



## The legal oversight of community treatment orders: A qualitative analysis of tribunal decision-making



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### ABSTRACT

Community treatment orders (CTOs) have been in place in various jurisdictions for over three decades, and yet are still a controversial aspect of mental health provision. One of the ethical concerns CTOs may engender is how difficult it can be to secure discharge from them, which in some jurisdictions can result in service users being subject to compulsion in the community indefinitely. Given the questions that can therefore be raised about the discharge process, it is important to understand the role of the mental health tribunal as a key safeguard in the management of CTOs. However, whilst a substantial body of literature exists on CTOs and on various aspects of tribunal practice in inpatient settings respectively, relatively little has been written about the role of the tribunal in the oversight of CTO discharge decisions. This article presents the results of an eight month ethnographic investigation into CTO use in England, focusing on the factors which contribute to tribunal decisions. A total of 62 participants were involved in the study, including 18 service users on CTOs, 36 mental health practitioners and 8 tribunal chairs. A combination of interviews, observations and documentary analysis are drawn upon to illustrate tribunal decision-making practice on CTOs. The key themes reported on are: the mediating influence of participant presentation and interaction in tribunals; tribunal framing and interpretation of insight and risk; and the importance of timing to tribunals, both in terms of the perceived stability of a service user's social circumstances, and the length of the CTO. The findings highlight the cumulative and interrelated effect of such factors on tribunal decision-making, and point to how tribunal judgements are heavily weighted towards upholding CTOs, with the implications that holds for individual rights.

### 1. Introduction

Over the last thirty years community treatment orders (CTOs) have gradually become an embedded aspect of mental health legislation and provision in over seventy-five jurisdictions across the world (Rugkasa, 2016). Their introduction is typically connected to three aims of promoting recovery and resource efficiency through a reduction in 'revolving door' hospitalisation, and managing risk through ensuring service contact and treatment adherence. CTOs require that service users in the community adhere to a set of conditions, particularly to engage with treatment and maintain contact with services. CTOs commonly include a mechanism for involuntary admission to a treatment facility if service users do not meet the conditions, or if their mental health is believed to be deteriorating.

The implications of extending compulsion from the hospital into the community means wherever CTOs have been implemented their enactment has brought much debate related to both ethical concerns and effectiveness. Supporters of CTOs argue that they provide a framework

for engagement, enable risk management, reduce rates and length of involuntary hospitalisation, improve clinical outcomes and promote community based care (Lawton-Smith, Dawson, & Burns, 2008; Munetz & Frese, 2001; O'Reilly, 2006; Swartz & Swanson, 2015). In response it has been contended that CTO efficacy remains undemonstrated across a range of outcomes, and that they encourage an unnecessary and stigmatising focus on risk, a loss of liberty and rights for service users, and the neglect of less coercive relationship-based approaches (Brophy & McDermott, 2003; Burns & Molodynski, 2014; Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006; Pilgrim, 2007; Vergunst, Rugkasa, Koshiaris, Simon, & Burns, 2017). This spectrum of opinion is reflected in studies on the perspectives of individuals made subject to CTOs, which suggest that they often express ambivalence towards the role of the CTO in their lives (Light, 2014). The CTO is often described as a stabilising intervention and a 'safety net', whilst also being experienced as restrictive, disempowering and anxiety-inducing (Corring, O'Reilly, & Sommerdyk, 2017).

Indeed, whilst service users tend to report that CTOs are preferable

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to involuntary hospitalisation (Stroud, Banks, & Doughty, 2015), experiences of coercion across various aspects of the CTO means that the cumulative effects of long-term compulsion in the community should not be discounted (Canvin, Rugkasa, Sinclair, & Burns, 2014). In this sense, a concern has also been raised that CTOs are analogous to a ‘lobster pot’, in that they can be easy to apply whilst also difficult to justify removing (Rugkasa, Yeeles, Koshiaris, & Burns, 2017). It should be noted that this is not a universally held concern. Indeed, some CTO researchers have long argued that lengthier CTOs result in better clinical and social outcomes, as they enable individuals to build on the stability the CTO may offer (see Cripps & Swartz, 2018). Conversely, it can be argued that because ‘indefinite’ CTOs result in long-term restrictions on service user autonomy, they can have implications for service provision, resource management, service user-care team relations and service user well-being.

The ‘lobster pot’ effect has been observed across a range of jurisdictions (Morandi, 2016). However, the prospect of continuous community compulsion is particularly relevant in jurisdictions such as England where the threshold for CTO application and on-going renewal is both flexible and low. It has been noted that mental health law in England can be broadly interpreted, and thus relies heavily on “the judgement of the practitioners who are required to apply it” (Peay, 2003, 118). The considerable space the legislation leaves for professional discretion means that there is an intrinsic ambiguity to legal boundaries, making it difficult to challenge what can be flexible interpretation of criteria (Fistein, Clare, Redley, & Holland, 2016). Indeed, a comparative analysis of mental health law in different Commonwealth regimes (Fistein, Holland, Clare, & Gunn, 2009) gave England a low ranking in safeguarding service user autonomy. This analysis noted that the lack of a capacity criterion, coupled with a less stringent test for risk is likely to enable strongly paternalistic approaches to involuntary treatment. More specifically, an analysis of CTO regimes in different jurisdictions shows that the regime for England can be classified as having a comparatively low threshold, taking account of capacity, risk, and reciprocity criteria, pre-conditions for use and judicial oversight (Jobling, 2016a). In this regard, the regime in England is aligned with CTO legislation in New Zealand, and most Australian states, whilst North American regimes are differentiated by much more detailed, prescriptive criteria and higher thresholds for application. Whilst the relationship between the nature of CTO regimes and rates of usage is not straightforward (Burns, 2016; O’Donoghue et al., 2016), broad legal criteria may be associated with rising use (Light, 2014). The cumulative use of CTOs in England has steadily grown from 3325 in 2010 to 5426 in 2016 (HSCIC, 2011, 2016), and recent analysis suggests the average length of CTOs in England is over a year (Trevisick, Carlile, Nodiyal, & Keown, 2018).

