggressive and abusive towards clinicians and family members when unwell. (Doctor).

Lack of continuity of care

This quote from an MHRB member illustrates the problems created by the common lack of continuity of service providers:

For some services it’s so common for them to say “I’ve only met the patient for the first time today or last week” and, you know, so of course there’s no rapport because how can there be. And the patient is understandably upset about having a different doctor every time and case manager rotating. And the ones where it’s good is where there’s time to build up a rapport and there’s continuity of treatment, but lack of resources in the public system that’s not always the case. (MHRB Member)

Poor crisis management or lack of access to acute services

Another common theme in these findings and supported elsewhere (Brophy & Ring, 2004) is the idea that a CTO will assist to ensure that CTO recipients have access to acute services as required:

The justification that’s sometimes presented by the mental health services is that if somebody is on a CTO they say it is easier for them to have the patient readmitted if the need arises. It’s never clear to me why exactly that is so; as far as legislation is concerned it shouldn’t really make any difference. (MHRB member)
Giving up on people

There’s also the opposite side of all of this and I’m often impressed by the fact that services persist with particularly difficult patients. You know, people get threatened, staff get threatened, they get bashed, they get reported here, there and everywhere and I am often really impressed. The easiest way of dealing with this would be to discharge them. (MHRB Member)

This quote helps to illustrate a point related to many of those discussed above, about the potential for the ‘kind’ of person who ends up being on a CTO being someone who may have otherwise been poorly serviced, slipped ‘through the cracks’ or otherwise not got consistent assistance. It is related to the idea of CTOs enabling mutual accountability.

Effects of substance abuse

He has to have the injections ......because he smokes still the cannabis. (Carer)

While CTOs cannot directly influence substance use, attempting to deal with or prevent substance abuse is raised here and relates to findings elsewhere that suggest that many consumers of mental health services who engage in substance abuse compound the difficulties of having a serious mental illness (Barrett, 2005; Castle & Ho, 2003). It seems that, even though this may be unrealistic, there are hopes that a CTO will assist in preventing or minimising substance abuse, mainly through the authority a CTO enables and the stability that may be achieved.

Deaths and coronial enquiries

I think I should say there is a certain level of anxiety among clinicians as to what is going to happen and whether I will be held responsible for it. (Doctor)

As discussed in earlier chapters, increased accountability in mental health, related to the need to manage and contain risk (Green, 2007; Rose, 1998; Sawyer,
2008), is an important driving force behind the implementation of CTOs. It has been argued that this has led to defensive practice and the need to attempt to avoid the criticism that may result from a critical incident, one that may result in death or serious injury and possibly a coronial enquiry (Green, 2007).

**Taking Family/Carers into account**

Being mindful of family/carer burden, needing to involve family/carers in decision-making and providing a direct service to family/carers, that is, ‘taking family/carers into account’, is an important theme in this research and this is demonstrated by an emphasis on using CTOs to prevent deterioration in health and relationships. It proved to be a feature of all four case studies as illustrated by the following quotes, each from a different case study:

- A trauma for her daughter (Case Manager)
- Help her be a good mother (Doctor)
- I’m scared (Carer)
- Has been abusive towards family (Case Manager)

There appeared to be an emphasis on achieving stability rather than prevention of violence. However, at least one carer interviewed expressed relief that she experienced less fear because her loved one had been violent towards her in the past. It seems that family/carers are often seeking stability and safety via a CTO and, as with those in a study in the USA, are experiencing less caregiver strain as a result of the CTO (Groff, et al., 2004). But family/carers also expressed awareness of the complexity of the issues. They tended to expect a high standard of care whether someone was on a CTO or not. So, perhaps as much as they are searching for stability and safety, they are also searching for quality of care. They can recognise that their relative is receiving a poor standard of care and may well become ambivalent about the CTO despite potential gains regarding relapse prevention. This is consistent with both Skegg (2002) and Hallam’s (2007) findings about the experiences of family/carers when it comes to involuntary commitment.
This research supports the proposal that family/carers are very important as stakeholders in CTOs. This is also consistent with NZ findings about family/carers being frustrated when not consulted about clinical decisions (Gibbs, et al., 2006). This frustration was also expressed by Lewisohn (2008) who emphasised, on behalf of carers in Victoria at a recent forum, the importance of carers being involved in decision-making and being consulted routinely by the treating team and the MHRB.

**Mutual obligation and accountability**

CTOs representing consumers and service providers meeting their obligations to each other have been an ongoing, persistent and consistent feature of feedback from CTO recipients and other stakeholders in the qualitative findings. It represents a key finding of this research. Consider the following quotes:

- It’s a commitment and it’s useful for the staff to know that I’m on a CTO and have to be looked after. (Consumer)
- (The carer) is less worried, because they know that you’ve got an obligation to see Joseph (Consumer). (Case Manager)
- The onus is not only on the client but also on the service to put in. (Senior Manager)
- Services always feel like they want to be doing the right thing…. so the CTO actually helps the service to achieve its task. (Doctor)

What these findings appear to be indicating is that CTOs are as much about those implementing them as they are about the recipients.

And, if that is accepted, it needs to be acknowledged that those who might be seen to be ‘on the bottom of the rung’, the CTO recipients, know what service providers should be doing, and they have demonstrated in this study that they are able to speak back, especially about quality of treatment and how they have learned to ‘negotiate’ a challenging system, at times even using CTOs in their interests. For example, consumers and family/carers in this study, and elsewhere, have expressed concern that discharge from a CTO may ‘fast track’ discharge from the service overall. This suddenly rejects the idea that discharge from CTO inevitably represents empowerment, as it can also
represent future abandonment. Perhaps it is then no surprise to have a finding that a consumer is prepared to stay on a CTO and be a ‘volunteer for compulsion’.

These findings suggest that in Victoria there is a need to ask the question: Why a CTO for mutual obligation? Perhaps the answer lies in structural and systemic pressures related to the under resourcing of mental health services and the problems attached to the provision of long term or whole of life care:

So I think there is a lot of concern out there and we often have to reassure them, nothing else is going to change if you’re discharged off the CTO. But I’m surprised how often we have to reassure them. (Doctor)

This study suggests that CTOs are complex in relation to their purpose, use and outcomes and that of key importance in their implementation is the relationship between service providers and CTO recipients. This becomes important in considering another question: When is a CTO coercive and when is it enabling?

I suppose the level of empathy that is shown by her clinicians has been helpful. I wonder now whether we can do this with the other patients as well, whether we can cut down on the use of CTOs. (Doctor)

The reader is invited here to think about to what degree the diversity in responses about the experience of CTOs is co-constructed by service providers and service recipients, that is, people have different responses and experiences because of the interaction between the service provider and consumer and the varying quality of those relationships. This is partially expressed in the following quote:

If we don’t walk (in their shoes), there’s a real huge percentage of people resisting, pushing back, being traumatised by the whole experience. (Senior Manager)

It is easy to presume that negative comments about CTOs from consumers relate to the characteristics of that person and their illness, such that the more insight you have, the more accepting you will be of the CTO. But, as the above quote suggests, perhaps this represents blaming the individual CTO recipient rather than attempting to
more fully understand their experience. This understanding could be enhanced through reflecting on the persons experience as also being about the interaction between service provider, family/carer and consumer.

**Common themes about good practice**

In this study there have been comments from all key stakeholders, in particular comments made by people on them, about what CTOs are for through the perspective of different key stakeholders, how CTOs could be improved and ideas about how the structure of the service, the skills and knowledge of staff and the availability of resources impacts on the person's experience of the CTO and their degree of cooperation. CTOs represent different things to different people involved and are attempting to meet, potentially, a number of different purposes. Therefore, the multiple attempts to discuss how they could be implemented well and how they could be improved need to be considered through this lens, one that does not lose sight of the diversity that exists in relation to what people are actually talking about, even within the same jurisdiction.

This research has established that any discussion about good practice with people on CTOs needs to be considered in the context of two important factors:

- The diversity of CTO recipients, such that CTOs appear to be responding to a range of needs and issues, and
- The existence and impact of resource limitations\(^\text{11}\), especially as they relate to continuity of care, staffing, opportunity for adequate review and staff development.

There is no doubt that, even with these precautionary comments in mind, when initially undertaking a content analysis on the qualitative data, people involved in the gathering of this data said many similar things about ‘What represents good practice with people on CTOs’. As well as the identification of good practice, some participants
tended to focus more on what they knew about poor practice. Indicators of poor practice included too much anxiety in the treatment team, impatience, being judgemental, lack of communication and lack of continuity. All of these appear to relate well to the factors indicating good practice discussed below. Another three nodes about poor practice have been included in the category of “Aiming for quality in service delivery”.

Table 21 sets out this data in its ‘raw’ form but organises these nodes into different aspects or categories of practice.

11 Resource limitations refers to, for example, the fragmentation of the service system, shorter inpatient stays, high case loads, inability to retain experienced staff and the shortage of full time consultant psychiatrists.
## Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice

### USE AND DEVELOP DIRECT PRACTICE SKILLS

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of sources</th>
<th>Number of references</th>
<th>Example of reference</th>
</tr>
</thead>
</table>
| Talking and listening (Includes tree nodes of positive feedback and service providers having skills) | 22 | **Total: 58**  
Consumers: **15**  
Case managers: **18**  
Doctors: **13**  
Carers: **2**  
Carer Group: **4**  
Consumer Group: **7**  
Senior Managers: **3** | In terms of other good practices would be sort of to... yes, the patient, respect their rights, I mean, respect their rights. And try and see them more frequently, at least in the beginning, and to not put too much emphasis on medication or biological treatment. Listen to them, giving some space to clients in your time. You know, what I mean is that you need to listen to what the patient is saying, whether it is positive or not I think, you know, sometimes patients have to say it because there is no one else they can explain these type of emotions. (Doctor) That’s it, that’s it. You have to be able to talk about it otherwise you’re going to go back there. At least if you can talk about it and make some sense of it in your mind you have less chance of it reoccurring. (Consumer) |
| Authenticity and transparency | 14 | **Total: 38**  
Consumers: **3**  
Case managers: **20**  
Doctors: **7**  
Carers: **1**  
Carer Group: Consumer Group: **4**  
Senior Managers: **3** | From a personal point of view, I think that I speak to the individuals and approach individuals all in the same way, in a respectful way, listen to them, attempt to engage what their perception of the problem is, what they want in their life. So that is just the same, all through. I guess, when it gets to a level where that’s obviously in line with what the CTO is about, then I will, again, respectfully highlight that, but detach myself, from a personal point of view, saying “I want to do this for you, because I feel this, this, this.” But, I guess, highlight it that this is law and these are the reasons why the treating team felt that you need to do this. My role, as a case manager, is to ensure that you’re being looked after, in the best possible...(Case Manager) |
| Flexibility and Negotiation (related to engagement) | 16 | **Total: 44**  
Consumers: **3**  
Case managers: **16**  
Doctors: **13**  
Consumer Group: **8**  
Senior Managers: **2**  
MHRB: **1** | As long as it doesn’t interfere with my life, and they’re very understanding with that, like if I get a job they work around it for me so I can’t ask for more, really. (Consumer) |
Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>Consumers</th>
<th>Case managers</th>
<th>Doctors</th>
<th>Carers</th>
<th>MHRB Group</th>
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<tbody>
<tr>
<td>Caring</td>
<td>11</td>
<td>4</td>
<td>9</td>
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<td>I don’t expect doctors and CM to be emotionally involved with our problems, but I expect them to show compassion, to show understanding and respect to my problems, to our problems. (Carer group member)</td>
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<td>Working with the Consumer’s construction of the presenting problem</td>
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<td>I mean I don’t talk about (my episodes) to just anybody. He lives in this house – his spirit of course not his body – but his spirit is here; there is nothing wrong with that Lisa, nothing wrong with it at all he’s comfort to me....Dr P tried to turn around and prove that I was nuts. (Consumer)</td>
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<td>Cultural sensitivity</td>
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<td>3</td>
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<td>I know one of the patient’s family is feeling very guilty. They feel that they might have caused the problem... they should not have migrated to Australia. So then we had a discussion about that; they feel a bit relieved, but not completely it won’t go away in one session. (Doctor)</td>
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<tr>
<td>Dealing with anger</td>
<td>6</td>
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<td>I think down deep she was very grateful that I copped the abuse and hung in there. I mean I wouldn’t stand around and have her abusing me, but I would go back. (Case manager)</td>
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<td>Engagement</td>
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<td>I think it does help him to take the medication as well but I would see that as an equivalent benefit to the actual engagement. (Doctor)</td>
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<td>Topic</td>
<td>Total</td>
<td>Consumers</td>
<td>Doctors</td>
<td>Senior Managers</td>
<td>MHRB Group</td>
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<tr>
<td>Stability</td>
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<td>5</td>
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<td>So again if she achieves a period of stability of where you know she’s reflective, she’s functioning well, she’s working with us around the medication, seems to understand the need for some ongoing treatment which is the same as last time really. It would be very similar. In other words I don’t think ‘oh that hasn’t worked one time. They failed, we failed, we won’t try it again’. In fact almost the converse. I would hope and expect that she’s learned something even more from the last time that will be a stronger platform for her in the future. (Doctor)</td>
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<td>Minimising the use of coercion</td>
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<td>1</td>
<td>3</td>
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<td>Where is the therapeutic benefit of forced treatment? If I am forcibly detained for my own or others’ safety, that is one thing. For me to be forcibly treated is another. A Clinician, who recognises the truth of this, has to find other ways of working with me so that forced treatment is avoided at all costs. This is better practice. (And we are not generally talking about treatments which, if not given, will directly result in loss of life). But this ‘better practice’ can only be a principle of care while ever the reality is that practitioners are engaged in forcible treatment of their clients. (Consumer)</td>
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<td>Face Saving (related to minimising use of coercion and engagement)</td>
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<td>So if the person is willing at least to talk a little bit about it and have some understanding, I don’t want them to dwell on it. (Doctor)</td>
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<tr>
<td>Genuineness</td>
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<td>4</td>
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<td>A lot of its nonsense and people say that stuff to make it easy. I just don’t think that people - people can see through you. I mean like they can see through, they’re very hypersensitive to this sort of stuff. You owe it to them to be honest with them even if they don’t like it. (Case Manager)</td>
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<td>Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)</td>
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<td><strong>Good practice is good practice</strong></td>
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<td>Case managers: 3</td>
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<td>Doctors: 1</td>
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<td>Carers: 1</td>
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<td>Carer Group: 2</td>
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<td>Consumer Group: 2</td>
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<td>Senior Managers: 2</td>
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<td>It’s listening to, it’s responding to and including and the belief that collaboratively you do trust and you do listen, you couldn’t get a better result. I think best practice involves some of those key words. (Carer group)</td>
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<td><strong>Develop rapport and relationships</strong></td>
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<td><strong>Total: 38</strong></td>
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<td>Consumers: 5</td>
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<td>Case managers: 3</td>
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<td>Doctors: 16</td>
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<td>Carer: 1</td>
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<td>MHRB Group: 4</td>
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<td>Dr J.’s a very nice person. I like Dr J.. He’s good talking, nice, lovely talking. (Carer)</td>
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<td>Effort put in to forming a therapeutic relationship. I know it has been argued by senior psychiatrists that that’s one of the benefits to the health service - it (the CTO) supports the practitioner to have that time to form a therapeutic relationship. I think, 9 times out of 10, you’re much more likely to form a positive therapeutic relationship without the coercion factor...but maybe there is something to be said for that short term. I also have met consumers who said, in retrospect, I can see that I needed that involuntary treatment. So maybe if it was a short term thing, with very tight boundaries placed around it, for the purposes of the practitioner getting to know the person - whether or not the person agrees - then maybe there you could see there could be the scope for that kind of practice. To give the person the ability to develop a therapeutic alliance. (Consumer group)</td>
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<td><strong>Respect (included tree nodes of autonomy and choice, boundaries or timelines and respect for personhood)</strong></td>
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<td>Doctors: 5</td>
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<td>Carer: 1</td>
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<td>Carer Group: 1</td>
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<td>MHRB Group: 1</td>
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<td>I think he’s getting heard. I think that’s very important for Peter, again, he’s someone that probably hasn’t felt terribly important or valued by a lot of people. (Case Manager)</td>
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Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Total</th>
<th>Sources</th>
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<tbody>
<tr>
<td>Set limits</td>
<td>8</td>
<td>Total: <strong>12</strong>&lt;br&gt;Case managers: 5&lt;br&gt;Doctors: 1&lt;br&gt;Carers: 1&lt;br&gt;Consumer Group: 3&lt;br&gt;Senior Managers: 2</td>
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<tr>
<td>Lack of communication (identified as poor practice)</td>
<td>8</td>
<td>Total: <strong>15</strong>&lt;br&gt;Consumers: 4&lt;br&gt;Doctors: 2&lt;br&gt;Carers: 3&lt;br&gt;Carer Group: 2&lt;br&gt;MHRB Group: 4</td>
</tr>
<tr>
<td>Anxiety (identified as poor practice)</td>
<td>7</td>
<td>Total: <strong>7</strong>&lt;br&gt;Doctors: 2&lt;br&gt;Case Managers: 1</td>
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<tr>
<td>Impatience, being judgemental and having a poor fit between service provider and consumer (identified as poor practice)</td>
<td>3</td>
<td>Total: <strong>3</strong>&lt;br&gt;Doctors: 1&lt;br&gt;Consumers: 2</td>
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<tr>
<td>Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td><strong>Practical support</strong></td>
<td>9</td>
<td><strong>Total: 13</strong></td>
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<tr>
<td>Consumers: 5</td>
<td>Doctors: 2</td>
<td></td>
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<tr>
<td>Carers: 3</td>
<td>Carer Group: 2</td>
<td></td>
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<tr>
<td>Senior Managers: 1</td>
<td>That’s also having enough time, it’s the skills and motivation of the people concerned. It’s being able to get to that point. Sometimes you have to do other things to get to that point and you have to make yourself practically useful to the person because they might have had very bad experiences over 20 years before you come on the scene as the worker. (Doctor)</td>
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<tr>
<td><strong>Psycho education</strong></td>
<td>3</td>
<td><strong>Total: 5</strong></td>
</tr>
<tr>
<td>Doctors: 3</td>
<td>Carer Group: 2</td>
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<tr>
<td>But my plan is to actually psycho educate him, based on his intelligence, to educate him and what it means for him to be on a CTO sort of thing too and where exactly he is coming from. (Doctor)</td>
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<td><strong>Therapy</strong></td>
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<tr>
<td>Doctors: 5</td>
<td>Carer group: 2</td>
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<tr>
<td>Consumer Group: 1</td>
<td>Why can’t they actually enforce other forms of treatment? If you’re going to take somebody’s freedom, you’ve got to justify that by counselling sessions, got to see their psychiatrist...go through that other than person isn’t compliant with medication. 9 times out of 10 all people have got is medication. Go back to the therapeutic value of what they are supposed to be doing. (Consumer group)</td>
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<tr>
<td><strong>Take Chances</strong></td>
<td>4</td>
<td><strong>Total: 4</strong></td>
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<tr>
<td>Doctors: 2</td>
<td>Consumers: 2</td>
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<tr>
<td>I’ve got three nights I’ll take them (the medication) by myself and I take them so they’re giving me a bit of privacy too. They know I take them because they even do blood tests occasionally. (Consumer)</td>
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<tr>
<td><strong>Taking time</strong></td>
<td>9</td>
<td><strong>Total: 12</strong></td>
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<tr>
<td>Case managers: 5</td>
<td>Doctors: 4</td>
<td></td>
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<tr>
<td>Consumers: 2</td>
<td>Carer Group: 1</td>
<td></td>
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<tr>
<td>Interviewer: So you’ve been to the movies. You’ve played pool. Phil’s just hanged out with you for a couple of hours. Joseph: Yes. Interviewer: Do you think that’s good? Joseph: Yes.</td>
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Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

