Community Treatment Orders and Care Planning: A Critical Ethnography

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ABSTRACT

Community treatment orders (CTOs) are widely contested due to efficacy, ethical, relational and human rights concerns. In Australia, CTO rates are comparatively high, with significant variation across regions highlighting the impact of broader issues on usage. Regardless of the debate, individuals, their families and clinicians are frequently required to engage within this context. CTO legislation states that treatment and care should be recovery-focused, although care is often experienced as coercive. In community mental health services, care planning occurs between individuals with the aim of conjointly developing plans to guide recovery-based mental health care; the process, however, is situated within broader systems and structures. This study has sought to understand the interpersonal and broader systems issues that impact on the care planning process. Carspecken's (1996) critical ethnography is the methodology that has underpinned this examination. Ethnographic methods of observation and interview have provided a detailed account of the multiple perspectives of individuals on CTOs, their families and clinicians over an 18-month period in two community mental health teams in Adelaide. This included following 8 individuals' care journeys with services over 12 months.

Findings reveal how care practices, and service and cultural structures, are perpetuating stigma, discrimination and harm for individuals on CTOs in a community mental health setting. Despite mental health legislation and policy assigning priority to recovery-informed care values, mental health services' emphasis on risk and risk management made it challenging for mental health clinicians in this study to work with individuals in ways that aligned with recovery values. Although some clinicians were working within a recovery-informed approach, coercive practices were occurring at the site which were facilitated at a systems level. Structurally, the biomedical model remained the dominant framework informing care contacts (at the micro level), service structures (at the meso level) and service options, policy and allocation of funds (at the macro level). Subsequently, care planning was not always being used as intended. Clinicians were found to foreground service needs over the needs of the person on the CTO in the care planning process, although many clinicians were frustrated with this position. Costs of this service focus on risk included a devaluing of the therapeutic relationship, silencing of consumers' and carers' voices in the care planning process, and reinforcing and compounding a service culture of risk and discrimination which disempowered consumers.

Social theories of risk and trust are used to illuminate the findings and provide an exploration of possible means for cultural change. This requires a de-emphasis of the paradigm of disease and an emphasis of the paradigm of discrimination through implementation of strategies, approaches and interventions that are supportive of individuals' recovering citizenship. While there is scope for change at the clinical interface in care planning discussions, change is required at the systems level to support recovery-focused practice.

DECLARATION

I certify that this thesis:

1. does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and
2. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Signed SDawson

Date 30/03/2021

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GLOSSARY OF TERMS

Capacity	The term “capacity” is used to refer to clinical interpretations of a person’s ability to look after themselves and decide what is best for themselves. Unless clearly stated, the legal definition of capacity is not being used.
Carer	Carers are here defined as individuals who provide informal care and support to a family member or friend who, in this instance, have a mental illness. Caring roles and activities are broad and may include assistance with a variety of daily living activities and providing emotional, social and financial support (Carers Australia).
Community treatment order	“A community treatment order (CTO) made under the *Mental Health Act 2009* (the Act) requires a person with a mental illness to comply with treatment for that mental illness even if they do not want to. A CTO affects the person while they are living in the community. It does not authorise involuntary treatment of a mental illness as an inpatient. A CTO can be made for a person when: (a) the person has a mental illness; and (b) because of the mental illness, the person requires treatment for the person’s own protection from harm (including harm involved in the continuation or deterioration of the person’s condition) or for the protection of others from harm: and (c) there are facilities and services available for appropriate treatment of the illness; and (d) there is no less restrictive means than a community treatment order of ensuring appropriate treatment of the person’s illness. There are two levels of community treatment orders: Level 1: maximum 28 days A level 1 order can be made initially by a medical practitioner* or an authorised health professional (a nurse, social worker, psychologist or occupational therapist recognised as having specialised mental health training). Level 2: maximum 12 months A level 2 order is made by the Tribunal on application from a medical practitioner, a mental health clinician, a guardian, medical agent, relative, friend, carer or any other person who is judged to have a “proper interest” in the matter (i.e. a genuine interest in the welfare of the person). Taken from Community Treatment Orders Information Sheet, Office of the Public Advocate, http://www.opa.sa.gov.au/. CTOs have various names in different jurisdictions worldwide, including assisted or mandated outpatient treatment and involuntary outpatient commitment.
Consumer	This term is used to refer to people who are receiving care and treatment from mental health services. This term was selected as it is used in Australia. In other regions, people with lived experience of mental health services may be called patients or service users.