In this context, tribunals play a key role in deciding whether a CTO is legally appropriate, as they should act as a ‘check and balance’ on practitioner discretion by safeguarding rights through the CTO appeal system. Further, research has repeatedly highlighted that positive perceptions of procedural justice, particularly communication and transparency in decision-making on CTOs, can mitigate service users’ sense of coercion (Francombe Pridham et al., 2015). It is therefore important to understand how tribunals oversee CTOs (Brophy, Campbell, & Healy, 2003), particularly due to the many legal, practical and ethical dilemmas CTOs bring. Yet whilst there have been studies of aspects of practitioner decision-making on CTOs (Dawson & Mullen, 2008; Manning, Molodynski, Rugkasa, Dawson, & Burns, 2011; Mullen, Dawson, & Gibbs, 2006; Romans, Dawson, Mullen, & Gibbs, 2004), and a significant international body of research exists on tribunal decision-making in relation to inpatient detention (see Thom & Nakarada-Kordic, 2014 for an overview), little has been written which combines the two fields and investigates how decisions may be reached in CTO appeals.

The literature on inpatient tribunals suggests they can fail to be effective in safeguarding service user rights in decision-making for a

range of reasons, including their tendency to go beyond legal criteria (Carney, 2011), rely on elastic concepts such as insight (Diesfeld & Sjostrom, 2007), take a paternalistic approach to ‘best interests’ (Diesfeld & McKenna, 2007), and privilege psychiatric evidence over other sources (Shah, 2010). The studies that do exist of CTO tribunals reflect these themes. Jaworowski and Guneva (2002) found that tribunal decisions largely aligned with clinical reasoning, which in turn may lead tribunals to be more inclined towards the testimony of psychiatrists. Research on tribunal decision-making on CTOs in Sweden (Zetterberg, Sjostrom & Markstrom) noted a lack of transparency in legal decision-making, which was connected to a blurring of boundaries between legal and extra-legal criteria. This study also postulated that by drawing implicitly on principles of ‘therapeutic jurisprudence’ (Winick, 2008) tribunals took a best interests rather than a rights-based approach, thus undermining the protection of legal rights.

As Carney, Tait and Beaupert (2008, 332) note, tribunals face a complex and challenging task in “synthesising incommensurable narratives...and ascribing them with a legal meaning” within contingent social contexts. Moreover, CTOs arguably bring an additional layer of complexity to decision-making due to the restriction on liberty being less tangible than it is in inpatient settings. This certainly appears to be a dilemma for practitioners when making decisions on CTO discharge, with Mullen et al. (2006) reporting that practitioners find it hard to judge the ‘right’ time to discharge a CTO as they do not want to reverse any progress a service user has made. Dawson and Mullen (2008, 278) contend that practitioners move along a “chain of reasoning” when making the decision to discharge, from a consideration of insight, to likelihood of compliance and the adverse consequences if compliance is not continued.

An analysis of tribunal decision-making on CTOs would both build on and make further connections between these discrete bodies of literature. Accordingly, by drawing on observational, documentary and interview data from a study of CTO practice in England, this article explores what the key factors and influences may be in tribunal decisions on CTO renewal or discharge. In doing so, the aim is to further develop understanding of how ‘continuous compulsion’ under the CTO can manifest, particularly within regimes such as England where the threshold for their imposition and continuation is low, leaving substantial latitude for interpretation of CTO criteria. Before introducing the study and findings, a description of the CTO regime and appeals process in England is given.

### 1.1. Community treatment orders and the role of the tribunal in England

CTOs were introduced in England and Wales,<sup>1</sup> under the revised 2007 Mental Health Act. They can be applied only immediately following compulsory hospitalisation for treatment under Sections 3 or 37 of the 1983 Mental Health Act. A responsible clinician makes the formal application for the CTO as part of discharge from hospital, with an approved mental health professional (AMHP) providing the second opinion. Responsible clinicians are typically psychiatrists who hold responsibility for the care and treatment of service users being treated under the Mental Health Act (1983). Approved mental health professionals are mostly social workers who have received specialist training in mental health law, and have additional statutory powers in relation to assessment and decision-making under the 1983 Mental Health Act.

Although CTOs are described as a “kind of contract” with service users in the guidance for their use (Department of Health and NIMHE, 2008, 17), and it is recommended that agreement on the CTO is reached with the service user, they do not have to consent to the imposition of

<sup>1</sup> The legal framework for CTOs is shared by England and Wales, but as this article draws on data from England only, it will refer to ‘England’ from this point. It is also worth noting that CTO regimes differ across the regions of the UK.

the CTO. The criteria for both the application and renewal of CTOs are included in Section 17 of the 2007 Mental Health Act, and are as follows:

- a) The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
- b) It is necessary for his health or safety, or for the protection of other persons, that he should receive such treatment;
- c) Subject to his being liable to be recalled as mentioned below, such treatment can be provided without his continuing to be detained in a hospital;
- d) It is necessary that the responsible clinician should be able to exercise the power under section 17E(1) to recall the patient to hospital; and
- e) Appropriate medical treatment is available for him.