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<tr>
<th>Node</th>
<th>Number of sources</th>
<th>Number of references</th>
<th>Example of reference</th>
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</thead>
<tbody>
<tr>
<td><strong>Awareness of rights</strong></td>
<td>12</td>
<td><strong>Total: 24</strong></td>
<td>In our team we almost encourage people to appeal if we feel there’s dissatisfaction. We don’t see it as a threatening thing to us (Doctor)</td>
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<td></td>
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<td>Case managers: 12</td>
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<td></td>
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<td>MHRB Group: 2</td>
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<td>Senior Managers Group: 1</td>
<td></td>
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<tr>
<td><strong>Advocacy</strong></td>
<td>6</td>
<td><strong>Total: 8</strong></td>
<td>It is hard though when they, I mean some people are not very articulate and they need some support to be articulate in those circumstances (MHRB hearings). (Case Manager)</td>
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<td></td>
<td></td>
<td>Case managers: 2</td>
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<td></td>
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<td>Doctors: 1</td>
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<td></td>
<td></td>
<td>Carers: 1</td>
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<td></td>
<td></td>
<td>Senior Managers Group: 2</td>
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<td></td>
<td></td>
<td>Consumer group: 3</td>
<td></td>
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<tr>
<td><strong>Procedural Fairness</strong></td>
<td>14</td>
<td><strong>Total: 33</strong></td>
<td>But when we were at the Board Meeting it was different because I could say that I’d rather be off it and be gone and that, done with, finish these complete. So they said there’s no other way so are you prepared to just continue the order and have an order, and continue the order and receive treatment and keep with my medication, a legal binding factor for medication and treatment (Consumer)</td>
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<td></td>
<td></td>
<td>Consumer: 1</td>
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<td></td>
<td></td>
<td>Case managers: 13</td>
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<td></td>
<td></td>
<td>Doctors: 11</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Carers: 1</td>
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<td></td>
<td></td>
<td>MHRB: 4</td>
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Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

<table>
<thead>
<tr>
<th>Use of authority</th>
<th>10</th>
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<tr>
<td>Case managers:</td>
<td>9</td>
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<tr>
<td>Doctors:</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Carers Group:</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Senior Managers</td>
<td>5</td>
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</table>

It's about necessary treatment. That’s sort of the crux of it, one of the risks that I see, the poor practice things is you saw that dilemma that clinicians are faced with every day. They want to operate within the least restrictive framework, but they’ve got someone who wants to come off an order, who wants to have their medication reduced. Who wants to come off depot onto oral, and they’re in this bind the whole time and it’s a daily struggle and a constant pressure. From where we sit we see that sometimes people succumb to that, and so one of the less effective things is when there’s not enough assertion in the treatment. So when people aren’t clear about this, I have to do this, this is my responsibility of this patient. So the threshold for risk and taking risk goes up all the time.

(Senior manager)

I think that’s a huge aspect of the CTO that if we as clinicians notice something that we may think may not be advantageous for the person then we can talk about it earlier rather than sort of thinking ‘well we may be wrong, we may be right, let’s just wait and see how it pans out’. If somebody’s on a CTO and I think we feel more able and even more obliged as a responsibility to talk about ‘that’s changed I wonder if that’s a sign of relapse or that’s a sign that some of those good ways of coping that you found, you’ve lost track of them or you’re not able to implement them at the moment, can we talk about, what’s going on?’.

(Doctor)
Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

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<th>Node</th>
<th>Number of sources</th>
<th>Number of references</th>
<th>Example of reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving compliance as good practice</td>
<td>14</td>
<td><strong>Total: 26</strong></td>
<td>”That’s one of the reasons why I’m on medication, because I had a history and a record of mental illness and they wanted to help me out, of course, it was hard to see. (Consumer)”</td>
</tr>
<tr>
<td>Prevention of relapse</td>
<td>3</td>
<td><strong>Total: 5</strong></td>
<td>”By having them on a CTO and following them up regularly, and that’s happening quicker where we find them quicker, and the less chaos and the less deterioration is kind of evidence for them that it’s actually better. The treatment is very helpful to them, that they’re confronted at a much more interpersonal way with people rather than in an aggressive way that people find scary. (Senior manager)”</td>
</tr>
<tr>
<td>Focus on wellness and strengths (recovery)</td>
<td>16</td>
<td><strong>Total: 28</strong></td>
<td>”So there’s some balancing there. We do take the past into account but you’re also not in just the negative way. You’re trying to look at achievements, strengths, goals that have already been achieved I suppose. That’s quite tricky because a lot of doctors don’t get the concept of strengths based practice and since doctors are kind of leading this discussion and the final decision. Yeah so we actually need to work a bit better on improving doctors’ ability to talk in those ways and use a strengths based approach. (Doctor)”</td>
</tr>
<tr>
<td>Recovery focus and holistic (includes developing skills and being holistic)</td>
<td>21</td>
<td><strong>Total: 60</strong></td>
<td>”I think there’s a lot of disabled people could work and I think the CTO, with the time they spend here I think they should be encouraged to do something productive, not just come here, “See you later”, come back next fortnight, whatever, I think they should... whatever that is, whether it be working or hobby crafts, whatever, I think that they should be encouraged to be more active. (Consumer)”</td>
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</tbody>
</table>
Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Count</th>
<th>Total</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Deal with substance abuse</td>
<td>3</td>
<td><strong>5</strong></td>
<td>That is my next aim is to focus on that. Being realistic I do not think we can actually completely stop him from using cannabis. He has used it for the last 10 or 15 years or so, only weekend use. If we can reduce that down and if we can get him into some sort of voluntary work that will help. (Doctor)</td>
</tr>
<tr>
<td>Empowerment</td>
<td>7</td>
<td><strong>7</strong></td>
<td>A clinician's practice in this framework would accentuate and look out for all areas where the consumer is able to exercise preference and choice. It means practice which resources the self-determination of the consumer. (Consumer group)</td>
</tr>
<tr>
<td>Focus on discharge</td>
<td>13</td>
<td><strong>22</strong></td>
<td>I believe it is possible for clinicians to adopt an attitude of health promotion. A manifestation of this would be that all therapeutic practice would be directed at achieving “non” Order status for each individual. This means all therapeutic interactions are framed by the five criteria for Orders, with a view to planning what needs to be done in order to come off them. (Consumer group)</td>
</tr>
<tr>
<td>Mutual accountability</td>
<td>12</td>
<td><strong>25</strong></td>
<td>Well, yes, it’s a commitment and it’s useful for the staff to know that I’m on a CTO and have to be looked after and stuff like that (Consumer)</td>
</tr>
<tr>
<td>Be Realistic</td>
<td>5</td>
<td><strong>8</strong></td>
<td>I don’t want a commit a doctor too much because I don’t want them to get excited and I don’t want them to get overlandish about medication or too much a high dose or asking for a reduction. That doesn’t work much these days. (Consumer)</td>
</tr>
</tbody>
</table>
Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

| Recognise complexity and individual differences | 1 | **Total: 3**  
MHRB Group: 3 | It’s such an individual thing and there’s so many variables, like I said before. It depends on their support system. Like the other day we had an Italian family and the mother was the patient and her daughter was there saying mum you’ve got to be on the CTO because you come off your medication, you don’t take it and the mother was oh yeah sort of. And we were really thankful that the daughter was there and so brave and had such a relationship with her mum that she could just come out with all this. Whereas in other cases … well, one the daughter said I don’t want to say anything, I’m just here to support my mother I’m not going to say anything and she’s too scared to make a comment about her mother’s health because it would upset mum too much. And it’s such an individual thing. (MHRB member) |
| Targeting | 5 | **Total: 10**  
Doctors: 8  
Consumer group: 2 | So certainly with people where it’s quite damaging and that’s a hard thing because you can’t pick who those people are in advance. There’s a few you might be able to pick I think but not all. (Doctor) |
<table>
<thead>
<tr>
<th>Node</th>
<th>Number of sources</th>
<th>Number of references</th>
<th>Example of reference</th>
</tr>
</thead>
</table>
| Continuity in practice – relates to both continuity of staff and continuity of care | 19 | **Total: 46**  
Consumers: 8  
Case managers: 14  
Doctors: **17**  
Carers:2  
MHRB group: 3  
Senior Managers group:4 | She have too many. She had Jill, she had Ben I think. John, one guy John. I don’t know. (Carer)  
They don’t go away when she’s sick. Even when she gets sick, Jill goes around. With other people it’s harder because they go away.(Carer)  
When people change you have to re-establish yourself and establish a relationship and know what’s going on .. Just to have to go through that again with new people is a bit difficult. Sometimes it makes it a bit hard on both sides.(Consumer) |
| Lack of continuity (identified as poor practice) | 9 | **Total: 16**  
Consumers: 4  
Case managers: 1  
Doctors: 5  
Carers:3  
Senior managers: 3 | One thing I always do wonder about is I think I am repeating the same thing which I repeated six months back is that consistency, that doctors being changed every six months in public setting and then as soon as you start doing file review by the time that you finish file review you starting taking some decisions, you talk with the patient you are gone.(Doctor) |
| Treatment Planning | 15 | **Total: 35**  
Consumers: 3  
Case managers: 5  
Doctors: **18**  
Carers Group:1  
Senior managers: 3  
MHRB Group: 5 | By having an effective treatment plan and a treatment plan that is practical and not just a general treatment. If you had a sort of just a textbook treatment, textbook approach to any treatment, it doesn’t really work. (Doctor)  
You can see treatment plans as being one attempt in the past that’s been made to improve I think the implementation of CTOs.(MHRB) |
| Maintaining regular contact and routine | 16 | **Total: 32**  
Consumers: 6  
Case managers: **11**  
Doctors: 7  
Carers:1  
Senior managers:7 | For the CTO to be effective there’s got to be some level of contact. But the level of contact required for each person will be different. And so that needs to be individually determined. For the CTO to be effective for somebody, it might be that they need to be seen weekly, but for somebody else it might be fortnightly or three weekly. (Senior managers) |
Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Total</th>
<th>Doctors</th>
<th>Consumer</th>
<th>Consumer group</th>
<th>Consumer</th>
<th>Carer group</th>
<th>MHRB Group</th>
<th>MHRB</th>
<th>Case Manager</th>
<th>Interviewer</th>
<th>Interviewee</th>
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<tr>
<td>Access to second opinions</td>
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<td>I’m not sure that the length (of CTOs) should be changed but there should be some more form of review before that. Say at six or nine months. Yeah that’s definitely occurred to me. Maybe that’s where something like a second opinion could be brought in even. So it’s a whole review but it incorporates a second opinion but it’s not a board as such. (Doctor)</td>
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<td>Good practice is tied to assessment. You go through the service, you’re seen by a doctor, basically does a recommendation you’re seen by psychiatrists, who have got the time. The professor that seen me did take the time. (Consumer group)</td>
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<td>Providing a pleasant and welcoming clinic environment</td>
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<td></td>
<td>But if they don’t send a direction and ask people to sit down or make them feel welcome it will work against you in the clinic. (Consumer)</td>
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<td>Improve resources</td>
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<td></td>
<td>Well of course the other thing that could improve CTO practice is just generally more resources. [laughs]. The more resources – and that’s true. There are actually studies that say to improve risk management for an individual you need to better resource the whole service. (Doctor)</td>
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<td>Lack of post CTO planning (identified as poor practice)</td>
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<td></td>
<td>Interviewer: so you decided that you just didn’t want to have anything to do with them after you’d got the CTO? Interviewee: No they gave me the flick. (Consumer)</td>
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<td>Lack of recognition of side effects (identified as poor practice)</td>
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<td>My daughter had a similar situation with the psychiatrist pumping the girl with anti depressant – and the girl reached 140 kilos and he was still giving – the girl was not depressed. I have common sense, you don’t have to have fluent English – to have commonsense. So I thought the doctor was doing wrong (Carer Group)</td>
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Table 21: Responses from all Individual and Group Interviews Regarding 'Good' Practice (Continued)

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<th>Node</th>
<th>Number of sources</th>
<th>Number of references</th>
<th>Example of reference</th>
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<tbody>
<tr>
<td>Thoughtful decision-making (includes tree nodes of accountability, reflective space and skills)</td>
<td>20</td>
<td>Total: 62</td>
<td>It’s just such an incredibly powerful piece of legislation, isn’t it? It’s just such an incredibly – which maybe as a service, as Mental Health, we forget how we can just do this to people, you know. Now I know this team and I know this organisation and I’m confident that we’re making considered thoughtful, caring decisions, ...I actually think certainly MST and our consultants struggle and they weigh up pros and cons and they’re not letting things just sidle on, which I think sometimes happens. (Case Manager)</td>
</tr>
<tr>
<td>Involving carers and family work</td>
<td>14</td>
<td>Total: 57</td>
<td>We are finding that families are one of the most important resources, not only for collecting history and all stuff, but also to involve them ...families do need to be supported; even if the patient is on CTO, it doesn’t matter. Families need to be involved. (Doctor)</td>
</tr>
<tr>
<td>Case Manager’s role</td>
<td>13</td>
<td>Total: 31</td>
<td>Have enough attachment to a case manager to think it is worthwhile to keep taking it (medication). (Case Manager)</td>
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<td></td>
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<td>Just going back to the earlier question about should case managers be at the board hearing, that’s one of the arguments why they should be at the board hearing because of the continuity.(Senior Managers)</td>
</tr>
</tbody>
</table>
| Consultant Psychiatrist’s role and consistent involvement | 4 | Total: 13  
Doctors: 12  
Senior managers: 1 | It could be argued that that’s where you do need some sort of minimum frequency of contact built into it. It’s not about how often the case manager or the treating doctor sees them, but there would be an argument about how often the psychiatrist who’s monitoring the treatment sees the person. Because that’s the person who actually needs the continuity to be able to make those decisions. (Senior manager)  
Just to add to that, if there are complex patients with multiple needs, it may be better off that the consultant himself looks after them, he becomes the clinic doctor and the consultant as well for that particular patient which makes it a lot easier in terms of making decisions and CTO. Obviously a rapport becomes much easier. (Doctor) |
| Supervision (by the consultant psychiatrist) | 6 | Total: 8  
Doctors: 5  
Case Managers: 3 | I think meeting with a consultant psychiatrist on a regular basis, is good practice, in that people do get that opportunity to discuss their CTO, and it’s not just a piece of paper that’s non-negotiable. (Case manager) |
| Team approach and collaboration (includes having non medical input) | 13 | Total: 37  
Doctors: 11  
Consumers: 6  
Case Managers: 13  
Carer group: 4  
MHRB: 1  
Senior managers: 2 | These reviews aren’t just the doctors on the whole. Now he’s made it very clear that it’s the doctor’s decision but the consumer’s and other people’s views including in the clinicians on the team will be considered and taken into account in the final decision. So quite often I think sometimes when I was in the CCT it was the doctors did the CTO review and if you’re not careful there could be a splitting or an unresolved disagreement between members of the treating team and that’s not healthy for the team or for the consumer ultimately. So maybe best practice would be about everyone is involved and owns it but the ultimate decision medico-legally still lies with the consultant not just the psychiatrist or delegate, yeah. (Doctor) |
**Good practice with people on CTOs**