Medical practitioner	This includes psychiatrists, registrars (those who have commenced the training program in psychiatry) and registered medical officers (those who are often in early stages of training following graduation and are referred to in this study as junior doctors).
Mental health clinicians	This term is used to refer to all professional groups that worked at the study site and is inclusive of the range of medical practitioners, allied health professionals (occupational therapists, social workers and psychologists) and mental health nurses (referred to as nurses).
World Health Organization (WHO)	“WHO works worldwide to promote health, keep the world safe, and serve the vulnerable. For universal health coverage, WHO: • focus on primary health care to improve access to quality essential services • work towards sustainable financing and financial protection • improve access to essential medicines and health products • train the health workforce and advise on labour policies • support people's participation in national health policies • improve monitoring, data and information. For health and well-being, WHO: • address social determinants • promote intersectoral approaches for health • prioritize health in all policies and healthy settings.” https://www.who.int/

ABBREVIATIONS

ACT	Assertive community treatment
CMHC	Community mental health centre
CRC	Community rehabilitation centre
CST	Critical social theory
CTO	Community treatment order
ED	Emergency department
GP	General practitioner
ICC	Intermediate care centre
LHN	Local health network
MF	Meaning field
MHS	Mental health service
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
OC	Observer comments
OT	Occupational therapist
SAAS	South Australian Ambulance Service
SACAT	South Australia Civil and Administrative Tribunal
SDM	Shared decision-making
SAPOL	South Australian Police
SW	Social worker
WHO	World Health Organization

WORKS ARISING FROM THIS THESIS

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CHAPTER ONE
INTRODUCTON

Introduction

This thesis reports on a critical ethnographic study that has examined the culture of practice and care planning for consumers on community treatment orders (CTOs) in two community mental health teams in Adelaide. This included an examination of the interpersonal and broader structural factors that were impacting on care planning processes for individuals at the study site and how the conflicting narratives of risk and recovery were understood and applied in clinical practice. This introductory chapter presents the research questions and objectives, and concludes with the thesis outline and summaries of each chapter. The rationale for undertaking this study is also presented, which includes my own professional motivations as well as the theoretical context.

Situating the researcher and study site

My interest in this topic comes from over 25 years working in mental health care settings in the UK and Australia. After graduating as an occupational therapist (OT) in the early 1990s, I moved from Australia to the United Kingdom (UK) where I predominantly worked in community-based mental health care settings. Almost two decades later, I returned to Australia to live and work. This was in 2008 and coincided with the introduction of legislation in the UK that enabled forced treatment and care in the community for individuals with a mental illness. On commencing work at a community-based mental health service in Adelaide I soon encountered the use of CTOs, which had been legislated some decades earlier. As an OT, I believe in the value of occupation as a health determinant and thereby a means to support people’s recovery. Although as an OT I have been professionally aligned with biopsychosocial frameworks, throughout my career in mental health care I have held the generic role of care coordinator. Thus, much of my clinical duties and responsibilities have included those activities explored in this thesis: care planning; risk assessment; and, more recently, managing CTO requirements.

On arriving in Australia, I was initially surprised by the extent of CTO use and frequently referred to my experiences in the UK, where forced treatment in the community had not existed. My colleagues would ask how it had been possible to engage people in treatment who were not voluntarily accepting of treatment without having a CTO as an option. I found this surprisingly difficult to answer. It had been possible as there were no alternatives in the community setting. Obviously it was not this straightforward or CTOs would not have been introduced in the UK context. On reflection, I have memories of various individuals whom I had worked with over the years who I believe would have been likely candidates for a CTO had this been a care option at the time. One such person was Mark (pseudonym). Mark came to our mental health services when he was in his late 30s. Mark was given a diagnosis of paranoid schizophrenia, although he did not agree with this diagnosis, had never been hospitalised and declined to take any psychiatric medication. Mark, however, was engaged with the local community mental health services. He regularly attended a day-service program where he participated in sporting and social activities, moved into supported housing and joined us on a service-facilitated holiday. Mark attended the doctor's appointments and kept in contact with his care coordinator. His parents attended a family support group and expressed relief that he had engaged with services after a long period of decline that had involved loss of employment and housing. I remember that Mark would often walk continuously around the building at a rapid pace, talking and gesticulating to himself. During these moments, he appeared tortured. I also remember frequent discussions among the treating team about whether he should be forcibly admitted to hospital to commence a trial of medication. This, however, never occurred during the 10 years that I worked at the site. Mark's choice regarding how he wished to engage with services was respected and maintained. Another client, Max, had several forced inpatient admissions due to mania during the time that I knew him. Max was about the same age as me (late 20s) and, after some time, started to disclose the shame and embarrassment that he felt following each admission. I wonder at the additional shame that he might have felt had a treatment order been imposed on him in the community while he was living his life and attempting to reconcile what having a mental illness meant for him alongside friendships, sexual relationships and study.