The legislation stipulates that in making their decision, the responsible clinician should have regard for: the patient's history of mental disorder and any other relevant factors; and what risk there would be of a deterioration in the patient's condition if they were not detained in a hospital (as a result of refusing or neglecting to receive the medical treatment required). There are two mandatory conditions that are attached to all CTOs: that the individual made subject to the CTO makes themselves available for assessment for renewal of the CTO, and (if necessary) for assessment by a second psychiatrist to review the treatment plan. The responsible clinician can attach additional discretionary conditions to the CTO, as long as they are necessary to ensure medical treatment; prevent risk of harm to the patient's health or safety; and/or protect others. The power of recall to hospital for involuntary treatment is how the CTO is enforced, and this can be triggered if the responsible clinician believes that the patient requires medical treatment in hospital, and that there would be a risk of harm to the health or safety of the patient or others if the patient were not recalled to hospital for that purpose. The responsible clinician may also recall an individual to hospital if they have failed to comply with the conditions of the CTO.

Unlike some other jurisdictions (for example states in the USA – see O'Reilly & Grey, 2016), the initial decision to apply for a CTO is solely clinical rather than judicial. The role of the tribunal in England is to scrutinise whether the legal criteria for a CTO continue to be met once the CTO is in use. CTOs are initially in place for a period of six months, and then can be renewed for a further six months, with renewals being yearly thereafter. Two forms of tribunal exist – the Managers' Hearing and the Mental Health Tribunal (formally known as the First-tier Tribunal (Mental Health)). Service users can choose to appeal to a Managers' Hearing at any time during the CTO, and an appeal to the Mental Health Tribunal can be made once in each CTO time period. There are also regular mandatory appeals. A Managers' Hearing has to be held each time a CTO is renewed. A Mental Health Tribunal has to be held within six months of the initial detention in hospital which led to the CTO, and then three years later, if the CTO is still in use. This 'two-track' appeals system of voluntary and mandatory appeals means that Managers' Hearings in particular are regular CTO events, often not at the behest of the individual who is on the CTO.

The organisation of Managers' Hearings is the responsibility of the local Mental Health Trust, and the three members that make up a Hearing panel are typically drawn from vetted and trained volunteers from the community. Mental Health Tribunals are run as part of the national HM Courts and Tribunals service and the panel must include a judge, a medical member, as well as a specialist lay representative. They are more formal than Managers' Hearings, in that hold greater powers and can lead to the formation of mental health case law. However, in practice the role of Mental Health Tribunals and Managers' Hearings in relation to CTOs is very similar, in that both must decide whether the legal grounds for the CTO are applicable at that point in time. For the sake of clarity, both bodies are simply referred to as tribunals throughout the remainder of the article unless it is necessary to

differentiate.

The process of the appeal is also generally comparable across both bodies. The tribunal members receive reports from the responsible clinician and care coordinator beforehand which make recommendations to the tribunal based on the service user's psychiatric and social history, and current circumstances including factors relating to risk, vulnerability, strengths, social support, capacity, cognition and behaviour. In most circumstances the service user and their representative have the right to read the professional reports before the tribunal occurs, and service users also have the right for a carer and a legal representative to participate in the appeal. Whilst service users are strongly encouraged to attend tribunals, they are not required to for tribunals to go ahead. Guidance emphasises that tribunals follow the general principle of making a decision that is the least restrictive (Department of Health, 2015).

## 2. The study

The findings presented here are generated from an ethnographically informed case study which tracked the progress of 18 CTOs from two English Mental Health Trusts over eight months. It has been noted that undertaking an ethnography of CTOs would enable "the particular context of social actors and groups and the social matrices of their thoughts and behaviour" to be accounted for (Swanson, 2010, 185). An ethnographic approach was thus employed in order to interrogate the everyday practice of CTOs. Specifically, drawing on an ethnographic methodology was aligned with the overarching aim of the study, which was to give an account of CTO 'pathways', and particularly to uncover the plural and complex ways CTOs are conceptualised and negotiated by mental health practitioners and the individuals made subject to them as they unfold over time. In turn, analysing CTO processes 'on the ground' was intended to demonstrate how the ethical questions on their use play out in practice, including in relation to 'down-stream' decision-making once a CTO is in place, with tribunals being a key focus of investigation.

### 2.1. Recruitment, selection and participants

The author was embedded within the largest Assertive Outreach Team in each Trust for the duration of the fieldwork. Assertive Outreach Teams were chosen as they typically work with a large number of people made subject to CTOs, and service users on CTOs made up approximately a third of each team's caseload. The 18 CTOs included in the study were selected to reflect a range of service user characteristics, reported perspectives on the CTO, and different stages of the CTO. Exclusion criteria for service user participants were if they: had a learning disability or diagnosis of dementia; did not speak English; were under eighteen; or were deemed to lack capacity to take part. Capacity was assessed using the 2005 Mental Capacity Act principles and code of practice, with initial screening taking place at the introductory meeting with the researcher, and iterative assessment taking place at each data collection point.