The above table has assisted in identifying five areas of good practice that have emerged as principles from the raw data. They are as follows:

- Use and develop direct practice skills
- Take a human rights perspective
- Focus on goals and desired outcomes
- Aim for quality of service delivery
- Enhance and enable the role of key stakeholders

There are examples above where particular groups appear to mention one node or theme in particular. Whilst all key stakeholders appeared to value talking and listening this is a theme that consumers most strongly endorsed when asked about good practice. Peaks for case managers can be seen in relation to being authentic, flexible and able to negotiate while also taking a team approach and maintaining a regular routine. Doctors have an overwhelming response in relation to thoughtful decision-making and they are also very strong in relation to involving carers in treatment plans. Doctors also expressed support for developing rapport, building relationships and focusing on strengths. Case managers frequently talked about the importance of taking a holistic approach and consumers and case managers appeared to equally see the value of working with the consumer’s construction of the presenting problem. Consumers frequently mentioned respect and the need for practical support. Doctors, in particular, discussed the importance of continuity of care. Overall doctors had the most to say about good practice, as indicated by figures 4 through to 10, although this finding needs to be considered in the context of doctors tending to be among the more articulate and talkative respondents.
Each of these five principles represents particular actions or processes. The principles, and processes that enable them to be realised, will now be presented and discussed in detail.
**Principle One: Use and develop direct practice skills**

Figure 4: Comparison of Number of References for Key Stakeholder: Use and Develop Direct Practice Skills

![Bar chart showing comparison of number of references for key stakeholders.](image)

This principle represents a synthesis of findings in this study that recognise the frustration that many consumers and family/carers experience, and other key stakeholders observe, about people not feeling heard and understood. This appears to relate to key stakeholders consistently coming across examples in their experience of mental health service providers not demonstrating basic direct practice skills when it comes to people on CTOs, including being genuine and respectful. Not feeling listened to, or heard, has contributed to an increased experience of powerlessness and potential for people to be reluctant to cooperate with health service providers, and this is consistent with findings from other qualitative studies (Watts & Priebe, 2002). These findings suggest some common understanding about what is basic good practice, whether someone is on a CTO or not, and the importance of this basic good practice not being overlooked or under developed when it comes to providing direct service to people on CTOs, especially when attempting engagement and building rapport. It is also apparent that some more advanced skills are required, including the ability to be authentic and transparent. Implementing CTOs requires being able to have ‘difficult’ conversations within which different views and perspectives are acknowledged openly. There is an expectation amongst these key stakeholders that service providers will be
able to negotiate and be flexible, while also aware of their authority in the situation, thus developing a shared understanding of limits or boundaries. Being able to work with, and involve, family/carers will be further discussed below. However, what is apparent in this principle is the need to also be able to provide advanced skills in assisting family/carers and consumers in their relationships with others, so being able to undertake family and individual work that has a therapeutic purpose. The challenge here is that whilst advanced direct service skills are expected, it is important to also provide practical assistance, even if this is time consuming. It appears that providing practical assistance is an important factor in achieving engagement and trust. This may be particularly important with people such as Joseph who struggle with talking and listening but can appreciate the benefits of practical support. The case studies also highlight the importance of cultural sensitivity in the work, by carefully understanding the meaning attached to the CTO and its impact on family relationships. Another expectation is that the worker’s potential anxiety, in the context of the pressure to manage risk, be contained. That is, the service providers are not so overtaken by the need to manage risks that they avoid taking chances or attempting to minimise, as much as possible, the use of coercion. Minimising the use of coercion is related to the finding that one of the most negative consequences of being on a CTO is the negative impact on personal agency and self-efficacy, factors that have been highlighted as important in achieving compliance with treatment and recovery (Mancini, 2007; Thorne, 1990; Watson, et al., 2007).
**Principle Two: Take a human rights perspective**

Figure 5: Comparison of Number of References for Key Stakeholders: Take a Human Rights Perspective

This second principle synthesises comments consistently made by key stakeholders about the importance of attempting to protect the human rights of people on CTOs. While CTOs may already represent a fundamental violation of human rights, respondents were generally not inclined to engage with this issue when discussing good practice (perhaps because they were not really asked directly whether they were ‘for or against’). Rather they talked about protecting human rights within the boundary of the CTO. In particular, ensuring that people on CTOs are made aware of their rights. It has been found elsewhere that this is not the simple requirement it seems to be (Brophy, et al., 2007, September; Rolfe, et al., 2008). Key stakeholders were aware that there were examples in their own experience, or in what they had observed, that suggested that people on CTOs and their family/carers did not really understand the CTO, its implications and their subsequent rights, even though key stakeholders thought this was an important aspect of good practice. One respondent suggested that a barrier to people being fully aware of their rights is that service providers might consider this threatening. What she seemed to mean was that having people appealing their orders, perhaps involving legal representatives or requesting second opinions, may represent a burden to service providers that they want to avoid.
Although not an opinion shared by all respondents, procedural fairness and encouraging people to attend and be involved in their Mental Health Review Board hearings was also seen to be part of good practice. This is consistent with recommendations by Winick (2003) who has promoted ‘therapeutic jurisprudence’ through a therapeutic application of OPC laws. Winick (2003) contends that this can be achieved through the experience of procedural justice and:

We should provide meaningful hearings that treat the individual with dignity and respect and satisfy his need for voice and validation (p. 133).

This contention is challenged by McKenna, Simpson, et al. (2006) who did not find as much support, in their linear regression analysis, for procedural justice as a factor that influences peoples experience of coercion in on-going community care. They speculate that perhaps this is an aspect of good practice held in higher esteem by clinicians.

The contradictions seen above, of clinicians both favouring and being wary of a human rights approach, is supported in a comment made by Bindman, Maingay, & Szmukler (2003) in their investigation into the impact of rights based legislation:

Although some clinicians might not welcome increased scrutiny of professional judgements by the courts, others may see the benefits of a counterbalance to the increasing social and political pressures to treat coercively. (p.92)

Consumers are very poorly represented in making comments that support this aspect of good practice. Indeed only one makes a comment that was coded under the node of procedural fairness, although there are three specific comments made in the context of the consumer group interview supporting the importance of consumers obtaining advocacy. Meanwhile no consumers seemed to make comments about the importance of having an awareness of rights and the appropriate use of authority. The lack of responses supporting this principle from consumers perhaps makes sense in the context of the MHRB and other human rights protections being seen to be remote or
not available. Consumers expressed futility about the role of the MHRB and administrative review, with a sense of a loss of hope that the MHRB would act in their interests. These findings appear to support the criticisms of the MHRB for being too closely attuned to the views of service providers, as found in a report published by the Mental Health Legal Centre in Victoria (Topp, et al., 2008).

What are the implications of these findings? It may be that this represents consumers, at least in part, rejecting the individualism that can be linked to a negative or first generation human rights approach (Ife, 2001). Furthermore, expectations that consumers will sign their treatment plans and attend their MHRB hearings, seems to be about meeting an inherently contradictory expectation of neoliberalism that there will be greater involvement of consumers, who should be seen as autonomous and self reliant individuals, while they are also increasingly regulated, controlled and generally only offered hollow choices (Webb, 2006). The limited availability of independent advocacy in Victoria is also problematic and perhaps contributes to consumers being less hopeful about human rights protections (Carney, et al., 2008; Department of Human Services, 2008b).

So, should the service provider’s support for taking a human rights perspective be ignored because it does not reflect the voice of the consumer and family/carers in this study? It seems that this is an aspect of good practice that for various reasons remains remote and poorly understood as far as consumers and their family/carers are concerned. It may be influenced by the finding that many of the consumers and carers interviewed already had a poor understanding of their rights including; the role of the MHRB, the relevance of procedural fairness, knowing how to get advocacy, to appeal or get a second opinion, accessing files and so on. It might also be about knowing what authority service providers do and do not have, and what their respective roles are in decision-making. Again these were thought to be very important things from a service provider point of view but not as commonly mentioned by consumers. Perhaps lack of knowledge regarding human rights issues explains why consumers did not speak up about it in the interviews.
Even so, one case manager interviewed was actively trying to address these issues through making use of audio visual material that had been prepared by the MHRB:

I think that’s again another one of the – a good practice around CTOs, that people actually know the process. I’ve actually had the DVD and shown it to Peter, from the Mental Health Review Board. I think that that was also an important element, particularly at his level of interest. I plan to show it to my other clients as well, because I think again, that medium of the audiovisual stuff is far more powerful than sitting there with a bit of paper, which I can read through with them. (Case Manager)

What seems to be important here is being able to recognise that empowerment, in the form of exercising ones human rights, is not necessarily confined to the neo-liberal strategies of individual autonomy and choice and what can subsequently be contradictory and potentially exposing and humiliating expectations (such as attending a MHRB hearing and not feeling heard). Rather it is about offering an ethical socialism that emphasises the need for shared responsibility in being able to make choices (Webb, 2006). What this might mean for workers and consumers is a genuine dialogue about rights and what might be the benefits of attending a MHRB hearing or asking for an advocate and facilitating the consumer’s subsequent choices.

There is no doubt that the strongest criticism of decision-making that too obviously favoured autonomy or an individualistic human rights approach to people on CTOs came from the family/carers interviewed. Although it needs to be kept in mind that, for various reasons discussed earlier, they were not strongly represented. The family/carers interviewed expressed high expectations regarding intervention, one even suggested taking her son away from drugs and gambling with the expectation that wherever he went, he would work. And she wanted this for not only her own son but for all the sons she had seen in this situation. This is part of what she said:

You know what I think, Lisa, I’ve got...with all that years and with the kids I see, because Joseph’s got some friends come round here and I saw...that boys. I think to myself, ‘Well, alright. I know about ten kids the same position with Joseph.’ What about other people? They know another ten kids and another ten kids...
something. Sometimes I think, back in the farm, all the kids to do something, you know. Not just let them hang around and pay you and that’s it. Finished. Not good, you know, for the parents and not good enough for them, too, because what they do. They come together. What do they think? Oh, smoke cannabis. Oh yeah, yeah. Cannabis. Joseph takes my car, without a license, and he goes to smoke cannabis. That’s a terrible thing. With all the other kids. They…do, because of the cannabis. They…disabled, too. You see. The government, I think, has to do something about it. You have to go for work, community work, for two or three hours a day. Otherwise, they cut your pension.

Later she adds:

The only thing it can help...like I tell you, for a few hours, an hour, you know. Maybe it costs the government a lot of money to do that. But the government no care. Like I tell you...they should have...far away from here. They put all these kids inside and they should work. Do community work or do something. (Carer).

It’s interesting here that this carer thought this service (of making people on CTOs work) wasn’t offered by the government because it was too expensive. Pointing out that it would violate human rights seemed irrelevant.

Although it might be argued that these comments represent an extreme or an exception, there are similar themes, about distrusting human rights based approaches, raised by Lewisohn (2008), a family/carer advocate, who argues against the involvement of legal advocates in MHRB hearings. Similarly, a carer group member was pleased her son didn’t attend a MHRB hearing because he trusted his doctor so much, and there are other examples. It appears that family/carer engagement with human rights issues is an important challenge when it comes to CTOs, in the context of the findings of this thesis.

There are indications that family/carers are justifiably becoming more powerful key stakeholders in mental health service delivery. For example recent and proposed changes to legislation that mandates carer involvement is just one development that supports this observation (Department of Human Services, 2008b, 2009). It seems that there is a risk that subsequently the focus on human rights, supported by many participants in this study, will not be supported by family/carers. No disrespect of any kind is meant to family/carers in this comment, but what it suggests is the need for greater sharing of information about the values and the priorities of different key
stakeholders in defining good practice. Enabling family/carers to see human rights from new perspectives and understanding the value they hold to other key stakeholders, including consumers, seems important.

**Principle Three: Focus on goals and desired outcomes**

Figure 6: Comparison of Number of References for Key Stakeholders: Focus on Goals and Desired Outcomes

![Graph showing comparison of number of references for key stakeholders]

I think they’re using CTOs more frequently than necessary. That’s my strongest opinion. (Doctor)

The issue raised by the quote above, and elsewhere (Dawson, 2005), is that there is considerable concern about overuse of CTOs in Victoria. It is possible that this occurs, in part, because of a lack of careful consideration of how and why CTOs are being used.

The principle of focusing on goals and desired outcomes emerged in the context of strong evidence of agreement amongst all key stakeholders that being mindful of who is on the CTO, why they are on it, and what outcomes are important to enable them to be discharged from the CTO, are core parts of good practice. The principle of being focused on goals and desired outcomes reflects the awareness in these findings about the diversity of people on CTOs. It acknowledges that, at least in Victoria, people are on CTOs for different purposes even though there may also be some important common issues, such as dealing with non-compliance with treatment. This diversity is
also reflected in the range of possibilities regarding what might be achieved during the time the person is on a CTO. It suggests setting realistic, achievable goals that build on the person’s strengths and interests, reflecting a holistic approach. It actively supports being able to address the issues that may be interfering with the person’s recovery, including the disempowerment they may be experiencing as a result of the CTO itself. Therefore, as many key stakeholders suggest, the focus is not a problem saturated perspective but rather it is one that tries to encourage self determination and empowerment to the extent possible. It is also about a relationship, between service providers and service recipients, which is based on shared responsibility and seeks to establish mutual accountability. Good practice in observing this principle relies on maintaining regular contact and routine in relation to appointments and expectations. For example:

He has expressed that he only likes to come here on Thursdays, because it doesn’t interrupt with his daily routine. I guess, in a way, that he wants to maintain a sense of control or a sense of ownership of something else in life, maybe another activity that he will only come here on a Thursday, to receive his depot. (Case Manager)

Exploring options such as ‘compliance therapy’ may be important to approach the problem of medication non-compliance (Kemp, Kirov, Everitt, Hayward, & David, 1998). The importance of dealing with substance use is referred to here. This relates to both quantitative and qualitative findings in this study suggesting that one of the key reasons why some people are on CTOs is because of substance use that is contributing to poor mental health. The findings indicate that, where this is the case, directly dealing with helping the person minimise or eliminate their substance abuse represents an important example of being focused on desired outcomes and goals. The importance of mental health services developing a willingness to provide improved service delivery to people with a dual diagnosis has been discussed elsewhere (Barrett, 2005) and underlies the recent development of the Victorian dual diagnosis initiative (Victorian Government 2007). It also builds on the importance of being focused on discharge by directly dealing
with the factors that have led to the perceived need for forced treatment. This also relates to exploring the complexities of non-compliance and developing strategies that will assist in preventing relapse.