On reflection, I was both surprised by and sensitive to the existence and use of CTOs when I first arrived in South Australia. I am also aware that over time I gradually became desensitised to CTO use and referred less and less to my UK experience. The sensitivity, however, returned acutely during this research as I observed the many care contacts that individuals on CTOs were having with clinicians, while simultaneously immersing myself in the literature to make sense of the study findings.

The selected study setting, two co-located community mental health care teams in Adelaide, was also my workplace before and during data collection. Ethical issues pertaining to this are addressed in detail in the Methods chapter.

Background

The following section provides the background for this study to further situate the problem and hence the research purpose and design. This includes a presentation of CTOs, current mental health care models, the role of care planning in provision of recovery-oriented care and the dichotomy of forced treatment within this context, specifically CTO use. A summary of the issues and concerns related to each of these domains is presented.

Community treatment orders

Mental health care is unique in that individuals with a mental illness can face restrictions, including forced hospitalisation and treatment, that are underpinned by legislation (Szmukler, 2020). This includes CTOs, which require individuals to comply with treatment plans for which they may not want or recognise the need for. Compulsory treatment orders in the community are legislated in more than 75 jurisdictions worldwide, including in Australasia, Canada, Northern Europe, the UK and the United States (US) (Dawson, 2005; Mikellides, Stefani & Tantele, 2019; Rugkåsa, 2016). CTOs vary in both form and title; for example, in the US they are known as assisted outpatient treatment (Dawson, 2005; Mikellides et al., 2019; Rugkåsa, 2016; Schneeberger et al., 2017). In most jurisdictions CTOs are initiated by clinicians and implemented by a mental health tribunal, except in the US where they are put in place by a judge (Dawson, 2005; Mikellides et al., 2019; Rugkåsa, 2016). Internationally, CTO length is most commonly 6 months, with variations in criteria and enforcement mechanisms (even differing across some cities within the same country) (Dawson, 2005; Rugkåsa, 2016). A key component of all CTO legislation, however, and justification for use is risk (Light, 2019). More recently, mental health legislation has required consideration of the person’s capacity to make a decision about their care and treatment, although how this is legally interpreted and applied in clinical practice remains under debate (Callaghan & Ryan, 2014; Szmukler, 2020).

In Australia CTOs are made after determining the person has a mental illness and, because of this illness, requires protection from risk of harm towards themselves or others (Government of South Australia, 2009). Applications for CTOs are made by clinicians and presented to the mental health tribunal board for consideration. Treatment typically involves appointments with mental health clinicians and receiving medication (often by injection). Mental health legislation states there must be services available to provide appropriate recovery-focused treatment, with CTOs considered a less restrictive option than inpatient admission (McDonald, O’Reilly, Kelly & Burns, 2017). In South Australia, if a person refuses treatment the powers of the CTO allow clinicians to request the help of ambulance or police officers to enforce treatment in the person’s home or provide transport to an authorised treatment centre (Government of South Australia, 2009). The typical duration of a CTO in South Australia is 12 months, although many people remain on orders for significantly longer periods (Office of the Chief Psychiatrist, 2016).

Although CTOs are embedded in mental health care practice, their use is widely contested due to efficacy, relational and ethical concerns (Light, 2019; Newton-Howes, 2019; O'Reilly, 2004; Rugkåsa & Burns, 2017). Recent reviews examining CTO effectiveness have found no benefits to individuals on CTOs in their social functioning or quality of life and no improvement in rates of hospital admissions or treatment adherence (Barnett et al., 2018; Kisely & Hall, 2014). Experiences and views of CTOs are varied. Forced treatment is at best considered neutral, but often experienced as coercive and dehumanising by consumers (Corring, O'Reilly & Sommerdyk, 2017; Newton-Howes & Mullen, 2011; Nyttingnes, Ruud & Rugkåsa, 2016; O'Hagan, 1993). Family members report mixed experiences of CTOs, although overall CTOs are viewed as being more beneficial than disadvantageous (Corring, O'Reilly, Sommerdyk & Russell, 2018). In clinical practice, clinicians have generally been found to endorse the overall benefits of CTOs (Corring, O'Reilly, Sommerdyk & Russell, 2018). Reported benefits of CTOs, however, are most likely due to good clinical care rather than coercion (Rugkåsa & Burns, 2017), with review recommendations including increased financial investment to enhance quality of community services as preferable to CTO usage (Barnett et al., 2018; Churchill, Owen, Singh & Hotopf, 2007).