12 of the service users were male, indicative of CTO trends, and 16 identified as White British, reflecting the field site demographics. The majority of service users (14) were between the ages of forty and sixty, almost all unemployed (15), and all had been in contact with services for a number of years (mean 14.7) due to a psychosis-related diagnosis. 7 of the service users had experienced two or more CTOs and the length of service users' current CTOs ranged from three months to just over two years. The majority (13) had two basic conditions attached to their CTO of treatment compliance and engagement with the care team, with the remainder having an additional condition related to drug and alcohol use. 5 of the service users had been recalled to hospital at some point during their CTO and 6 were discharged from their CTO during the fieldwork period (all at review). Whilst service user attitudes towards the CTO were generally complex, 10 of the 18 service users were

broadly positive about their status.

Alongside the service users, 36 mental health practitioners (nurses (12), social workers (16), occupational therapists (2) and psychiatrists (6)), and 8 tribunal chairs, participated in the study. The practitioners represented an array of organisational roles, including responsible clinicians, AMHPs, care coordinators, clinical leads and team managers. Length of professional experience ranged from forty years to one year. By nature of their position, the tribunal chairs were experienced in tribunal practice, with the minimum time in role being three years.

Initial agreement for access was given by senior management in each Trust, with follow-on agreement negotiated with the Team Managers. A series of meetings were held with the practitioners in each Team prior to fieldwork starting in order to introduce the research. Service users were initially approached via their care coordinator before an introductory meeting was held with the researcher. Individual participants were given information sheets and written consent forms covering all aspects of their involvement. Given the longitudinal nature of the fieldwork, on-going verbal consent was obtained from participants at each data collection point. Carrying out research with mental health service users can be ethically challenging for a number of reasons (Keogh & Daly, 2009) and care was taken to ensure all contact with service user participants accounted for this. Ethical and governance approval was obtained through each Trust's Research and Development Office, and the national Social Care Research Ethics Committee.

## 2.2. Methods and data

The core of the data derived from the 18 CTO cases and were generated via a combination of methods including:

- Semi-structured interviews with each service user ( $n = 22^2$ ), their care coordinator, responsible clinician, and the AMHP ( $n = 20$ ) who had agreed their CTO, using participant-relevant topic guides to explore perceptions, feelings and experiences of CTOs. Interviews averaged one hour in length and all were audio recorded and fully transcribed.
- Observations of 32 key meetings (average 2 per case) including tribunals ( $n = 10$ ), reviews ( $n = 12$ ), hospital discharge ( $n = 3$ ) and home visits ( $n = 7$ ). Due to ethical considerations these were not recorded, but detailed and verbatim notes were taken during and immediately after each meeting, using a structured protocol (Lofland, Anderson, Snow, & Lofland, 2006; Spradley, 1980).
- Case file analysis for each case, in which written notes were taken from both paper and electronic files, starting from the initial CTO. This data related to CTO use only, and included regular case recordings, records of formal CTO decision-making, reports to tribunals from care coordinators and responsible clinicians ( $n = 37$ ), and tribunal summing up ( $n = 33$ ). All data points were transcribed into a 'timeline' of actions and decision-making for each case.

The above 'case-related' data were supplemented by contextual data on CTO practice more broadly, drawn from key informant interviews with clinical leads and managers ( $n = 16$ ), tribunal chairs ( $n = 8$ ), and observations of team meetings, everyday practice and informal discussions of CTOs.

## 2.3. Analysis

Analysis combined thematic and narrative approaches in order to generate CTO 'story-lines' through the different CTO stages, whilst at the same time developing themes across cases relating to the individual, interpersonal and contextual factors which influenced CTO use as they

<sup>2</sup> Repeat interviews were conducted with four service users whose legal status had changed during the fieldwork period.

progressed (Floersch, Longhofer, Kranke, & Townsend, 2010). McCracken's (1988) approach of close reading of data in order to draw out 'first order' and then 'second order' concepts before categorising them was applied to each set of data in turn, creating analytical frameworks. Given the narrative aspect to analysis, the service user interview data was the starting point for a foundational analytical framework, which was then applied to and expanded by the other kinds of data (practitioner/key informant interviews, observations, documents), with points of connection and disparity across perspectives and kinds of data accounted for, in an iterative and refining process. Explanatory memos were drawn up for each of the categories within the developed analytical frameworks in order to fully explore their meaning, distinctiveness, and relationship to each other, and to test out their plausibility (Hammersley, 1992). Throughout the analytical process, emerging findings were discussed in workshops with groups of researchers, practitioners and service users to sense check and further support authenticity. Some of the narrative oriented findings have been reported on elsewhere (Jobling, 2016b). The focus in this article is on the cross-cutting themes as they relate to the particular turning point in CTOs of the tribunal appeal.

## 3. Results

The data presented in this paper are drawn from the interviews with service users, practitioners and tribunal chairs, observations of tribunals, and the documentary analysis of professional reports made to tribunals, as well as tribunal summing up of their discussion and decision. Data are therefore a mix of case-related and broader perspectives on CTO practice. It should be noted that although the interviews and tribunal reports sometimes referred to discharges from CTOs by tribunal, none of the observed tribunals ended in discharge. Out of the ten tribunals observed, eight were mandatory, with five being attended by service users and four by legal representatives and carers. Pseudonyms are used for service users, and practitioners are referred to by their organisational role.