Assisting people to gain employment appears to have been an important potential goal raised here. In Joan’s case, she was convinced that employment had been very important to her recovery and she anticipated it would be useful for others. Joan’s view is supported by evidence that employment has been identified as an important social determinant in relation to mental health. Unemployment, for example, has been found to be the most consistent variable in high readmission rates to psychiatric inpatient units (Kammerling & O’Connor, 1993). However, unemployment has also been an intractable problem amongst people with serious mental illness (Herrman & Harvey, 2005) and, as can be identified in the cluster analysis, a consistent characteristic of people on CTOs. Despite the difficulties, introducing more individually tailored rehabilitation goals that focus on occupation and social inclusion may prove to be an important part of assisting someone on a CTO to work toward discharge from the CTO and/or recovery, as Joan and others have suggested (Herrman & Harvey, 2005).
**Principle Four: Aim for quality of service delivery**

Figure 7: Comparison of Number of References for Key Stakeholders: Aim for Quality of Service Delivery

![Bar chart showing number of references for different key stakeholders](chart.png)

This area of direct practice is in many ways dominated by the theme of ‘continuity’. In the opinion of many key stakeholders, many of the problems attached to CTOs might be minimised if there was greater continuity of care. However, this principle also includes aiming for a higher standard of care that involves thorough assessment, rigorous review, careful treatment planning and the development of more attractive or less abhorrent treatment options. It also warns against the possibility of services being orientated toward the treatment of people on CTOs such that discharge from a CTO puts the person at risk of being abandoned by a resource limited service. This concern has also been expressed in Scotland, where CTOs have been relatively recently introduced. Psychiatrists surveyed expressed concern that the care of informal or voluntary patients was being adversely effected by the new Act because of a concentration of resources on those subject to the Act’s powers (Carswell, Donaldson, & Brown, 2007). This suggests that there is a current problem, if not at least the potential risk, that mental health services, in prioritising involuntary clients, may be doing this at the expense of ethical practice that honours the principle in the *Mental Health Act, 1986* (Vic) of providing care and treatment in the least restrictive environment. This principle is poorly interpreted if it results in inappropriately discharging people before their needs from an appropriate
public mental health service are met. There were other problems about access to services discussed by the informants. In particular, observations that CTOs are being inappropriately used to guarantee follow-up in the community. Again this is a very problematic, presumably unintended outcome of CTOs, one that reflects an interrelationship between resource issues, the characteristics of the consumers (who might not otherwise get access to follow-up if they are not on a CTO) and the potential for instrumental or functional, rather than care and treatment, driven use of CTOs. This was discussed with one doctor as follows:

Interviewee: I mean I’ve been in this service for so long and I do the allocations, and any person that comes in for allocation immediately would be on a CTO because there is that level of concern for the referring clinician if the patient is not on a CTO, rather than she needs services and to be observed so that is something I’m observing …a bit more frequently.
Researcher: So it’s almost like setting up a contract that can’t be breached.
Interviewee: Yes.
Researcher: Like if someone is on a CTO we can’t not accept them.
Interviewee: Exactly.
Researcher: So it’s almost a way of ensuring that they have access to the community based services.
Interviewee: So that thinking of people, what can work around that, you know, I mean, based on it still would be desirable to see patients who are not on a CTO. And, yes, I’ve seen patients being on a CTO for drug induced psychosis and you know can you modify anything there? No, they’ll still use drugs and they’ll become unwell. And there are patients who are on CTO just for antisocial personality disorder. I don’t know the reason for that but whether this will be treatment of clinicians on the other end, you know, they just don’t review the situation as to the context of CTO so they just keep extending the CTO for longer periods and they see it as the culprit.

Hence, there seems to be a rather ‘dark side’ of continuity of care when it involves inappropriate use of CTOs to ensure continuity from one point of service delivery to another in a complex mental health system. This has been observed by participants as most often from the inpatient unit to the community, but other studies have related this to ensuring access to crisis assessment teams (Brophy & Ring, 2004). This is another unintended consequence of CTOs that may be addressed through the
clearer application of principles, such as aiming for quality service delivery, whereby there is a stronger commitment to providing care and treatment that is driven by the needs and wishes of the consumer, rather than by the limitations of the service system.

Continuity of care, as it relates to the need for continuity of service provision, establishes a dilemma for many mental health services that are also teaching facilities; tolerating the need to rotate psychiatric registrars (usually every six months) as part of their training needs. It also raises awareness of the problems mental health services appear to have in maintaining consistent staff. Whilst the rotation of registrars is expected, the difficulties in recruiting and retaining case managers was also apparent in this research, as was the frustration this generated for consumers, family/carers, the MHRB and the service providers themselves.

Quality service delivery in relation to CTOs is frequently discussed in the literature. Not so much in relation to good practice but in relation to the question of whether better resourcing of outpatient care and other improvements in service delivery may minimise the use of CTOs, or improve outcomes. However, Churchill, et al. (2007) suggest that there is minimal current evidence to better understand the process by which CTOs might work. Doctors demonstrated considerable support for aiming for quality service delivery and perhaps this expressed their awareness of a lack of innovation and development of treatment models with regards to practice with people on CTOs, unlike other areas of psychiatry.

It is suggested in these findings that there is an interaction between quality service delivery, CTOs and improved outcomes, and this needs to be more fully understood. It relates to this principle in that, while key stakeholders gave considerable support to aiming for quality service delivery, the question remains as to what impact this or any of the other five principles of good practice might have on outcomes. It seems that key stakeholders assumed that a better outcome would result. However, there were probably multiple definitions in use about good outcomes or what it means to say that a CTO works. This research supports the idea that implementing good practice is a good outcome and it relies on quality service delivery.
Principle Five: Enhance and enable the role of key stakeholders

The key stakeholders highly valued thoughtful decision-making and identified enhancing and enabling the role of key stakeholders as central to decision-making that is accountable, reflective, collaborative and skilful. Thoughtful decision-making seemed to be particularly important to medical staff. They made the vast majority of references to this as an important aspect of good practice. It is possible that this reflects the current emphasis on decision-making being the ‘domain’ of medical staff with others only contributing rather than being central or essential. Barriers to good decision-making appeared to be related to a lack of meaningful participation and ensuring that those who are making decisions have access to all the relevant information and informants. Other barriers included minimal genuinely enabling and responsive opportunities for CTO recipients to be heard. Family/carers were seen to be important, particularly when considering how often the family/carer’s interests are being considered in the implementation and continuance of CTOs.

As discussed above a barrier to enhancing and enabling the role of key stakeholders is the rotation of medical staff and subsequent perceived lack of continuity of care. In respect to this principle, one ‘antidote’ suggested, particularly by the
consultant psychiatrists interviewed, was that their role should be enhanced to compensate for the rotation of psychiatric registrars. One even suggested that perhaps people on CTOs should only be assigned to consultants (or authorised psychiatrists), although this was challenged by others who thought this would interfere with the importance of doctors being trained to develop competency in working with people on CTOs. Either way, there was considerable support amongst medical staff, case managers and senior managers for increased involvement by the consultant or authorised psychiatrist, particularly in situations where they have the authority, but are not the treating doctor. This was considered important in assisting with the difficulty of maintaining continuity of care but also seen as helpful in improving decision-making because of the experience and knowledge that a consultant psychiatrist can bring to the situation. They may also maintain a long term – if rather remote – involvement that can represent a good position to recognise patterns, including improvements in the person’s functioning, and possibly changes occurring in relation to the purpose of the CTO. For example:

I think some of the barriers that I thought were in any mental health services, it is quite common that they have different conditions, say like they (doctors) are just rotating through the clinics every six months, so that there’s hardly any time for them to get to know the patients. If there was a clinician who had known a patient from that service for 12 months, I would say that’s a reasonable time to be telling what needs to happen. (Doctor)

Involving consumers in decision-making about their treatment and giving recognition to their concerns, particularly about medication and side effects, is an important part of this principle and the processes required to enable it. This goes back to the concern about not being heard, and the value given to talking and listening. However, it is supported on the proviso that consumers are not pressured into providing a particular ‘type’ of involvement, such as having to read and contribute to a treatment plan. Although this is inevitably important for some, appreciating different levels of literacy and comfort with such an expectation is important. Therefore involving consumers is potentially a complex task, requiring thoughtful consideration that takes
into account the persons views, needs and capacity. Tools such as advance directives may offer valuable support to the implementation of this principle for consumers (Swartz & Swanson, 2007).

Similarly involving carers and family members was given considerable support, to the point where one consumer seemed to prefer service providers talking to his mother rather than trying to engage him in conversation. This is in line with principles developed by the World Fellowship for Schizophrenia and Allied Disorders (1999) (cited in Bland & Renouf, 2006). These principles recommend collaborating with families and treating them as equal partners in planning and providing treatment and care. However, again, there is diversity here that needs to be carefully negotiated. Firstly it needs to be acknowledged that family/carers may be involved in a number of different ways and there may be multiple goals being undertaken. First, they have been supported in being involved in treatment planning by this study. However, at least one consumer expressed concern about family involvement in treatment planning, perhaps because she did not see her daughter as a ‘carer’. Involving family/carers in treatment planning involves sensitive and careful negotiation to balance maintaining engagement and preserving family relationships (Bland & Renouf, 2006). The second aspect of involving family/carers requires the advanced direct service skills discussed above. This suggests a therapeutic role, assisting directly with family relationships, such as via family therapy. Again advanced skills are required in being able to ensure that family/carers’ needs are being heard and that their involvement reflects these needs, whilst also accommodating the interests and needs of consumers. What is particularly important in working collaboratively with family/carers, in the context of CTOs, is located in the findings reported earlier - that often it is the family/carers’ interests that are being taken into account when decisions are being made about whether a CTO is required or whether it should continue. Consider the following:

And we really need to listen to those families, because the families that are saying please don’t take that order away because it makes a difference, are most likely the families who are most burdened at the point of relapse, and are most
burdened overall generally by it, in every way, emotionally, financial, physically
often burdened by it. That’s in one way why I think we should listen to them. I
know least restrictive can mean lots of things, and maybe it’s least restrictive for
our client. Maybe we need to look at least restrictive for the families as well. It
doesn’t fit into the legislation. (Case Manager)

This comment and observation is consistent with the findings of Groff, Burns, et
al. (2004) that CTOs can reduce the strain that family/carers can experience when caring
for someone with a severe and enduring mental illness who is reluctant to receive
treatment. The discussion about the potential diversity in how carers and families might
be involved in CTOs suggests that it is particularly important for service providers not to
make assumptions (or even guess) about the needs and experience of the carers and
family members involved, especially considering the potentially profound impact this
appears to be having on the implementation of CTOs.

Case manager involvement in all aspects of decision-making has been strongly
supported throughout the interviews. Whilst there is no doubt that case managers are
actively involved already, there is minimal recognition of the importance, perhaps even
centrality, of their role in the Mental Health Act, 1986 (Brophy, et al., 2003). Therefore,
their potential for a significant role in key decision-making is, at least formally,
minimised. There are findings here that case managers are not always well equipped
and prepared for this role, suggesting that if participation and involvement by case
managers is to be supported and enhanced then it also requires staff training and
development that builds expertise.

**Conclusion**

This chapter has attempted to further develop understanding about what
processes and principles represent good practice with people on CTOs, the fundamental
question of this thesis. Using the emancipatory values of social work to guide the
investigation has been important because it has ensured that the views of multiple key
stakeholders have been heard and valued. There has been a dual process of both
individualisation and deindividualisation. That is, recognising the need to consider
particular individuals and their circumstances, and this was particularly enabled through case studies, and also being able to discuss the issues raised by particular groups, through thinking into the issues potentially faced by those in the different clusters, and also through grouping the views of key stakeholders.

Generally there is agreement amongst the key stakeholders about good practice although some differences in emphasis between key stakeholders seemed to have emerged. Doctors tended to generally say the most about each of the principles. The doctors enthusiasm about talking about their ideas about good practice possibly reflects their current position of having considerable responsibility for the implementation of CTOs and therefore experience to draw on. Their considerable support for enhancing and enabling the role of key stakeholders perhaps reflects their preparedness to share more of this responsibility with others who can provide a range of perspectives.

Emancipatory values have proved to be useful in interpreting the findings. These values helped provide the descriptions for themes such as empowerment and authenticity. The degree to which the principles and inherent processes are strongly aligned with the underlying values of social work appears to deserve comment here. It does not seem flippant to say that these findings could be summarised as good practice with people on CTOs is well represented by ethical, competent and value driven social work practice (Bland & Renouf, 2006).

Furthermore, the findings, as represented by the five key principles listed, are consistent with the recommendations that have previously been made by Mullen, et al. (2006) and also the Chief Psychiatrist in Victoria’s guidelines (Chief Psychiatrist, 2005). In particular, there is considerable agreement here about the role of family/carers and the need for strong therapeutic relationships. However, the previously published guidelines do very little to consider how they might vary or be adjusted depending upon the characteristics of the CTO recipient or the different purposes or goals of the CTO.

The lack of adequacy of the current guidelines and also, potentially, the lack of importance given to them by service providers in Victoria is represented in the following comments:
These guidelines should be on when to consider to make someone involuntary instead of voluntary, or discharge them off CTO, that might be helpful because at this stage I think many clinicians are reading matter of fact differently, you know, it depends on the experience of the ... and they may be placing more people on CTO and that’s wrong. (Doctor)

And:

Interviewer: Have you got a copy of the CTO guidelines?
Interviewee: No, I don’t think... I think I’ve got an abbreviated version of it from someone’s summary but I don’t have an actual book of it. (Case Manager)

These findings have led to a much more in-depth understanding of the use and experience of CTOs in Victoria via a case study of one of 22 area mental health services in Victoria. This case study suggests that CTOs are used for a variety of purposes for a diverse group of people. However, one of the great dangers of CTOs is that they are at risk of being used as a ‘one size fits all’ insurance policy that loses sight of the ‘fine print’; the need for careful implementation, reflection and decision-making that values full participation by all key stakeholders. This study has also confirmed that people on CTOs are generally a disempowered and stigmatised group of people whose interests need significant protection. This is not meant as a patronising comment. To patronise would be inconsistent with another finding, that people on CTOs are, in the main, able to ‘speak up’ about being on a CTO, including offering valuable insights into ideas about good practice and the mental health system they find themselves negotiating. But they are caught up in a situation that has a profound impact on their personal freedom and one that has significant current limitations in its ability to protect their interests. This is not only at the level of what can be described as their ‘negative’ rights, such as those of bodily integrity and procedural fairness, but also in relation to ‘positive’ rights such as access to adequate care and treatment when on a CTO. This also includes the quality of treatment and care they receive, and their access to the range of support services required to meet their needs.
Chapter Eight: From Theory to Practice: Applying the Principles to the Case Studies

Introduction

In the previous chapter, as a result of qualitative data analysis, five principles, and the processes required to enable them, were identified. These principles have been identified in order to guide good practice with people on CTOs. The principles emerged from an analysis of the data gathered from all the respondents in the case studies and the group interviews about what represents good practice. To reiterate, the five principles identified are as follows:

- Use and develop direct practice skills
- Take a human rights perspective
- Focus on goals and desired outcomes
- Aim for quality of service delivery
- Enhance and enable the role of key stakeholders

The research design now also enables another layer of analysis because of the opportunity to revisit the case studies. In order to further develop the discussion of the relevance of the principles and in some ways ‘test’ the validity and relevance of these findings, each of the case studies will be revisited enabling some discussion of how the principles have been, or may be, applied (and potentially modified) when thinking about the different ‘types’ of people on CTOs identified by the cluster analysis.

Revisiting the case studies is consistent with the critical social science paradigm that has guided this research. Neuman (1999) explains that:

The critical approach separates good from bad theory through praxis: by putting the theory into practice and using the outcome of practical applications to reformulate theory (p.70).
Whilst the ‘testing’ below ideally should be occurring in the domain of current practice, applying the principles back to the case studies provides a beginning point for praxis.

**Applying the principles to the case studies**

This chapter revisits the findings presented in Chapter Five. The comparative table developed at the end of that chapter is repeated here.

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Case Study One

Returning to the findings of this case study, it was established that the following three themes were particularly relevant:

- Comparative liberty
- Family/Carer interests
- Flexibility and rapport.

How then might the five principles be applied to Joan’s case?

Use and develop direct practice skills

Joan was particularly articulate about her need to see well developed interpersonal skills among her treating team. She expressed some frustration (although kindly) about what she perceived as the inexperience of her case manager and the limited nature of their interactions. She discussed how important it was for her to ‘debrief’ about her experience as an inpatient and appreciated opportunities to talk and get support. Meanwhile her doctor expressed some pride during his interview about how well he had engaged with Joan and how he hoped that he could apply these skills in other situations where perhaps, like in Joan’s case, the degree of coercion could be minimised and the length of the CTO reduced. His statement below summarises the situation:
I don’t want to take any credit on her engagement with the service but I suppose the level of empathy that is shown by her clinicians has been helpful. I wonder now whether we can do this with the other patients as well, whether we can cut down on the use of CTO. I think the CTO can make for instance the change and then it might cease to be effective after a while if you got a good rapport (Doctor).

**Take a human rights perspective**

There is evidence in Joan’s case that considerable effort was made to treat Joan in the least restrictive environment possible within the boundaries of the CTO, consistent with the principles of the *Mental Health Act*, 1986. This is demonstrated in the CTO being used to enable earlier discharge from hospital (a place Joan found abhorrent), and in the degree of flexibility and negotiation that was demonstrated in Joan’s treatment and care. It seems that this was appreciated by everyone involved and possibly led to Joan’s positive comments about her overall experience of being on a CTO.

Joan attended a MHRB hearing, without representation and without even her doctor present. He was only able to give his evidence by telephone. Joan seemed to have an understanding of the role of the MHRB and, whilst she said she respected the process, she seemed cynical about the degree to which her interests were being represented. If Joan had received advocacy as a matter of course then perhaps this would have been a much different, more positive, experience (Carney, et al., 2008; Winick, 2003).

**Focus on goals and desired outcomes**

Joan was very keen to return to paid employment and she thought she did most of the work to enable re-connection with job support services and, even then, wasn’t confident that they would help very much. She expressed frustration, more for other
consumers she was aware of than herself, that very little was offered by ‘the clinic’ to help people in ways other than making sure they were taking their medication. She said she thought it would be good to see people having more opportunity to go to work or be engaged in meaningful activity, something she saw as the key to her own recovery:

I think there’s a lot of disabled people could work and I think the CTO, with the time they spend here I think they should be encouraged to do something productive, not just come here, “See you later”, come back next fortnight, whatever, I think they should... whatever that is, whether it be working or hobby crafts, whatever, I think that they should be encouraged to be more active (Consumer).