Importantly, concerns regarding use of CTOs have increasingly extended into the arena of human rights, with arguments made against restrictions of liberty, as well as the right to care and treatment (McDonald et al., 2017; Rugkåsa & Burns, 2017; Szmukler & Weich, 2017). The latter reasoning often includes situating mental health care legislation in the context of reduced budgets and service availability (Szmukler & Weich, 2017), giving a political, economic and social context to CTO use. The absence of consumers' and ex-service users' voices in this debate has been highlighted, alongside criticism regarding how evidence and knowledge are constructed in psychiatry (Brosnan, 2018). Further highlighting ethical concerns, the United Nations Committee on the Convention on the Rights of Persons with Disabilities (CRPD) has recommended the repealing of legislation that allows for the use of CTOs in various jurisdictions including Australia (Brophy et al., 2018; Newton-Howes, 2019). However, despite ongoing debate CTO use is widespread internationally (Rugkåsa, 2016). In the Australian context, rates are comparatively high, with significant variation across regions, further highlighting the impact of broader issues on usage (Light, 2019; Light, Kerridge, Ryan & Robertson, 2012).

Recovery-oriented care planning

Care planning is the context and conduit for the provision of care and treatment in mental health care settings. The care planning process supports the formation of care plans to meet individuals' needs and link with relevant supports (Ross, Curry & Goodwin, 2011). In mental health care, the process should be collaborative, personalised and recovery-focused, with the value of positive therapeutic relationships consistently highlighted as necessary to support a person's recovery (Coffey, Hannigan & Simpson, 2017; Davidson & Chan, 2014; Leach, 2005; Simpson et al., 2016). Key processes of personal recovery include connectedness, hope and optimism for the future, positive identity, meaning in life, and personal responsibility and empowerment (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). Recovery-promoting care relationships require clinicians to understand an individual's values and treatment preferences, focus on amplifying strengths and ensure care planning aligns with the person's chosen goals (Bird, Leamy, Le Boutillier, Williams & Slade, 2014). Additionally, care that is recovery-focused requires an acknowledgment of the broader contextual barriers to recovery, including lack of housing, poverty, unemployment, and loss of social roles, identity and personal agency (Davidson, O'Connell, Tondora, Lawless & Evans, 2005; Slade & Longden, 2015).

Recent research, however, highlights the challenges and barriers in the provision of care planning in mental health care that aims to be collaborative, recovery-focused, relevant to the individual and inclusive (Brooks, Lovell, Bee, Sanders & Rogers, 2018; Brophy, Hodges, Halloran, Grigg & Swift, 2014; Hannigan, Simpson, Coffey, Barlow & Jones, 2018; Jones, Hannigan, Coffey & Simpson, 2018). Consumer involvement in care planning has been found to be tokenistic and thereby a barrier to engagement, as service contacts are not perceived to be personally relevant (Bee, Price, Baker & Lovell, 2015; Brooks et al., 2018; Simpson et al., 2016). Furthermore, international and national critiques of mental health services identify a continued overemphasis on clinical as opposed to personal recovery (UN Human Rights Council, 2017). These challenges become more significant for individuals on CTOs, who may disagree with service treatment recommendations or experience a level of illness that impacts on their capacity to participate.

Research significance

International criticism of public mental health care services continues to highlight shortfalls and barriers to provision of recovery-oriented care, with forced care and care planning key issues in these critiques (UN Human Rights Council, 2017). Care planning in mental health care settings has been found to be misaligned with policy, with clinicians constrained by their service contexts (Hannigan et al., 2018). To add to the complexity, CTO use that enables forced care is an additional barrier to the provision of care which aims to be person-centred and recovery-oriented (Pilgrim, 2018). CTO use, however, is embedded in mental health care settings in many jurisdictions worldwide (Rugkåsa & Burns, 2017), including Australia (Rugkåsa, 2016). Given the importance and complexity for all parties of negotiating care using CTOs, it is important to understand how the conflicting concepts of risk and recovery are applied and experienced in clinical practice (Light, Robertson et al., 2015; Pilgrim, 2009). The taken-for-granted enactment and prioritising of these conflicting discourses are best displayed in everyday discussions between clinicians and in their consultations with consumers (Pilgrim, 2009). Thus, critical ethnographic methods have been employed to examine the research questions and objectives, as detailed below.