Investigation of tribunal practice illuminated the following themes in relation to CTO decision-making: the mediating influence of the presentation of service users and their perceived relationships with professionals; the centrality of considerations of insight; the variety of ways risk is accounted for; perceptions of social support and stability; and the underlying temporal dimension to decisions. There was considerable interplay between these factors, and they are reported on sequentially below.

### 3.1. The presence and interactions of key actors

The majority of service users interviewed stated that they did not see the point in actively pursuing voluntary appeals or attending mandatory tribunal appeals. Those service users who felt mostly positive about the CTO saw no reason to attend because they were happy for it to be renewed. The majority of service users who felt unhappy about the CTO also saw no significance in the appeal because they believed they would not be listened to, as Sarah sums up:

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

However, not attending could risk a self-fulfilling outcome. Whilst tribunals were heavily inclined towards professional (and particularly responsible clinician) accounts, all the chairs reported that service user

participation in appeals informed their ability to make a well-informed decision. Being able to see *the whites of their eyes* as a couple of chairs stated, was deemed important to bringing into focus the reality of a service user's circumstances, particularly when the decision to renew was not deemed clear-cut. One chair described a decision they had made recently to uphold a CTO thusly:

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

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

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

Indeed, when there was little reciprocity and practitioners did not appear to know service users well, it could influence tribunals' views on the validity of their evidence. For instance in Michael's tribunal, the chair expressed dismay that the responsible clinician had only met Michael once. In their ensuing decision-making, the tribunal had a lengthy discussion about whether to discharge or not, with the chair saying:

I was a bit shocked at how long he'd been in the community and not having a review for almost four months. And this doctor has only seen him once. It's not clear from this report at all that there'd only been one meeting.

How tribunals accounted for professional expertise and how much they felt able and willing to question professional claims was central to decision-making. The possibility of contrast between service user presentation and practitioner description, and the ways practitioners displayed knowledge of the service user were both important mediating factors in such decision-making.

### 3.2. Interpretation of insight

The foundational question that tribunals considered when deciding to discharge a CTO was whether the power of recall to hospital for involuntary treatment was still necessary. This in turn was based on probabilistic beliefs around whether the individual being considered would maintain contact with services and take medication if the CTO was not in place. In other words, the possibility of being discharged from the CTO was increased if the tribunal was convinced the service user would keep to their treatment plan. Accordingly, a key factor that tribunals appeared to base their decision on was the perceived presence or not of insight in the service user. As this chair points out:

Insight is the biggest thing. If you feel the patient has insight into their condition, then they are more likely to continue the medication and obviously the power of recall is tied to the insight into the condition.

Chairs ranged in their perspectives on insight, with some being more critical of the concept than others:

The concept of insight is something that we've been taught well. I've been advised to challenge, in other words, insight means agreeing with your doctor [laughs] therefore if you disagree with your doctor clearly you lack insight and if you lack insight you clearly need to be medicated. So I think it's something that I haven't thought about before I was advised in this respect but I do think one needs to bear that in mind.

However in practice, the task of challenging and analysing what practitioners meant by insight could be difficult for tribunals to do, especially with limited information and if the service user was not present. Practitioners sometimes talked in appeals about service users *paying lip service* to the CTO, or *saying the right things*, hence differentiating between surface and 'true' change. In this sense, the gaining or recovery of insight through the CTO indicates a process of internal change, but this could be difficult to qualify. One signifier of insight that tribunals relied on was if and how much the service user had actively sought help when necessary, for example requesting voluntary admissions to hospital. In these cases, service users were seen to be taking responsibility for their treatment and acknowledging that they required support, hence the need for the responsible clinician to retain power of recall could be questioned. Therefore, tribunal conceptions of insight were closely aligned with their perceptions of responsibility. In a tribunal report where the service user was discharged, the reason given was:

The panel were impressed with the patient's insightful presentation. The key element in reaching the decision to discharge is that her freedom is limited by the MHA. She is keen to take personal responsibility and there seems to be an acceptance by the team that she needs to be given an opportunity for self-reliance.

When a service user was deemed unable to gain insight, the CTO could be seen as supporting them to maintain a semblance of 'normality' and responsibility regardless, as this chair explains:

There is a lady I saw who came with her husband and the comment in the psychiatrist's report was that this was one of the most insightful patients he'd ever met and to me that speaks volumes. The CTO was continuing to be extended and I think she was in her second year. And it does seem an awful long time but then you think well she could live a reasonably productive life, she had a small part-time job, her kids had a good relationship with her, she's got a husband and you think, wow, if the CTO can facilitate that...you think what a success story that is.

### 3.3. Framing of risk

As a follow-on from considering whether on-going treatment adherence was likely, tribunals weighed up the potential implications if adherence was not maintained. Where there was evidence that a service user presented a serious risk of harm to self and/or others, CTOs were always renewed. However, the converse was not necessarily the case; if a service user was believed to be low risk they would still be unlikely to win an appeal if they demonstrated little insight. Following Craig's tribunal, the judgement in favour of the CTO noted that there was a lack of evidence regards threats to his safety or others, but because Craig lacked insight, there did remain a risk to his mental health deteriorating if the CTO was lifted. This suggests that the tribunal accepted a broad interpretation of 'health or safety' as a basis for their decision. Therefore whilst concerns about the seriousness of the implications if a service user did not maintain engagement were certainly present, they appeared to be secondary concerns for tribunals.