Aim for quality of service delivery

Joan maintained some continuity of care and this is not surprising considering the relatively short time she was on CTO. However, by the time of the follow-up interview, her case manager had moved to a different team. She had been discharged from the service to her general practitioner prior to the follow-up interview and expressed some disappointment at this time that she had been discharged prematurely by the service following being taken off the CTO. Her situation supports the idea that being discharged from a CTO does increase the risk of premature discharge from community based services, although Joan did describe herself as doing well at follow-up and she remained engaged with follow-up services.

Another interesting issue in Joan’s case is that of the application of evidence based practice. Dawson (2005), in his review, comments on findings that suggest that CTOs are unlikely to be of benefit for people who have a diagnosis of bi-polar affective disorder and this is supported by a comment made by a service provider in another case study:

I don’t think as physicians we’re really good at picking (those who will do well). There’s a clear group of people with bipolar disorder who don’t do well I think (Doctor).
Perhaps Joan’s case highlights the problems around the use of ‘evidence’ in the context of so much diversity. The need for review and second opinion seems important when there are doctors, in the same service, who might have formed a different view about whether it was ever appropriate for Joan to go on a CTO.

Enhance and enable the role of key stakeholders

In Joan’s case two issues in particular come to mind. One is the inexperience of her case manager who admitted to being unprepared for working with people on CTOs, who was unclear about her potential role at the MHRB and she was basically learning about this ‘on the job’ without any specialist training and development. This did not go unnoticed by Joan. Another area of particular relevance is the dilemmas created in this case study when it came to the family member involved. Firstly, there was the fundamental problem of a lack of shared understanding of whether Joan’s daughter was a carer. Certainly Joan consistently did not see it that way during her interviews. So, even though Joan’s daughter was being supported through the use of a CTO, from the treating team’s perspective she was ‘locked out’ of active participation in Joan’s care and treatment. There is consistency here in Joan not wanting her daughter interviewed in this research. Involving Joan’s daughter and other family members in her treatment and care would require advanced negotiation and direct service skills, and this highlights the degree to which the principles do not stand alone – they are interconnected and interdependent.

Case Study Two

In Peter’s case the key themes that emerged were:

- Mutual Accountability
- Achieving Compliance
- Recovery focused or holistic approach to treatment
The impact of the CTO on personhood

Applying the principles to Peter’s situation provides the following commentary:

Use and develop direct practice skills

Both of the case managers who were interviewed emphasised how important providing practical support to Peter had been in their attempts to engage with him and develop a positive relationship. This had not necessarily been easy because of some of Peter’s difficulties with independent living. He was also ambivalent about the workers and mental health services. Even so, the intensive support that Peter was receiving as a result of being cared for by the MSTT appeared to be seen to be helpful. Talking and listening was also supported, particularly in giving Peter time to talk about being on a CTO and its meaning for him. It was apparent that the service providers were required to combine advanced interpersonal skills with preparedness to undertake practical support, such as helping with household tasks.

Take a human rights perspective

This principle seems to be particularly important to Peter’s situation. He had been on a CTO for many years and he expressed considerable ambivalence about it. He was aware of how it offered him a guarantee of service, but he also thought the CTO compromised his autonomy, self-efficacy, and potentially his recovery. He was aware of the MHRB and his case manager mentioned that he had sought legal representation. Peter was very preoccupied by this and his case manager lamented:

Yeah, look, just because of the constant explaining. I really feel that it wastes so much time, us sitting and debating the pros and cons of being on a CTO. I feel frustrated as a case manager that we can’t get down to the nitty gritty of helping him work on his quality of life. And being able to build other things into his life, that are meaningful, that he might benefit from, like socialising with people at
The Exchange, going on respite holidays, having more contact with his family. I can’t work with him on those sorts of issues, because we debate the pros and cons of his CTO all the time, for hours (Case Manager).

Peter was seen to be a high risk and complex person, but this was particularly based on serious incidents that had occurred many years ago. There did not seem to be a plan to get Peter off the CTO, although this was partly due to Peter’s ambivalence about what it would mean if he was off the CTO. Again, Peter may have benefited from a personal advocate who could regularly review with him his rights while on the CTO and assist him to negotiate the many reviews and MHRB hearings that he participates in. Perhaps his situation is a good example of when the separation of these functions from the treating team may be particularly valuable.

**Focus on goals and desired outcomes**

This relates to the discussion above about establishing Peter’s independent living skills. It is consistent with what Hatfield, et al. (2001) have suggested, that providing social support such as housing and daytime activities is as important to risk management as achieving compliance with medication. In Peter’s case there is considerable evidence that a holistic approach was being undertaken with a goal orientated intervention plan.

**Aim for quality of service delivery**

Peter generally did not engage well with psychiatric registrars and tended to see the authorised psychiatrist (or consultant psychiatrist) as his doctor, even though he only had infrequent consultations with her. He also had a change of case manager during the period between the initial and follow-up interviews. Peter and his treating team gave the impression that this transition had been difficult for Peter, even though it seemed to have been thoughtfully managed by the service providers. His treating doctor - a psychiatric registrar - also changed between interviews. Peter generally seemed to be
benefiting from an experienced team that was resourced sufficiently to be able to be holistic in its service delivery, and there was leadership from the authorised psychiatrist around working in this way. However, Peter did seem to worry that the CTO is what guaranteed him treatment and established mutual accountability. Consider the following:

I think he talks more about his individual service plan. He is one of the few people who will say ‘Right, it’s time for us to look at the ISP and what are we saying we need to do and what am I sort of agreeing to?’, and we will go into even things like his house is rather messy and he needs some support with that. I honestly believe he thinks that he wouldn’t get that support without the CTO (Case Manager).

**Enhance and enable the role of key stakeholders**

This again seemed evident in Peter’s case. He has the support of a senior psychiatrist who, although she didn’t see Peter often, seemed to have a long standing knowledge of his situation and there was considerable respect generated. The psychiatric registrar had less of a role, at Peter’s preference. His case manager was at the forefront of his treatment and care, and the importance of case managers being a key person involved in MHRB hearings, or any consultant psychiatrist reviews, is highlighted here.

Peter’s family had only a distant role in his ongoing treatment and care, although there was an impression of their more active involvement in the past. This again highlights the interdependence of these principles whereby probably working on building Peter’s connections with his family and community perhaps precedes any attempts at participation in decision-making that would be meaningful.

**Case Study Three**

In Maria’s case, five interrelated themes were found to predominate. They are:

- Family/Carer interests and involving families
• A team approach to difficult decision-making
• Maintaining continuity of care and reducing vulnerability
• Power, authority and the use of coercion
• Stigma, loss of personhood and strategies to enable recovery.

The following discusses how the good practice principles are relevant to Maria’s case.

**Use and develop direct practice skills**

Maria expressed considerable appreciation when she observed good communication and interpersonal skills being used by those around her. She also appreciated practical support and extra touches, such as her case manager giving her a lift somewhere, or being nice to her son and engaging him in an activity. The service providers appeared to be working hard to try to come up with ways to help Maria be compliant with medication, and try to respond to her concerns about her medication. They also recognised the difficulties Maria experienced in relation to stigma and disempowerment. It was possibly because of the limitations of the interview questions but, even so, there was minimal discussion of interpersonal strategies that might help to deal with Maria’s loss of self-efficacy and feelings of disempowerment. This seems to be a fundamental challenge with people on CTOs such as Maria. How can the service providers, who are imposing the CTO, also assist with dealing with these negative outcomes? In other words, to what degree can the care and control dimensions be integrated? It seems that in Maria’s case this is the challenge when using and developing direct practice skills. Furthermore, Maria’s sometimes fraught relationships with her family members suggested the need for, not only participation by Maria’s family in her treatment and care, but also the need for therapeutic intervention that targeted Maria and her family.
**Take a human rights perspective**

Like Peter, Maria’s situation was complex. She had multiple potential sources of coercion, and the service providers held considerable power (for example, in relation to her access to her son). This degree of power and authority seems to highlight the importance of taking a human rights perspective. Maria and the service providers did not indicate that Maria had at any time received any advocacy and she was ambivalent about the MHRB, seeing this as a remote group of professionals that was unlikely to respect and listen to her.

Researcher: Have you ever been to one of the Mental Health Review Board meetings?
Interviewee: I think I have, I have and I didn’t like that.
Researcher: What didn’t you like about it?
Interviewee: Well I had no hope. There was all old people sitting there – not old but older – and I’ve got no chance.
Researcher: What was it about them being old people sitting there?
Interviewee: No, no I’m just saying like intellectually that’s the way I felt because they have been doing their job for years obviously and I just didn’t feel like I was up to their standards.
Researcher: Yes so it wasn’t like you could relate to them is that what you mean?
Interviewee: I didn’t feel like I could explain myself to them.
Researcher: So it just felt like they would just probably do what the doctor said is that what you mean?
Interviewee: Yes.
Researcher: So you’ve never been back again to check that out?
Interviewee: No.
Researcher: Fair enough.
Interviewee: A lot of the staff know me and I’ve had some incidents; I get a bit violent. They put me in HD (the high dependency unit in the inpatient service) and I said to one of them I want a cigarette can I please go out and have a cigarette. He said no so I went to slap him and he blocked it and he puts me in the isolation room for hours and hours. All I wanted was a cigarette; they’re cruel to you.

Whilst recognition of her rights was attempted in the day to day practice, with attempts at medication reduction at her request, more formality in relation to the implementation of this principle did not seem evident in Maria’s case. This is despite
considerable indication that Maria’s human rights were significantly violated, and her experience of high levels of coercion during her time in the mental health system. Maria may have benefited from an opportunity to prepare an advance statement or directive (C. Henderson, et al., 2008). An advance directive may have helped someone like Maria, who has relatively frequent experiences of relapse and hospital admissions that have a significant impact on her functioning and relationships. An advance directive may help her maintain a voice in relation to her preferences for treatment and care during times of crisis (Papageorgiou, et al., 2002).

**Focus on goals and desired outcomes**

A significant issue for Maria in relation to why she was on a CTO was related to episodes of non-compliance with medication. Maria explained this non-compliance as often being the result of weight gain from her medication. It may also have related to the stigma she experienced, although this was not as clearly stated.

Another important part of her situation was her role as a parent, and enabling her to remain stable for the sake of her child. Maria’s case manager had recognised the gender and power issues inherent in Maria’s situation and in response had referred Maria to a group for women who had experienced domestic violence. This indicated an attempt to engage in a holistic approach to Maria’s care.

The consultant psychiatrist was reluctant to see the relapse and admission that Maria had had between the first and follow-up interview as representing a ‘failure’. Rather she was interested in thinking about what both the treating team and Maria had learned from the relapse. Although the researcher was unable to do a follow-up interview with Maria’s mother, an impression gained from the other interviews was that she was distressed by the relapse and was subsequently very worried about changes in treatment or approach that might represent taking risks with Maria’s care and treatment. Maria’s mother strongly supported Maria remaining on a CTO, so Maria attempting to negotiate changes to her medication or legal status inevitably impacted
on their relationship. The goals of reducing family conflict and maintaining Maria’s supports, while also respecting Maria’s choices and potential for greater autonomy, are highlighted as areas of contention in this case study. Working towards these potentially competing goals requires advanced interpersonal skills on the part of the service providers.

Again what is highlighted here is the interdependence of the principles. It highlights the need for carer and family member participation in developing a shared understanding of treatment goals, that may depend on their approval and co-operation. This principle suggests that service providers are required to work with family members in order to gain their support, or work with their reluctance.

**Aim for quality of service delivery**

Maria’s was the only one of four case studies with the same case manager and doctor interviewed at initial and follow-up interviews, thus enabling considerable continuity of care by particular service providers, as well as the same treating team. Consideration was given to providing Maria with the best possible treatment and listening to her concerns, particularly about the weight gain she attributed to her medication. However, her case manager had taken some leave and did make a link between taking leave and Maria’s relapse. She reflected that she would take more care in future with her handover and do more to ‘trust her instincts’, as she had a vague impression before going on leave that Maria was not compliant with her medication. This suggests the need for opportunities for reflection, review and careful formulation that is based on a team approach rather than located with a particular individual.

**Enhance and enable the role of key stakeholders**

Maria’s case highlighted the difficulties that psychiatric registrars, consumers and carers experience in developing rapport and therapeutic relationships when they
have such a relatively short involvement. In this case it was apparent how well this had been mediated by the consultant psychiatrist’s long term, and relatively active, role in maintaining contact with Maria and having a critical role in decision-making that was able to be aware of the long term patterns and goals. The challenge around this is described below:

I think I might have said this before, is that judgement enabling the person to take risks versus minimising those risks. When you go into the space where they’re not on a CTO and you then let them become more autonomous and responsible but knowing that in the past, in some of those situations, that’s led to an adverse outcome, ie a relapse …particularly relationships with others, putting themselves in a vulnerable situation. So it’s, that is still the core of the issue with her. To what extent, she’s integrated past learning and is able to use that to move forward. (Doctor)

In this case, Maria’s mothers’ involvement was critical but, as described above, challenging and probably dependant on attempts to ‘bring her on board’ in relation to the goals of the CTO and the relevance and fairness of taking risks when all the circumstances were taken into account. Consider, for example, the possibility that Maria’s mother was upset and not talking to her because she had heard about a medication reduction. Whilst Maria’s autonomy has to be respected there are such significant consequences for her when her mother does not agree with treatment decisions (for good reason since she has often ‘picked up the pieces’). The challenge for good practice in attempting to implement this principle, as discussed above, seems to be ensuring that relatives know what is happening. But, it is also about helping them develop an appreciation of why it is happening, and perhaps giving them the chance to challenge the decision to the extent that this is appropriate.

**Case Study Four**

In case study four, the key themes that emerged from the five interviews undertaken with Joseph, his mother, his doctor and case manager were:

- Family/Carer interests and involving families.
Dealing with substance abuse.

Poor engagement

The principles of good practice are applied as follows:

**Use and develop direct practice skills**

Joseph, as discussed more than once earlier in this thesis, has highlighted the difficulties attached to emphasising ‘talking and listening’ as part of good practice. He is a notable exception, and did not seem inclined to be involved in talking and listening at all. However, on reconsideration of the interviews, it is important to note that his mother greatly appreciated talking and listening and was very much aware of the ‘quality’ of service providers, and she valued those who were respectful and demonstrated good communication skills. Joseph’s case manager also reflected on how engagement and trust with Joseph could be developed through communicating respectfully with his mother and demonstrating interest and concern about her. Joseph’s case provides considerable support for the value of highly skilled family work in this situation, that is particularly sensitive to the impact of a dual diagnosis of schizophrenia and drug abuse. Joseph’s mother also expressed guilt, fear and sorrow about Joseph’s development of serious mental illness. Providing support for Joseph’s mother, and other family members, around these issues is likely to be extremely important in attempting to address some of the problems that were apparent in the case study (Bland, 1998). In particular, Joseph’s ongoing anti social behaviour towards his mother (for example stealing and selling her lawn mower) and difficulties in establishing independent living. The treatment team tended to relate these problems back to a dynamic between Joseph and his family. Consider the following discussion with his case manager:

Interviewee: So he comes out of just – out of routine. He receives his depot and meets with me for a while. I guess he will just go on his way and continue in participating in the same sorts of activities. I guess there’s been a few times
when we have attempted to change that cycle, change his routine, through attempting for him to engage in residential psycho-social rehab, which, at that moment in time, wasn’t successful. Family, I guess, weren’t behind that, as much as they thought they would have been. So there’s a whole...

Researcher: That they would have been or you would have been?
Interviewee: Well, initially, they wanted for that, but I guess they probably weren’t – they didn’t realise the effect that that would have had on them, when Joseph was out of the house, etcetera. Joseph kept on coming back home every single morning and wasn’t willing to engage in activities with the group.

Take a human rights perspective

It is very difficult to think about how this principle might be applied in Joseph’s case. It seems limited to a rather formulaic approach to making sure that he understood the CTO, his rights, and helping him understand the review processes and so forth. He gives an impression that he is limited in his capacity to take all this in, however, this should not be underestimated, or there is considerable risk of paternalism. There is the possibility that advocacy for Joseph may be able to mediate his limitations in being able to engage with issues around his rights. This would depend on the type of advocacy offered. It is likely to require more than an approach based on simply taking his ‘instructions’ (Carney, et al., 2008).