Nevertheless, risk figured as a constant factor in practitioner testimony, even if it was not entirely applicable to the case in question.

Indeed, in many cases there appeared to be a risk ‘shorthand’ whereby risk was talked about in a nebulous sense without delineating what it actually meant for that service user. Risk was conceptualised by practitioners in reports and oral evidence in a number of ways, including ‘nuisance’ or socially problematic behaviour. Further, practitioners did not always differentiate between theoretical and evidenced risk, as shown in the following exchange about Sheila:

Chair: Would there be a risk to her safety?

Responsible clinician: Yes because when she is a psychotic state she is more vulnerable and at risk of being harmed by others.

Chair: Do you consider this a potential risk?

Responsible clinician: Yes.

Second panel member: But there's no history of her being harmed in this way?

Responsible clinician: No, but she's put herself in danger.

Second panel member: So it's not an actual risk as there's no evidence of this happening in the past.

There was at times a ‘stickiness’ to accounts of risk, whereby one-off or long-ago incidents would still be referenced by practitioners in their arguments for the CTO. With Gwen, the responsible clinician wrote the following in his report:

As she has a history of lacking insight when becoming unwell with associated risks of the illness which include taking overdoses and aggression towards her mother, it is necessary that I should be able to exercise the power of recall.

In the appeal it became evident that Gwen, now a woman in her forties, had taken an overdose in her late teens, and had pushed her mother once during an argument five years earlier. There is a marked disparity between the responsible clinician's written presentation of these events in order to justify renewal of the CTO based on risk, and the accounts given at the tribunal.

### 3.4. Social support and stability

Out of all the observed tribunals, Gwen's appeared to be the strongest for discharge from the CTO, in that she had been stable for three years with no recalls, was accepting of medication, and there was little evidence of risk of harm to her or others. However, her case highlighted how important consideration of social support could be in tribunal decision-making, specifically here the influence of family. Gwen's parents attended the appeal and argued strongly for the CTO to continue, as her mother said in the appeal:

It took us three years to get help for Gwen and we feel the CTO is there to help provide a safety net for her. The CTO is a comfort factor, it reassures us.

Whilst Gwen's parents were vocal during the meeting, Gwen said little aside from stating that she was happy to remain on the CTO. The tribunal decided to extend the CTO for a further year, and it was evident in their discussion of the case the views of the parents were integral to that decision:

Second panel member: If she has sufficient insight you could argue she doesn't need the power of recall in order to take medication.

Third panel member: I think she's functioning fairly well but it would appear that she's getting an awful lot of support from family and from services to a lesser extent actually. But we need to renew to keep that all in place.

Chair: But it would be in place anyway.

Third panel member: Yes but the parents would see it as a disaster. At the moment they desperately need the term ‘CTO’ to feel supported.

Although it could be questioned whether Gwen met the legal criteria for the CTO, even being as broad and flexible as they are, the

symbolic value the CTO held for her parents was influential in the tribunal's final decision to uphold the CTO.

In a wider sense, the stability or not of the service user's life circumstances was significant in tribunal discussions on whether the criterion for ‘health or safety’ was met. It appears that it was not only service user's ‘internal’ stability (via insight) that was deemed important, but also ‘external’ stability in terms of their housing, occupations and relationships. Many of the service users lived precarious lives, where constant change was a given, and consequently practitioners often justified continuation of the CTO on the basis of ‘life stressors’. As this chair answered in response to a question about the kinds of arguments that practitioners made for CTOs:

Well, a likely change in the person's placement, moving from a hostel to independent living...Some sort of change in their circumstances that would cause them stress. Because I think the psychiatrists are very aware of stress factors that could cause a relapse...you know anything in their personal circumstances that has changed, and you know that can cause a quick dip in their mental health and that's really what the psychiatrists are looking at.

### 3.5. Length of the CTO

On this basis, if a service user was deemed to have insight and be low risk, but was going through a period of change such as a housing move, then the CTO could be justified as an anchor during that process. This brings us to the final factor that influenced decision-making, that of timing. CTOs in England are open-ended in that they can be renewed without limit and some chairs reported that they were more cautious about renewal the longer the CTO:

It gets more difficult because obviously they are on the mend in terms of progress they are making. So I think funnily enough it brings a bigger challenge to decide at what point we will not support the renewal. I've certainly had instances where I feel the clinician is being too risk averse and we have to really intervene to stop that, because otherwise it can go on forever.

But there could be a tension between this stance and practitioner views on making the CTO work. The majority of practitioners took the view that for the CTO to be effective, it had to be in place for a significant amount of time. Hence even in cases where the CTO had been in place for some time, with adherence and stability achieved for a year or more, and no recent ‘risk events’, practitioners would argue that the CTO should be retained in order to maintain progress. As this care coordinator states:

And I've said in CTO tribunals, ‘if it ain't broke, don't fix it’. The patient has to be on the CTO for a while before the full benefit can be achieved, so lots of times even though the patient is engaging very well, they are saying all the right things, they are happy to take the treatment, they are happy to see us, we are still going for a renewal.

Tribunals often seemed to accept this argument, with the following comment in an observed tribunal discussion being typical:

I think it's quite a difficult one. If there had been two or three months more of progress then I'd think more about whether to renew or not. But it's just a bit early now.