Focus on goals and desired outcomes

Joseph’s situation appears to require intervention at a number of different levels, including: practical support, skills of daily living and social support, employment, education and training, drug and gambling treatment, family intervention, medication compliance and cognitive assessment. And that is probably not the full list. Furthermore, there are considerable challenges present, including: cross cultural understandings and language difficulties, lack of appropriate community based resources, and so on. Joseph represents a reminder that this work may be relatively slow, which requires emphasis on realistic and achievable goals, in the face of what may seem like an overwhelming set of needs (Bland & Renouf, 2006).
Aim for quality of service delivery

Joseph’s case provides great insight into the potential for many people on CTOs to not have continuity of care when it comes to service providers, and he is also notable as an example of a person whose situation can change when more continuity of care is introduced. One perspective is that continuity of care is provided by the service, not individual practitioners. However, considering the difficulties Joseph experiences in relating with others, it can be presumed that having so many changes of doctor and not being able to sustain having the same case manager (and even being without an actively involved case manager for a period due to resource constraints), is a difficulty in providing quality of service delivery. This situation reinforces the need to fulfil this principle in light of quality of service delivery being critical to enabling the other principles to be implemented. When Joseph had a more experienced doctor, who was able to work with him over a relatively long period of time, positive outcomes were achieved. Joseph’s doctor was interviewed twice over a six month period and he had significant continuity in Joseph’s case (even though Joseph hardly attended any medical appointments over the six months, he just continued to come in for depot and take his medication). Despite not seeing Joseph very often his doctor, who was the authorised psychiatrist rather than a registrar, decided to discharge him and he gave the following reasons why, and discussed how it related to his ideas about good practice:

I think one was me going back and seeing what is the relevance of CTO in his case, to actually go through his file and seeing that he had been on CTO and what has CTO done for him. Then to come up with a decision whether he really needs to be on a CTO or not?

So actually I know he has been on a CTO in the past, he was non-compliant with the medication, but that has changed over the last few years and he has been compliant. There has been a change in his attitude towards medication, although he may not have an insight about his illness, but there is some need for treatment and he was okay with that.

I think that is one of the good things... we need to keep re-evaluating our reasons and that is what I think that improved understanding helps me to decide if he does need to be on a CTO.
Plus I think it was mum’s anxiety also because he has been unstable for some time so she is also very comfortable and because he is now seeking medication at night for his illness, she was also confident.
So it is not only the patient, but also the carer because we need to make sure that they both are safe. (Doctor)

Enhance and enable the role of key stakeholders

As Joseph’s doctor has explained above family/carer interests are at the forefront and his mother is an important key stakeholder. Enabling and enhancing her participation in decision-making seems important, although again this relies on having skilled service providers who are able to be insightful and work with the family dynamics, language difficulties and the cross cultural issues involved. Joseph’s case is an excellent example of how having the authorised psychiatrist know the person well (even if from a rather remote position), relying on the reports of others, and detailed revision of the clinical file, can achieve improved decision-making. The absence of a case manager at follow-up, just when Joseph was being discharged from his CTO, was notable and likely to have implications. There was a sense of Joseph not being fully informed about what was going on and it may be that not having an actively involved case manager contributed to these communication difficulties. As previously highlighted, Joseph seemed to struggle already with verbal communication and may be even more reliant on having a case manager who is able to ‘interpret’ the system, including things as basic as explaining what his doctor says or means.

Discussion

Applying the five principles to the case studies has enabled an opportunity to ‘test’ the degree to which they may be relevant to the diversity of CTO recipients represented by the findings of the cluster analysis. Although this is not necessarily generalisable (perhaps these clusters are changing all the time), this research continues to support the assumption that the diversity recognised in the cluster analysis justifies
the view that there is a diversity of CTO recipients that is not well understood, if only overall general descriptive indicators are considered.

The application of the principles established their relevance to four very different people on CTOs and generated considerable discussion. It also enabled further findings to emerge. One of the important findings of this exercise is the degree of relationship and interdependence between the principles. They are difficult to consider in isolation. They are not ‘stand alone’ ideas and unlikely to be useful if not accompanied by each other.

The second finding that emerged was the degree to which, although they were relevant to all the case studies, some principles had more prominence in some situations than others. In particular, taking a human rights perspective seemed to be particularly important for people in the ‘chaotic’ cluster, Maria and Peter. This seemed to relate to the length of time these people spent on CTOs, and also the multiple sources of coercion they were experiencing, or had experienced. It appears logical that as a CTO continues, and begins to have a long term impact on the recipient’s sense of self-efficacy, human rights issues become even more prominent, with increased requirement for protection. This is an important finding in the context of the current review of the Mental Health Act, 1986 that is exploring how protecting human rights can be incorporated into the policies and procedures surrounding CTOs. Currently protections are emphasised in the beginning of the implementation of the CTO, with a 24 hour statutory review, an eight week review, then an annual review (although the person can appeal at any time). There is currently no requirement that, for example, after someone has been on a CTO for what might be considered a long time (perhaps two years), a second opinion is required or that a more rigorous review takes place. The findings here suggest that increased rigour in these protections may be important to people who have been on CTOs for many years.

The other important finding is how resource constraints have an impact on the degree to which the principles can be realised. It became clear that people being cared for by the Mobile Support and Treatment Team (MSTT) were able to receive a lot more
practical assistance and continuity of care than those being cared for by the less intensive Continuing Care Team (CCT). This is summarised by one MSTT based case manager:

I’ve never worked on a CCT, and that’s probably – and I really have no interest or motivation for working on a CCT to be honest, because I find it difficult to remain – all this level of intensity with our clients, and I want to make sure that we’re crossing all the T’s and dotting all the I’s and making sure that our consumers are doing that.
And I think that with a caseload of 30, and I know not all of the clients would be on CTOs, but to ensure that you’re still instilling them with all that hope, and making sure their issues… it would be too hard. (Case Manager)

However, both services had to deal with the limitations imposed by the apparent lack of suitable community services, particularly those focused on rehabilitation activities and employment. There appeared to be barriers to accessing even the services that were available, suggesting that some people on CTOs, in particular the group represented by Joseph, require specialist services that are able to meet their needs.

The issue of the resources available goes back to the question asked earlier in this thesis about the degree to which reciprocity is achieved when someone is on a CTO. The question of reciprocity asks whether there is a match or some balance between the impact of the deprivation of liberty the CTO represents with the care and treatment offered (Richardson, 2007). These findings suggest that in many cases the answer to this question is ‘no’. It has been observed here that people can be on CTOs and receive only minimal continuity of care (to the extent that it is represented by having consistent service providers). They can have minimal intervention that represents advanced direct practice skills and the staff who work with them can be inadequately prepared for that role. The teams they are assigned to may simply be too busy to cope and the alternative resources in the community are often not structured to meet their needs or there are too many barriers to achieving access. The vast majority of people on CTOs do not receive legal representation and independent advocacy. They tend to have minimal faith in the external review process that is currently in place to protect their interests, and it
has been suggested here and elsewhere that this protection is inadequate. There are indications that, although it can be compensated for, providing training and support to trainee medical staff has been prioritised over the best interests of people on CTOs and that they are affected by high rates of clinical staff turnover. They experience considerable medicalisation in their treatment even though there is significant agreement that social and structural factors play an important role in why they were placed on a CTO. Their families may be seen as requiring and receiving protection, but the other issues for their families, such as guilt, grief and the need to develop and improve relationships (Bland, 1998), are not necessarily routinely addressed. And even in the medicalisation of their treatment, they have problems associated with the unpleasant nature of their medication and not feeling heard about their complaints, with an emphasis being placed on depot medication. This is even though research has suggested that injections may not be routinely necessary and can result in greater potential for consumers to be missing out on other, potentially more effective or less unpleasant, medication options (Muirhead, et al., 2006).

To give some balance to the above, there are other findings here that offer examples of good practice, as it has been defined in this research. There are examples of people’s experience of coercion being minimised through the use of negotiation and a flexible approach. There are times when people have felt heard about their problems with their medication, and it has been changed or adjusted even if there are risks attached. Indeed there have been examples of taking risks in the interests of the person that moves away from the notion that CTOs are all about ‘insurance’ rather than change or possibility.

The research has given voice to service providers who highly value taking a holistic approach to care and treatment. What they seem to mean by this is recognising the importance of the persons relationships and environment to their well being and recovery, as well as compliance with medication. There have also been occasions when decision-making has been undertaken thoughtfully with the involvement of other key stakeholders.
Conclusion

This case study of an area mental health service in Victoria, in relation to its implementation of CTOs, has enabled an understanding of what represents good practice with people on CTOs. What this study suggests is that CTOs are used for a range of purposes with a diverse community of CTO recipients. This study has identified that there are numerous, and potentially competing, expectations of CTOs being made by key stakeholders and that this can be explained through the use of the analogy of an ‘insurance policy’. Key stakeholders also share common and divergent views about the efficacy, value and impact of CTOs. The research findings, as well as the literature review, suggest that there are important social and structural factors that influence the use of CTOs, including the needs of family/carers and the availability of resources.

Good practice in this multi layered context requires practitioners to be mindful of emancipatory values that encourage a broad perspective and preparedness to formulate their understandings and plan their interventions beyond individualistic interpretations. The five principles identified via this research are available to guide ethical practice in a potentially constraining and resource limited environment.
Chapter Nine: Recommendations, Future Research Questions and Conclusion

The construction of a case study has opened up the territory within which the research took place and provided a multi layered perspective via the experience of the ‘actors’ (Marecek, et al., 1997; Punch, 1998). Thus, as expected, while the findings have been interpreted, and a contribution to the question of what represent good practice with people on CTOs has been made, future research questions have also been generated. This chapter presents these questions as well as recommendations for practice around each of the five principles developed in Chapter Eight. These recommendations need to be mindful of the findings in Chapter Nine, that the principles are interdependent and more relevant to some people on CTOs than others. The recommendations are also presented in the context of good practice operating in a constrained service environment with a diverse community of CTO recipients.

Recommendations regarding future directions for good practice with people on CTOs

The principles identified suggest directions for future practice in order to realise the potential for implementing these research findings. The following provides recommendations in relation to each principle.

Use and develop direct practice skills

The findings regarding the importance of using and developing direct practice skills when working with people on CTOs are in line with recommendations made by Codyre (2006) who suggests that coercion can be minimised in order to facilitate the potential for the person to recover only when:
Support and clinical staff work together in a highly skilled and complementary recovery focused way, and orient clinical staff and support services around and behind a point of co-ordination with each individual consumer, which is based on relationship, active listening, and indeed healing, as the basis of service delivery (p.48).

This proposal is supported by Van Dorn, Elbogen, et al. (2006) who found that social support can act as a moderator in relation to the negative impact of coerced treatment. Codyre (2006) recommends the approach taken at Hawkes Bay in New Zealand, entitled “Whatever It Takes”, as the model closest to the exceptional mental health service, implementing best practice that has the characteristics he describes above. He claims that by using this approach emphasising flexible packages of support and care, compulsion is able to be the exception rather than the rule and many people can be discharged from CTOs.

Similarly Hatfield, et al. (2001) discuss the need for advanced interpersonal skills when working with people on supervised discharge orders in the UK. Ryan, et al. (2004)’s findings are also relevant here because they reinforce the importance of skills in relationship building being essential to developing expertise in mental health social work.

The above relies on training and skill development, an issue that respondents this case study were able to acknowledge did not happen, at least not thoroughly or in a considered way. There seemed to be an expectation that any specialised skills required to work well with people on CTOs was either learned by ‘osmosis’ or could be completed as part of the persons orientation activities and subsequent self education. This principle suggests the need for specialised staff training and development activities focused on working with people on CTOs, minimising the use of coercion through developing advanced direct practice skills.
Take a human rights perspective

The criticisms of Topp, et al. (2008) need to be heard by both the MHRB and service providers if they are to realise their support for taking a human rights approach. Furthermore, if findings that suggest that people on CTOs are generally poorly informed about their rights can be generalised to other times and jurisdictions then again there is a significant problem. People cannot be expected to readily exercise their human rights (or indeed talk about their importance) if they are unclear what they are (Rolfe, et al., 2008).

One attempt to deal with this problem was undertaken in Canberra, Australia, where a research study confirmed that offering personal advocacy to all patients who were involuntarily admitted to a psychiatric hospital enhanced their knowledge about their rights, decreased their experience of coercion and actually assisted in maintaining their engagement with the service post discharge (Rosenman, Korten, & Newman, 2000). Advocacy has also featured in mental health law reform in Scotland and New Zealand. How this might be relevant to developments in Victoria has been discussed in the Victorian government’s consultation paper (Department of Human Services, 2008a). Carney, Beaupert, et al. (2008) recommend systemic advocacy and structural changes to complement individual advocacy because legal representation is:

A necessary component of an acceptable system of mental health review but is not a sufficient contribution towards the creation of the genuinely participatory review processes in which consumers can enjoy recognition of their interests in gaining access to high quality services or supports while avoiding unnecessary restrictions on liberty (p.142).

Donnelly (2008b) addresses the problem in England and Wales where traditional human rights approaches, those concerned with liberty and autonomy, appear to have become more limited in the context of CTOs. She contends that because CTOs operate outside the formal structure of the institution, and the traditional methods of control, human rights responses need also to be modified. Whilst a traditional rights discourse may provide a backdrop, Donnelly (2008) argues that human rights arguments need to
become more sophisticated picking up on issues such as how to make restrictions placed by a CTO consistent with the European Convention on Human Rights (ECHR). This convention might be considered to be a bill of rights for members of the European Union. She traces how the changes to the draft mental health bill in England and Wales was influenced by arguments that could be traced back to the ECHR and establishes how this had been important in ensuring that human rights remain relevant in the post modern context.

This is relevant here because of the Victorian Charter of Human Rights and Responsibilities, 2006 and the United Nations Convention of the Rights of Persons with Disabilities, 2008. Both provide a legislative framework that promotes and protects human rights in Victoria. Victoria’s new legislation will need to be compatible with the rights protected in the Charter and consistent with the UN convention as discussed in the review of the Mental Health Act, 1986, Consultation paper (Department of Human Services, 2008b). Hence there is further support for a principle of good practice being one about taking a human rights perspective and suggests the relevance of the use of principles established in law to bring about systemic and structural change (McSherry, 2008).

The challenge of appropriately using authority is raised within this principle of maintaining a focus on human rights. This issue is also discussed by O’Reilly, Keegan, et al. (2006) when clinicians interviewed discussed their difficulties in ‘balancing the subjects right to self determination with the benefits of a treatment order’ (p. 516) and having to therefore make ‘tough choices’ (p.520). Consider the following, a quote from a very experienced case manager who seems very comfortable with this use of authority:

I mean my view of a CTO, well I say it flippantly I suppose to some clients, look what does it matter if you’re on a CTO or you’re not on a CTO - it’s as restrictive as you want to make it. If you want to buck it and carry on and not, you know, take your treatment it’s going to be restrictive and you’re going to have us in your face, the CAT team in your face, the doctors in your face, it’s going to be a pain. If you accept it, because it’s there to help you, yeah it’s legal, it’s legal restrictions, but you know it’s there so that you get treatment and you’re fine, if you’re not well - blah blah blah. It’s not going to be too bad (Case Manager).
Trotter (2006) discusses these difficulties in the context of the dual role workers generally have when working with involuntary clients, that of ‘a legalistic or surveillance role; and a helping, therapeutic or problem solving role’ (p.4). Many interviewees may have been satisfied that procedural fairness and thoughtful decision-making might resolve this tension around the common ethical dilemma in social work of autonomy versus best interests. Some actually seemed comfortable, such as the person quoted above, with ‘knowing what’s best’. However, one social worker/case manager offered the following support for multidisciplinary teams to mediate the use of authority as follows:

It should be a tension and a struggle particularly the social work case manager, that as an instrument of the State we’re actually saying “You must do these things even if you say because of your illness or whatever reason I do not want to do this”. “You’re making me do something that I - not only dislike, but….“ …Now that’s illness thinking for a lot of the individuals, but I think this should always be a struggle and a tension and you shouldn’t feel comfortable about it and you should be saying “Is this the least restrictive way of supporting this person?”. That’s what should always be there. So shoot me I’m a social worker. (Case Manager)

**Focus on goals and desired outcomes**

As discussed throughout this study there appears to be considerable diversity amongst CTO recipients and what purpose the CTO has in different situations. As discussed with the case study participants, being mindful of the purpose or goals of the CTO, and why the person was put on a CTO in the beginning, is an important part of treatment planning and monitoring. It has been suggested in this study that there are risks that these initial justifications and goals may be lost or fade from significance due to factors such as changes in service providers and treatment team. Therefore it is recommended that more transparency be required when initially making a CTO to include on treatment plans the specific purposes of the CTO (such as engagement with community based services, enabling early discharge and/or ensuring compliance). This
would then provide support to a further expectation that the goals and strategies
detailed in the treatment plan are clearly connected with the reasons why the CTO was
implemented. Such an approach will potentially assist with concerns that people are
‘languishing’ on CTOs and staying on them for too long. As previously discussed, the
state government’s treatment plan guidelines remain in draft form (Chief Psychiatrist,
2004) and, depending on whether treatment plans are included in the new legislation,
there is potential to use statutory treatment plans to ask service providers to be more
specific about the purpose of the CTO and any future draft of the guidelines could
recommend this.

Understanding more about the outcomes for people on CTOs becomes
important here, but what is suggested by this principle is that outcome studies develop
more sophistication in looking at the outcomes for different types of people on CTOs.
Perhaps this would enable more capacity to target those most likely to benefit and assist
in recognising what timeframes will be required to achieve these benefits.

The situation of people on CTOs also needs to be considered in light of the
general problems attached to gaining more positive psychosocial outcomes for people
with serious mental illness who are in contact with community based services in Victoria
(Herrman & Harvey, 2005). Reliance on medication-only regimes with minimal
psychosocial intervention remains the experience of many consumers and is a source of
general dissatisfaction. Therefore it appears that people on CTOs are likely to benefit
from any advances in providing care and treatment in community based services that
represent a clearer focus on implementing ‘individually tailored psychological, social and
occupational interventions’ (Herrman & Harvey, 2005 p.89).

**Aim for quality of service delivery**

Achieving continuity of service providers for people on CTOs represents a key
aspect of fulfilling this principle. Greater emphasis could be placed on the role of the
authorised or consultant psychiatrist in having a more central role in monitoring the
progress of people on CTOs and also being more directly involved in their treatment and care. An attempt to consider the best way of involving consultant psychiatrists with a view to improving practice and making best use of their skills, as a relatively limited resource, is the ‘New ways of working’ project in the UK (Department of Health, 2005). Monitoring how this approach translates to the introduction of CTOs in the UK will be interesting and may provide guidance regarding the role of consultant psychiatrists in Victoria.

It has also been noted that family/carers have high expectations in relation to the quality of service delivery for their loved one and increasing their participation in treatment, developing more opportunities for them to make complaints and provide compliments increases the potential for service improvement. This has been raised in the Mental Health Act 1986 review consultation paper (Department of Human Services, 2008a), with the suggestion that complaint systems be improved.

There is very little evidence in this case study that specialised interventions, particularly focused on the needs of people on CTOs, were being implemented. Options might include ‘compliance therapy’ (Kemp, et al., 1998) or increased assertive outreach (Wales & Hiday, 2006). It is therefore recommended that innovation be encouraged in order to design interventions specifically focused on assisting people on CTOs. This may enable less restrictive and intrusive treatment in the longer term. This is in agreement with Carney (2008) who suggests that:

The priority for future research lies in exploring the factors which enhance treatment access and outcomes for the mentally ill rather than debate the shape or content of mental health law (p.484).

The above depends on specialised staff training and development and again evidence for this appeared to be lacking in the case study. Prioritising people subject to involuntary treatment seems essential to ensure that specialised interventions are developed, services are made more accessible and the skills of service providers enhanced. However, such prioritising should not hold the risk that community based mental health services limit their target group to people on involuntary orders. This
research has produced a warning sign that this could potentially corrupt the use of CTOs, such that they are used to gain access to continuity of care in the public mental health system. The potential for this to be a widespread development needs to be carefully monitored and curtailed by a regulatory authority such as the Office of the Chief Psychiatrist.

**Enhance and enable the role of key stakeholders**

Improving decision-making in how CTOs are being implemented in Victoria has been supported by Dawson (2005) who has suggested that one of the ‘pitfalls’ clinicians in Victoria should avoid is:

Failure to review actively the need for the CTO with patients who have been on them for long periods of time (p. 6).

The recent review of the *Mental Health Act*, 1986 in Victoria has also raised questions regarding the lack of participation by consumers in MHRB hearings (Department of Human Services, 2008a). The consultation paper described Victoria’s challenge as having the ability to:

Conduct informal proceedings that are fair, inclusive of involuntary patients that promote recovery, and enable involuntary patients to feel that their position has been ‘fully and clearly articulated’ (p.53).

The review also proposes the possibility of carers being notified about MHRB hearings and invited to attend to provide their perspective. Whilst MHRB hearings are only one place where critical decision-making about CTOs takes place, the above attempts to discuss how decision-making could be improved through improving the participation of all key stakeholders, a proposal that is consistent with this good practice principle.

This study has offered considerable support to the contention that often CTOs are implemented in the interests of family/carers and that family/carers involvement
and assisting family/carers is a central part of good practice. Therefore it should also be
good practice to enable family/carers to be more mindful of the autonomy versus ‘best
interests’ dilemma that is inherent in direct practice and decision-making with people
on CTOs for service providers. This would enhance mutual exchange of ideas and
perspectives, with workers aware of, and acting on, family/carer burden, while
family/carers are also aware of the ethical dilemmas faced by clinicians and the
importance of observing human rights issues for the sake of the personhood and
citizenship of consumers. Another example is helping carers not only to be involved in
MHRB hearings but also understand more about the purpose of the hearing and the
value of administrative law and advocacy. In other words, to truly have shared decision-
making that meaningfully involves all key stakeholders, there needs to be more
trialogue between key stakeholders, particularly consumers, carers and clinicians, to
build understanding, shared knowledge and trust (Lefley & Johnson, 2002).

As discussed in Chapter Seven, case manager involvement in all aspects of
decision-making has been strongly supported throughout the interviews. Whilst there is
no doubt that case managers are actively involved already, there is minimal recognition
of the importance, perhaps even centrality, of their role in the Mental Health Act, 1986
(Brophy, et al., 2003). Therefore, their potential for a significant role in key decision-
making is minimised. There are findings here that suggest that case managers are not
always well equipped and prepared for this role. Thus it is recommended that if
participation and involvement by case managers is to be supported and enhanced then
it also requires staff training and development that builds expertise.

Future research questions:

Primary future research questions

There are two primary questions and investigations that any attempt to take
these findings into the future requires. The first refers to how meaningful the findings of
the cluster analysis are over time and in other area mental health services. To answer
this question it may be useful to both repeat the cluster analysis at NWAMHS and also
conduct a similar analysis in another area mental health service to compare and contrast what clusters emerge. The second question is whether the implementation of the five principles identified would indeed result in a shared recognition of good practice by all key stakeholders. Exploring this question could be undertaken through, first, the implementation of the recommendations made above, followed by the development of more comprehensive guidelines around these principles via a collaborative process involving all the key stakeholders and an evaluation of the implementation of the principles and guidelines.

Other emergent research questions

Other research questions have emerged through this research activity. The following are some examples of these research questions:

1. This research did not explore in any depth practice specific to revocation of CTOs, one aspect of what Dawson, et al. (2003) refer to as ‘downstream’ decision-making. This study did not include consumers who are frequently appealing their CTOs and/or having them revoked on a regular basis. Are these people experiencing considerably more coercion and distress than others? While participants in this research did indicate that these people are part of the implementation of CTOs, they are unlikely to be recruited using the methods adopted here. How can this hidden population of consumers on CTOs be reached through research? How relevant are the principles of good practice to their experience?

2. How useful are alternative ideas about ethics such as ‘relational individualism’ (Radden, 2003 p. 9) to good practice with people on CTOs?

3. Will the proposed changes to the to the Mental Health Act 1986 in Victoria, Australia be able to address the current criticisms of the implementation of CTOs, especially the claims of over use of CTOs in Victoria?

4. Can implementing good practice, as it has been defined here, make services more attractive, and enhance their capacity to engage with consumers, thereby
reducing the need for CTOs? The questions raised by Wales and Hiday (2006) and others (Churchill, et al., 2007) about how to reduce coercion while maintaining compliance with treatment and care needs ongoing exploration. Are there viable alternatives to CTOs, such as advance directives? Will they reduce the use of CTOs?

5. How do CTOs work and with whom? Why are most CTO recipients persuaded by them? Can evidence about effectiveness contribute to improved decision making?

6. Are CTOs incompatible with recovery? Can people on CTOs work towards recovery or do CTOs fundamentally challenge any chance of recovery? Furthermore, can good practice mediate the impact of a CTO such that recovery remains the fundamental goal of intervention?

**Conclusion**

In conclusion, this study confirms that qualitative, practice based, research is increasingly seen to be informative and able to provide direction in relation to CTOs. There is a place for qualitative evidence to enable the facilitation of improved practice in a potentially hostile environment.

Psychiatric services need to acknowledge that CTOs represent an ethical quagmire that is negotiated whilst also carrying the pressure to manage risk, manage resources and meet the needs of a very diverse community of CTO recipients.

Qualitative findings support the importance of values such as fairness, respect, reciprocity and authenticity in implementing CTOs in order to avoid the potential problems of unnecessary use of coercion and the potential for ongoing net widening in the use of CTOs.

This research was guided by the emancipatory values of social work. These values, along with a critical theory perspective, have not only guided the way the research was conducted but have also proven important in assisting to interpret the research findings. Anfara and Mertz (2006) suggest that a theoretical framework
’pervades almost all aspects of the study’ (p. 189). Here what becomes apparent is the degree to which the emancipatory values of social work appear to add relevance and again provide a framework, but at this later stage, for a way of thinking about and presenting the processes and principles of good practice with CTOs that have emerged. Perhaps it has been the role that these values have taken in the research design that has directly contributed to the continuing relevance of concepts such as authenticity, empowerment, citizenship and social justice (Thompson, 2000). It also suggests the value of a social work investigation into CTOs and the potential relevance of social workers in good practice with people on CTOs. This study confirms that, given a voice, family/carers, consumers and front line service providers are able to articulate goals in relation to the implementation of CTOs that are very much in line with this value base. This perspective enables CTOs to be seen as continually influenced by structural and social dimensions.

This study has established that even though CTOs might be primarily seen by many to be about dealing with non-compliance in a specific population of people who lack insight into their illness, this is a very superficial and inadequate account of their purpose and the lived experience of those involved. Understanding the complexity and range of issues such as gender, stigma, resources and service delivery models and how these impact on how CTOs are used, also informs how good practice can be understood and developed.

Working well with people on CTOs isn’t going to come out of thin air, nor will it come from simplistic interpretations about what CTOs are for and who is subject to them and what their needs are. There has been an extraordinary consistency in qualitative research findings about CTOs both nationally and internationally. This creates opportunities for further development of good practice based on the knowledge and evidence that is emerging.

This research contributes to a sense of hope and possibility for people on CTOs. In the current ten year plan for Victoria’s mental health reform strategy (2009-2019) (Department of Human Services, 2008a, 2009), mental health services in Victoria are
moving towards greater emphasis on prevention and recovery. In this context it is important that people on CTOs are not left behind, with less than adequate standards of service because they are difficult to work with or because the gains that could be achieved are likely to be slow to obtain or relatively small. Otherwise there is the possibility that many people on CTOs will become those who are in the new but invisible ‘back wards’ of the community. Key stakeholders in this study all agreed that people on CTOs deserve a high standard of care that acknowledges the challenge of their involuntary status on their road to recovery. The impact of the CTO in relation to disempowerment and self-efficacy needs to be taken into account and service providers should be able to have ‘difficult’ conversations. Realistic and achievable goals need to be set that reflect why the person was placed on a CTO. Furthermore, there needs to be proper and accountable monitoring of their progress. It is important that services involved with people on CTOs do not ignore the need for specialised and advanced skills and knowledge when implementing CTOs and caring for CTO recipients. This should not be compromised by resource constraints and other pressures on the service network.
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Appendix A: Participant information for case study participants

Project Title: Understanding how to provide better assistance to people on CTOs by learning more about their experience.
Participant Information: Case Study Participants

Introduction:
My name is Lisa Brophy, and I am writing to invite you to participate in a research project that I am conducting as part of my PhD in social work at the University of Melbourne. My supervisor is Dr Fiona McDermott. This project has received ethical approval from the University of Melbourne, and the Behavioural & Psychiatric Research and Ethics Committee of the North Western Mental Health. The following is my attempt to answer some questions you might have about this project but please don’t hesitate to contact my supervisor or me if you have more questions not covered here.

What is this project about?
This project aims to understand more about the impact of Community Treatment Orders on consumers and their carers. I am interested in finding out more about how service providers, including both case managers and doctors, make decisions about people on CTOs and what ideas all the different people I am interviewing have about what represents “good” practice with people on CTOs.

What will you be required to do?
There are three different parts of the project (cluster analysis, case studies and group interviews) and you have been asked to be a participant in the case studies, either as a consumer, carer, case manager or treating doctor. I will be doing at least 4 case studies all involving people who are consumers at North West Area Mental Health Service. A carer will only be interviewed if the consumer is able to nominate a carer (this could be a friend, partner, family member or an outreach worker) and gives their permission for that person to be interviewed.
With the permission of the consumer involved, each person in the case study (up to 4 people) will be interviewed on his or her own by me for about an hour. I have a set of questions that I will be asking you and then I will invite you back within a year and ask you the same questions again, although I will also ask you about what’s changed since we last met. I will be asking questions related to either your experience on a CTO, if you are a consumer, or about your experience caring for and/or treating someone on a CTO if you are a doctor, case manager or carer. With your permission I will be audio taping the interview.

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What are your rights as a participant in this project?
Your participation in this project is voluntary, and you can stop your involvement in the project at any time, without prejudice. You can suspend the interview at any time and either withdraw from the project or re-schedule the interview. You can also withdraw any data that you have provided, provided it can be linked to you.

How will you benefit from your participation?
There are really no direct benefits to you from this research although you might find it good to talk about your experience.

What are the possible negative consequences of your participation?
Hopefully there will be no negative consequences although it is possible that you might find recalling some experiences distressing. I will therefore make sure that you have access to debriefing if you ask for it, preferably by someone you nominate or I will organise someone with the appropriate experience to provide you with debriefing.

How will your privacy be protected?
When I write up the case studies I will use pseudonyms (fake names), you might be able to identify your own comments or the comments made by other people in your particular case study but it should not be identifiable to anyone else.

What will happen to the data that I provide?
Your data will be kept confidential, subject to legal constraints. For example, if a court subpoenaed my research data, I would have to provide it. With your permission I will be audio taping the interviews and transcribing them and I will keep all the information either in a locked filing cabinet or in a password protected computer file. After I have finished I will keep all the information securely stored for seven years and then I will dispose of all the raw data (tapes and transcripts).

How will I find out about the results of the study?
I will provide you with transcripts of your interview, I will also send you a summary of my findings on completion of the study and inform you about how you can access further information (such as my thesis or publications).

Who should I contact if I have any questions or concerns?
Please do not hesitate to discuss any concerns you have about participating with me directly, or you can contact my supervisor, Dr Fiona McDermott in the School of Social Work at the University of Melbourne (ph: 8344 9400). If you would like to speak with someone not directly involved with the study you are welcome to contact a representative of the North Western Committee on telephone number 8345 1681 (attention secretary) or The University of Melbourne Ethics Committee on (03) 8344 7507.
Thank-you for your time and I hope this information has assisted you in deciding whether or not you will participate in the project.

Yours sincerely

Lisa Brophy
Chief Social Worker, North West Area Mental Health Service (ph: 9355 9700), and
Doctoral Student, The School of Social Work, University of Melbourne.

Participant signature:

Date:
Appendix B: Participant information for group interview participants

Project Title: Understanding how to provide better assistance to people on CTOs by learning more about their experience.

Participant Information: Semi-structured Group Interview Participants

Introduction:
My name is Lisa Brophy, and I am writing to invite you to participate in a research project that I am conducting as part of my PhD in social work at the University of Melbourne. My supervisor is Dr Fiona McDermott. This project has received ethical approval from the University of Melbourne, and by the Behavioural & Psychiatric Research and Ethics Committee of the North Western Mental Health.
The following is my attempt to answer some questions you might have about this project but please don’t hesitate to contact my supervisor or me if you have more questions not covered here.

What is this project about?
This project aims to understand more about the impact of Community Treatment Orders on consumers and their carers. I am interested in finding out more about how service providers, including both case managers and doctors, make decisions about people on CTOs and what ideas all the different people I am interviewing have about what represents "good" practice with people on CTOs.

What will you be required to do?
There are three different parts of the project (cluster analysis, case studies and group interviews) and you have been asked to be a participant in one of the semi-structured group interviews. You will be a representative of one of four different groups: Consumers, Carers, Senior Managers and Policy Advisors or Mental Health Review Board Members. Each semi-structured group interview will be facilitated by me and be conducted for no more than 90 minutes. I have a set of questions that I will be asking you about what you think represents “good” practice with people on CTOs. I am very interested to get a range of different perspectives on this topic. With your permission I will be audio taping the interview.

What are your rights as a participant in this project?
Your participation in this project is voluntary, and you can stop your involvement in the project at any time, without prejudice. You can leave the interview at any time and

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either withdraw from the project or try to find an alternative way to provide your comments, for example by giving written responses. You can also withdraw any data that you have provided, provided it can be linked to you.

**How will you benefit from your participation?**
There are really no direct benefits to you from this research although you might find it good to talk about your experience.

**What are the possible negative consequences of your participation?**
Hopefully there will be no negative consequences although it is possible that you might find recalling some experiences distressing. I will therefore make sure that you have access to debriefing if you ask for it, preferably by someone you nominate or I will organise someone with the appropriate experience to provide you with debriefing.

**How will your privacy be protected?**
When I write up the group interviews I will not use identifying information or attribute comments to specific individuals. You might be able to identify your own comments or the comments made by other people in your particular group interview but it should not be identifiable to anyone else.