Whilst in theory panels needed to consider whether the legal criteria for the CTO were still valid at that point in time, in practice it seemed that they often took a longitudinal view on CTO legitimacy by agreeing with maintaining the status quo if the CTO was seen to be effective. Conversely, as highlighted throughout, if there was evidence of any difficulties in relation to insight, risk or social support despite the presence of the CTO, this too could justify continuation, as practitioners argued that the CTO provided a framework to manage such issues over

time.

#### 4. Discussion

Tribunals are an integral part of established mental health systems across the world and they perform an important function in oversight of the operation of mental health law. Given the minimal published literature on tribunal practice for CTOs, this article makes a valuable contribution to knowledge both in terms of tribunal decision-making more broadly, and specifically for decision-making on CTOs in relation to how the ‘lobster pot’ effect might be generated. The results reflect the themes present in literature on tribunals, which highlights high levels of agreement between practitioners and tribunals; significant interplay between legal and extra-legal factors; and the therapeutic intent of tribunals which may converge with an orientation towards a ‘best interests’ framework (Carney, 2011; Diesfeld & McKenna, 2007; Shah, 2010). What is also evident is that the issues raised about tribunal practice more broadly are sharpened in the context of CTOs. Tribunals in England are more likely to discharge from involuntary inpatient care than they are CTOs; in 2015/16 the rates of discharge were 14% and 4% respectively (Care Quality Commission, 2016, 51). As Szmukler (2014) comments, criteria for involuntary in-patient treatment do not translate easily to decision-making on compulsion in the community. Whilst deciding whether an individual should be retained in an inpatient setting is not always straightforward, it may still be more clear-cut than applying similar legal criteria to an individual already in the community, where the restrictions on liberty brought about by the CTO are less literal. Although the overarching purpose of tribunals is to ensure the least restrictive approach is taken (Carney et al., 2008), it can be questioned whether they always actively consider what the less ‘visible’ and negative effects of indefinite compulsion in the community might be. This was acknowledged by some study participants, with one practitioner describing the CTO as a *virtual asylum*. It appears then that in weighing up the potential implications of renewal or discharge from a CTO, the odds are heavily stacked in favour of renewal.

In this sense, tribunal decision-making echoes what is known about practitioner decision-making on CTO discharge, in the dilemmas that can arise when applying legal criteria to “an individual being deemed well enough to live in the community but not to make his or her own decisions about matters such as treatment” (Gergel & Szmukler, 2016, p. 224). The complexity this brings to decision-making is demonstrated in studies of practitioner decision-making which suggest that the decision to renew or discharge a CTO involves inherent uncertainty and can be based on a double-bind (Mullen et al., 2006). If a service user is perceived as doing well, the justification for CTO renewal is to maintain progress, but if a service user demonstrates a lack of progress, the justification for renewal is to maintain treatment adherence. This analysis of practitioner reasoning suggests that the renewal of CTOs can be justified whether service user responses to its imposition are positive or negative, as discharging a CTO would be taking a risk in both cases. Similarly, tribunals took a longitudinal rather than cross-sectional perspective on the legal grounds for a CTO, based on judging whether progress had been sufficiently embedded for the ‘safety net’ of recall to be dispensed with. There is a tendency then for both tribunals and practitioners to make negative predictions as to the consequences of discharge from the CTO regardless of the perceived effects of the CTO in the present. The problematic nature of risk prediction within the context of defensive mental health practice has been well documented (Campbell & Davidson, 2009; Szmukler & Rose, 2013). In this context, tribunals may promulgate the extension of defensive decision-making in the community via their replication and corroboration of practice norms.

A key aspect of decision-making in this regard for tribunals was their interpretation of service user’s level of insight. As Diesfeld and Sjoström (2007) note, the invocation of insight enables tribunals to operate with ‘interpretative flexibility’ in both grasping and addressing

the complex cases they are faced with. However, the use of insight as an evidential concept in legal decision-making can be problematic. It is an “unhelpfully inexact” concept (Diesfeld, 2003, 371) and can lead to tautological reasoning whereby “treatment adherence is used both to measure insight, and attributed to degree of insight, at the same time” (Dawson & Mullen, 2008, 270). Whilst tribunal members might take a critical distance to concepts such as insight, it was also difficult for them to ‘step outside’ the prevailing discourses in mental health as filtered through professional explanations and consider alternative accounts. Certainly, it seemed that tribunals were prone to conflating insight with the likelihood of on-going compliance to treatment, and signifiers such as service users actively seeking treatment were therefore viewed as important in judgements of insight. Consequently, insight acted as an evaluative resource for tribunals to decide whether service users should be allowed to regain autonomy and responsibility for their ongoing treatment.

This use of insight in this way equates it to a large extent with that of capacity, with decisions being made by tribunals based on best interests (Diesfeld & McKenna, 2007; Zetterberg, Sjoström, & Markström, 2014). As Fistein et al. (2016) point out, mental health law in England further reinforces ‘hard’ paternalism through the broad criterion of ‘health or safety’. Evidence of high-risk behaviour (such as a forensic history) would lead to tribunals upholding CTO renewals in order to ensure monitoring. However, similarly to insight, risk of harm was presented by practitioners and understood by tribunals in a mutable way, relating to a variety of concerns about service user behaviour and vulnerability. As Glover-Thomas (2011) points out, risk can be put to use as a fluid concept in argumentation, which makes it difficult to counter. Furthermore, risk was not only linked to tribunal assessment of service user agency, but also to contextual circumstances. In England, CTOs are put in place to ensure engagement with treatment, but recall can also be used if a service user’s mental health deteriorates, regardless of whether they are continuing to engage with treatment or not. It is here that tribunals’ accounting for a service user’s social support and stability comes into play, in that renewing the CTO was seen to both maintain the stability necessary to prevent deterioration in mental state, and to be a supportive framework should there be a change in social circumstances which could trigger a relapse.