**What will happen to the data that I provide?**
Your data will be kept confidential, subject to legal constraints. For example, if a court subpoenaed my research data, I would have to provide it. With your permission I will be audio taping the interviews and transcribing them and I will keep all the information either in a locked filing cabinet or in a password protected computer file. After I have finished I will keep all the information securely stored for seven years and then I will dispose of all the raw data (tapes and transcripts).

**How will I find out about the results of the study?**
I will provide you with transcripts of your interview, I will also send you a summary of my findings on completion of the study and inform you about how you can access further information (such as my thesis or publications).

**Who should I contact if I have any questions or concerns?**
Please do not hesitate to discuss any concerns you have about participating with me directly, or you can contact my supervisor, Dr Fiona McDermott in the School of Social Work at the University of Melbourne (ph: 8344 9400). If you would like to speak with someone not directly involved with the study you are welcome to contact a representative of the North Western Committee on telephone number (03) 8345 1681 (attention secretary) or The University of Melbourne Ethics Committee on (03) 8344 7507
Thank-you for your time and I hope this information has assisted you in deciding whether or not you will participate in the project.
Yours sincerely

Lisa Brophy
Chief Social Worker, North West Area Mental Health Service (ph; 9355 9700), and
Doctoral Student, The School of Social Work, University of Melbourne.

Participant signature:

Date:
Appendix C: Consent form for case study participants

NORTH WESTERN MENTAL HEALTH
BEHAVIOURAL AND PSYCHIATRIC ETHICS COMMITTEE
P.O. BOX 1071, ST. ALBANS. 3021
PH.: 8345-1681 FAX: 9364-3792

CONSENT/REQUEST TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF RESEARCH PROJECT: ........... Understanding how to provide better assistance to people on CTOs by learning more about their experience.

RESEARCHER:

I, ...........Lisa Brophy.................................................CERTIFY THAT I have fully explained the aims, risks, and procedures of the research to the SUBJECT/PATIENT named herein (or to the lawful guardian of such patient) and have handed to the SUBJECT/PATIENT (or guardian) a copy of this Consent together with a PLAIN ENGLISH STATEMENT of aims and procedures of the experiment and any risks to the SUBJECT/PATIENT.

In my opinion the PARTICIPANT (or lawful guardian thereof) appears to understand and wishes to participate.

I undertake to the PARTICIPANT (or lawful guardian thereof) that the confidentiality and anonymity of the PARTICIPANT and his or her records will be preserved at all times.

SIGNED: ........................................................................................................

DATE: ............................................................................................

CONSENT OF PARTICIPANT OR PRIMARY CARER

The purpose of the above project has been fully explained to me and I have read and signed the attached PLAIN ENGLISH STATEMENT. I UNDERSTAND the aims and

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procedures of the experiment and any risks to myself which are involved and I REQUEST to participate on condition that I can withdraw my Consent at any time.

I agree to the audiotaping of the interview ☐ yes ☐ no

If applicable:
I agree to the researcher also interviewing my:
Doctor ☐ yes ☐ no
Case manager ☐ yes ☐ no

Carer ☐ yes ☐ no
Name of carer:
Contact details:

SIGNED: ..........................................................................................

DATE: ..........................................................................................

WITNESS OF PARTICIPANT'S SIGNATURE

I, ..........................................................................................................................

of ..........................................................................................................................

As an independent witness I confirm that the aims and procedures of the experiment and any risks to the PARTICIPANT has been adequately explained to the PARTICIPANT whose signature I witness. In my opinion he/she appears to understand and wishes to participate. Refer to Handbook for further pro-forma.

Signed: ................................................................. Date: .................................
Appendix D: Consent form for Group Interview Participants

NORTH WESTERN MENTAL HEALTH
BEHAVIOURAL AND PSYCHIATRIC ETHICS COMMITTEE
P.O. BOX 1071, ST. ALBANS. 3021
PH.: 8345-1681  FAX: 9364-3792

CONSENT/REQUEST TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF RESEARCH PROJECT: Understanding how to provide better assistance to people on CTOs by learning more about their experience.

........................................................................................................................................................................

RESEARCHER:

I, ..........Lisa Brophy.......................................................CERTIFY THAT I have fully explained the aims, risks, and procedures of the research to the SUBJECT named herein (or to the lawful guardian of such patient) and have handed to the SUBJECT (or guardian) a copy of this Consent together with a PLAIN ENGLISH STATEMENT of aims and procedures of the experiment and any risks to the SUBJECT.

In my opinion the PARTICIPANT (or lawful guardian thereof) appears to understand and wishes to participate.

I undertake to the PARTICIPANT (or lawful guardian thereof) that the confidentiality and anonymity of the PARTICIPANT and his or her records will be preserved at all times.

SIGNED: ........................................................................................................

DATE: ........................................................................

CONSENT OF PARTICIPANT OR PRIMARY CARER

The purpose of the above project has been fully explained to me and I have read and signed the attached PLAIN ENGLISH STATEMENT. I UNDERSTAND the aims and

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procedures of the experiment and any risks to myself which are involved and I REQUEST
to participate on condition that I can withdraw my Consent at any time.

I agree to the audiotaping of the interview  □yes  □no

SIGNED: ...........................................................................................................

DATE: ..........................................................................................................  

WITNESS OF PARTICIPANT'S SIGNATURE

I, ..........................................................................................................................

of ..........................................................................................................................

As an independent witness I confirm that the aims and procedures of the experiment
and any risks to the PARTICIPANT has been adequately explained to the PARTICIPANT
whose signature I witness. In my opinion he/she appears to understand and wishes to
participate.

Signed: ................................................................. Date: .................................
Appendix E: Research newsletter sent to semi-structured group interview participants

Research Newsletter

Understanding more about how to provide better assistance to people on CTOs by learning more about their experience.

Researcher: Lisa Brophy

This newsletter is an update for people who have been involved, or expressed an interest, in my research about my progress so far and some preliminary findings.

A part time PhD can mean that despite a commitment to keeping those involved in the project updated with findings there can be considerable delay. This is an opportunity to report on preliminary findings – and invite some feedback as well.

There are three main components to my research:

- Semi-structured group interviews,
- A cluster analysis of people on CTOs, and
- Case studies.

Semi-structured group interviews:

So far I have conducted 2 of the 4 semi-structured group interviews I plan to undertake. The purpose of these interviews is to gather the views and experiences of key stakeholders – consumers, carers, the Mental Health Review Board and senior staff.

I am in the process of applying my understanding of qualitative research to the two interviews I have conducted so far with consumers and carers. This involves transcribing the tapes then listening to them and reading the transcripts over and over again to enable themes to emerge. The data is coded so that both similar and divergent themes can be identified across the groups.

Some preliminary findings (and please don’t quote me because I have more data to collect and more analysis to do) are the following:

Common themes:

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Both groups expressed concerns about Community Treatment Orders related to increasing stigma about people with mental illness. They expressed concern about an over emphasis on medication that had too many significant side effects and psychiatrists not spending enough time with their patients to fully understand what is happening. Both groups had general concerns about the quality of service they received.

Both groups tended to think of CTOs as a safety net that potentially reduced risk to self and others and helped family relationships. Families and carers described less pressure to “police” the situation and felt that the service was sharing more responsibility for the CTO recipient. However, they were frustrated about how little a CTO could help regarding drug abuse and dual diagnosis. Consumers and Carers both thought that CTOs helped ensure access to services.

Consumers appreciated CTOs as a less restrictive option than hospital, but expressed frustration with the discharge process which appeared to lack consistency and transparency. They described a lack of reciprocity – that is the onus was on the CTO recipient to “do the right thing” while the service didn’t have to do very much at all – like, for example, have after hours appointments or better medications with less side effects or staff more skilled at listening.

Both groups tended not to talk very much about “rights”; they hardly mentioned the Mental Health Act and whether CTOs should exist in the first place. The participants tended to focus a lot more on issues related to the process and quality of care and treatment. Information sharing – particularly the “hidden story” or the lack of opportunity for the “real story” to be heard - is really important. Some carers thought the CTO helped increase the sharing of information while consumers tended to be less satisfied that they were being heard when on a CTO. Consumers and carers were both concerned that mental health staff were not as skilled as they expected and possibly this could contribute to more use of coercion.

The ideas this has given me so far about my question of what would improve practice includes:

- Skill development
- More collaborative family work
- Greater transparency in decision-making
- Placing greater value on emotional support in treatment
- Improve resources to try to respond to consumer and carer need

Cluster analysis:

Another activity in my PhD research has been to do a cluster analysis of 164 people on CTOs at NWAMHS. the purpose of this was to explore whether there were any
identifiable sub groups of people on CTOs and to assist as a sampling technique for the next stage of my research which is to conduct case studies.

Below is a general description of the overall 164 people:
The majority of the sample were single men \( (n=114) \) who had never married \( (n =94) \), aged between 20 and 71, while women tended to be older (38.5 years for men versus 43 years for woman) and not likely to be partnered or divorced. The majority of the sample was reported to be living in rental accommodation. Most were on unemployment or disability pensions and had experienced multiple admissions. Considerable diversity in country of birth was represented in this client group (31% were born outside Australia) and this reflects the diversity of the catchment area. The vast majority had a principle diagnosis of Schizophrenia.

Below is a description of the three groups I found within this large group:

Cluster 1 \( (n=27) \): The majority of people in this relatively small group were female with minimal history of difficulties in relationships (as recorded by additional diagnosis). They had a high likelihood of being born outside of Australia and many are married or in defacto relationships. They often live with other family members. They have had a relatively low number of admissions to hospital and very few have a history of homelessness and drug and alcohol abuse.

Cluster 2 \( (n=33) \): This slightly larger group are mostly males in their 30’s. A high proportion have a diagnosis of paranoid schizophrenia. They are unlikely to be married or have ever married and almost all were born in Australia and many live with their families. A high percentage have a history of drug or alcohol abuse.

Cluster 3 \( (n=68) \): This is the largest cluster group I found. They are equally likely to be male or female. They have history of difficulties in relationships and a high proportion are living either alone or in residential services. They often have a history of violence, irritability or anger and multiple problems. They have a history of frequent admissions and a high proportion have a history of drug or alcohol abuse. They are the most likely to have a diagnosis of schizoaffective disorder.

An analysis of the 36 people who did not fall into the three clusters did not reveal any notable trends in their profiles on the clustering variables.

**Case studies:**

I would now like to find at least three people whose characteristics, in general, match the cluster groups described above. My plan is to interview them and, with their permission, a family member or carer they nominate, plus their case manager and treating doctor. I will then plan a follow-up interview with all members of the case study within 6 to 12 months.
Thank-you for your assistance or interest in my study so far. If you were in one of the semi-structured group interviews then you can contact me to get a complete transcript of the interview and I will send it to you. You can contact me at North West Area Mental Health Service by phoning 9355 9700 or email me l.brophy@pgrad.unimelb.edu.au. You are also very welcome to discuss my research with me any time.

I hope that this investigation will assist in obtaining qualitative data that informs good practice in working with people on CTOs and contributes to the building of a greater evidence base for our practice. I also hope that my approach will give greater voice to the views of consumers and carers.

With thanks

Lisa Brophy
Chief Social Worker
North West Area Mental Health Service, and
PhD student, School of Social Work, The University of Melbourne.
Appendix F: Research update sent to NWAMHS staff

Lisa Brophy  Research Update –

Request for case study subjects in investigating good practice with people on CTOs!

Research question: Using the emancipatory values of social work as a guide to the investigation: What processes and principles represents good practice with people on Community Treatment Orders?

or (and this more user friendly title is on the information sheets and consent forms):

Understanding more about how to provide better assistance to people on CTOs by learning more about their experience.

As part of my PhD research I have done a cluster analysis of 164 people on CTOs at NWAMHS. This was to explore whether there were any identifiable sub groups of people on CTOs and to assist as a sampling technique for the next stage of my research which is to conduct case studies. I would now like to find at least three people whose characteristics, in general, match the cluster groups described below. My plan is to interview them and, with their permission, a family member or carer they nominate, plus their case manager and treating doctor. I will then plan a follow-up interview with all members of the case study within 6 to 12 months.

Below is a general description of the overall sample using CMI data:

The majority of the sample were single men (n=114) who had never married (n =94), aged between 20 and 71, while women tended to be older (38.5 years for men versus 43 years for woman) and not likely to be partnered or divorced . The majority of the sample were reported to be living in rental accommodation. Most were on unemployment or disability pensions and had experienced multiple admissions. Considerable diversity in country of birth was represented in this client group (31% were born outside Australia) and this reflects the diversity of the catchment area. The vast majority had a principle diagnosis of Schizophrenia.

Below is a description of the three groups I found within this large group using CMI data:

Cluster 1 (n=27): The majority of people in this relatively small group were female with minimal history of difficulties in relationships (as recorded by additional diagnosis). They

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had a high likelihood of being born outside of Australia and many are married or in defacto relationships. They often live with other family members. They have had a relatively low number of admissions to hospital and very few have a history of homelessness and drug and alcohol abuse.

Cluster 2 (n=33) : This slightly larger group are mostly males in their 30’s. A high proportion have a diagnosis of paranoid schizophrenia. They are unlikely to be married or have ever married and almost all were born in Australia and many live with their families. A high percentage have a history of drug or alcohol abuse.

Cluster 3 (n=68) : This is the largest cluster group I found. They are equally likely to be male or female. They have history of difficulties in relationships and a high proportion are living either alone or in residential services. They often have a history of violence, irritability or anger and multiple problems. They have a history of frequent admissions and a high proportion have a history of drug or alcohol abuse. They are the most likely to have a diagnosis of schizoaffective disorder.

An analysis of the 36 people who did not fall into the three clusters did not reveal any notable trends in their profiles on the clustering variables.

I would really appreciate you discussing with me any clients who you think falls generally into one of the groups above. The next step would be for you to ask for their permission for me to contact them and go over the purpose of the study with them. If I can arrange a preliminary meeting I will then go through the ethics documentation and obtain their consent to be involved in the interviews and to make contact with their treatment team and carers. Participation will involve an audio taped semi-structured interview either at Broadmeadows or Moreland that will go for about one hour. I will try to time the interview around regular appointments to minimise any inconvenience. You can contact me via email: Lisa.Brophy@mh.org.au, ext: 5700 at MCCT or on my mobile: 0438544097

You are also very welcome to discuss my research with me any time. I hope that this investigation will assist in obtaining qualitative data that informs good practice in working with people on CTOs and contributes to the building of a greater evidence base for our practice. I also hope that my approach will give greater voice to the views of consumers and carers.

The clusters are again summarised below in table format:

<table>
<thead>
<tr>
<th>Summary Profiles of the Three Clusters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Cluster (n = #)</td>
</tr>
<tr>
<td>--------------</td>
</tr>
</tbody>
</table>
| 1 (n = 27)   | Lowest number of admissions and days per admission  
               | Mean length of CTO 359 days (shortest)  
               | Lowest number of times a primary and additional diagnosis recorded  
               | Most likely to have main diagnosis of “other schizophrenia”  
               | No history of homelessness recorded  
               | No history of violence or irritability/anger  
               | More likely to be born outside of Australia  
               | Most likely to be married/defacto and live with family |
| 2 (n = 33)   | The youngest (mean age 34 years)  
               | The most likely to be male (32 male/1 female)  
               | The least likely to have ever had a partner  
               | The most likely to be born in Australia  
               | The most likely to have a diagnosis of paranoid schizophrenia  
               | The least likely to be tertiary educated |
| 3 (n = 68)   | Largest group  
               | 54 percent of clustered males and 50 percent of clustered females  
               | Average age 42  
               | History of homelessness, drug use, violence or irritability/anger, live alone or in a residential service  
               | on the Disability Support Pension  
               | Highest in number of admissions, mean number of bed stays, referrals to CATT, length of CTO, number of diagnoses recorded  
               | Most likely to have schizoaffective disorder  
               | Average number of times a primary and additional diagnosis was recorded = 50  
               | Mean length of current CTO 436 days |
With thanks
Lisa Brophy
Chief Social Worker
North West Area Mental Health Service, and
PhD student, School of Social Work, The University of Melbourne.
Appendix G: Candidate's Statement of Contribution to Jointly - Published Work

The following two publications were included in the thesis and were substantially unchanged:

As principal author I undertook the literature review and made the primary contribution to the design and implementation of the cluster analysis and the preparation of both articles.

Statement of contribution by others:
The co-authors contributed to the development of ideas and provided detailed critical feedback in the preparation of the paper/s.

Signed: Lisa Brophy  
Candidate

Signed: Dr Fiona McDermott  
Principal Supervisor

Signed: Assoc/Prof John Reece  
Co-author
Author/s:  
Brophy, Lisa Mary

Title:  
Using the emancipatory values of social work as a guide to the investigation: What processes and principles represent good practice with people on community treatment orders?

Date:  
2009

Citation:  

Publication Status:  
Unpublished

Persistent Link:
http://hdl.handle.net/11343/35217

File Description:  
Using the emancipatory values of social work as a guide to the investigation: What processes and principles represent good practice with people on community treatment orders?

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