Tribunals followed a similar reasoning pathway to that of practitioners (Dawson & Mullen, 2008) from insight to adherence and the perceived probability of negative consequences if adherence was not maintained, with the additional contextual factor of external threats to stability. This reinforces the high bar that is set for a CTO to be discharged, involving the successful negotiation of the multiple and compounding factors highlighted here. The way tribunals handled testimony in negotiating their understanding of these factors also supports what is known about how tribunals can struggle to critically assess clinical claims (Shah, 2010; Zetterberg et al., 2014). Where tribunals appeared to most be able to challenge clinical testimony was when there was tangible evidence which cast doubt on the claims made. Tribunals are known to perform a therapeutic function in critiquing and advising on care plans (Carney, 2011) but this emphasis on therapeutic interaction and outcomes can also influence their decision-making, with importance placed on observed relationships and perceived quality of care. Thus, whilst the findings reported here align with Zetterberg et al.’s (2014) conclusion that tribunals’ emphasis on therapeutic outcomes underpins best interests oriented decision-making, it is also evident that therapeutic concerns could be part of a broader consideration by tribunals of an individual’s ‘positive’ rights to care and support. Consequently reciprocity, although not present in the legal criteria, was accounted for by tribunals in their judgements on CTOs.

#### 5. Conclusions

One of the aims of the study from which the results presented here are drawn, was to explore how the key ethical questions that CTOs raise

are dealt with ‘on the ground’. This article focuses specifically on what the data tells us about the ethical dilemma of CTO discharge, and specifically how and why CTOs may be continuously renewed. A combination of broad legal criteria, the flexible use of concepts such as insight and risk in practitioner testimony and subsequent tribunal reasoning, and the cumulative and compounding ‘tests’ deemed necessary to prove the case for discharge, demonstrate the challenges inherent in reaching a discharge decision. The elements of timing and social circumstances are particularly worth highlighting. Whilst it is likely they would be present as considerations in inpatient tribunal reasoning, the emphasis placed on them may be sharpened by the very nature of the CTO as community-based, with a key objective being the maintenance of equilibrium. In this sense, tribunals were inclined to make decisions largely based on paternalistic predictions about the consequences of CTO discharge. By largely framing the adverse implications of discharge from the CTO in terms of best interests, tribunals appeared to minimise their role in protecting ‘negative’ rights based on least restrictive principles. In turn, the potentially harmful consequences of continuous community compulsion were largely absent from tribunal discussion. At the same time, a best interests orientation could also lead tribunals to implicitly advocate for ‘positive’ rights through their questioning of the legitimacy of CTOs where elements of care and support were noticeably absent.

The issues raised here can be connected to the current agenda in England for a reformation of mental health law. Specifically, a review is being undertaken of mental health legislation (Wessely, Gilbert, Hedley, & Neuberger, 2018) and CTOs are one of the areas under scrutiny. There have been calls for a more prescriptive framework for CTOs to be adopted, in order to reduce both initial applications and continuation of CTOs (Royal College of Psychiatrists, 2018). More broadly, there is a need to further interrogate how the ‘double-bind’ that can exist in CTO discharge practice may be broken. It may be that applying wider arguments on the place of legal capacity in mental health law (see Weller, 2017 for an overview of current debates) to CTOs is one way forward in restricting the ‘hard’ paternalism (Fistein, 2016) which can underpin decisions. However, as Fistein (2016) also notes, the common conflation of insight and capacity may constrain such rights-based legislative changes in practice. Indeed, it can be questioned how much shifts in legal frameworks influence ‘street-level’ mental health practice (Szmukler, 2014). Questions of problematic and ‘exceptional’ legal status need to be embedded in the social, political and economic context within which they arise (Weller, 2017). This brings challenges for limiting long-term CTOs, particularly in relation to how they may be used as a way of managing resources in times of scarcity.

Finally, this is a small-scale exploratory study, which examines CTO practice in English tribunals only, with all the contextual implications that brings. It has value in that it sheds light on an aspect of CTO practice on which little is known, and the use of multiple data sources and perspectives enables a holistic analysis. Moreover, although long-lasting CTOs are not seen as ethically problematic by all, exploration of the ‘lobster pot effect’ has relevance across jurisdictions (Morandi, 2016). Nevertheless, whilst the study is embedded in the discrete international literatures on tribunal and CTO decision-making, thus extending existing theoretical claims, it cannot be said to reflect tribunal CTO practice in other jurisdictions. In light of the conclusions drawn related to CTO decision-making, a larger-scale and more systematic study of decision-making - perhaps comparing practitioner reasoning and decisions to tribunal members as Jaworowski and Guneva (2002) did in Victoria, Australia - and a more in-depth analysis on how appeal panels understand and apply CTO criteria, would provide valuable evidence for when, how and why CTOs are discharged. Further a cross-national comparative analysis of practice in different jurisdictions would add significantly to what we know about common and distinctive themes about discharge from CTOs across contextualised settings.

## Declarations of interest

none.

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