Research questions

1. What is the culture of care planning for consumers on CTOs?
2. What are the micro (relational), meso (organisational) and macro (cultural) factors impacting upon the care planning process?
3. How do the concepts of risk and recovery impact upon care planning?

To answer the research questions, an examination of the perspectives of all participants in the care planning process was required. Additionally, as care planning occurs within service systems, understanding the broader social and cultural views of mental illness and mental health care provision, and how this impacted on care planning processes, was also required. The research objectives below further guided this investigation.

Research objectives

- To gain an in-depth understanding of the process of care planning with consumers on CTOs in two community mental health teams in South Australia
- To describe the culture of practice and involvement in care planning from the perspectives of consumers on CTOs, their family members and mental health clinicians
- To examine the relationship between the community mental health centre (CMHC), local sites of relevance, and broader social and cultural views regarding mental illness and mental health care provision
- To explore how mental health clinicians and service conceptualisations of risk, risk management and engagement influence care provision that is recovery-focused

Thesis outline

Chapter 1: Introduction to the study

This chapter provides the context to and rationale for the thesis.

Chapter 2: Literature review

This chapter presents an integrative literature review that has sought to gain an in-depth understanding of consumers', carers' and mental health clinicians' perspectives and experiences of care coordination and care planning for consumers on CTOs in community mental health care settings. The published literature review (Dawson, Lawn, Simpson & Muir-Cochrane, 2016) is followed by a synthesis of the CTO literature relevant to the review question that has been published since that publication. Details of the research process that were applied to the review were included. The review sets the context for the thesis by identifying the current issues and gaps in knowledge pertaining to care planning with consumers on CTOs.

Chapter 3: Methodology

This chapter presents a detailed discussion of Carspecken's (1996) critical ethnographic methodology, which underpins this research. Carspecken's (1996, 2012) conceptualisation and use of Habermas's critical social theory (CST), combined with ethnographic methods, have informed data collection and analysis. Communication transmits culture, although when people communicate a significant amount of knowledge remains implicit (Carspecken, 2012). A core tenet of Carspecken's (1996) theory is the acknowledgement of power and oppression as a constraining feature on all communicative acts. This is relevant to this enquiry as consumer participants were subject to legislated forced care. Thus, this methodology was selected as it provided a clear and rigorous means of examining the culture of care planning and the constraining features that were operating at the micro (communicative action), meso (service culture and structure) and macro (policy and legislative) levels.

Chapter 4: Methods

This chapter details how Carspecken's (1996) five-stage framework was applied to data collection and analysis. Concepts central to the methods and rigour of an ethnographic study are discussed, including the ethical considerations and conduct that were adhered to throughout data collection. As I was a member of one of the community mental health teams during data collection, an examination of researcher positioning and ethical issues pertaining to this is also addressed.

Chapters 5, 6, 7 and 8 present the findings of the thesis

Excerpts from ethnographic observations and interviews are drawn upon throughout these chapters to illustrate the findings. The different findings and discourses were often simultaneously present in conversational excerpts; hence, some excerpts are drawn upon several times in the various findings chapters to illustrate different concepts.

Chapter 5: Setting the context: Care provision at a community mental health centre

This chapter presents an ethnographic account of the care planning processes that were occurring for individuals who were on a CTO at the study site. A description of the broader context that informed care planning at the site is provided, including mental health legislation and policy, service documents and reviews, and other locales related to the site. The chapter concludes with a summary of the study participants and details of the fieldwork.

Chapter 6: A culture of risk

This chapter provides a detailed description of the culture of care planning and the impact of this on participant positionings in the care planning relationship. Findings highlight that the service preoccupation with, and definition of, risk strongly influenced how consumers on CTOs were perceived by clinicians. The differing understandings of risk from each of the participant groups and the related concept of insight are examined. The chapter concludes with an exploration of differing care contacts that were occurring at the site that were informed by situating the person in their broader context, compared with the narrower lens of risk.

Chapter 7: Care planning with consumers on CTOs

This chapter complements the previous findings chapter and focuses on an exploration of the impact of the participant positionings (and differing power relations) on the care planning relationship. This includes an exploration of how the key components of care planning – engagement and decision-making – were enacted during service care contacts. Data from ethnographic observations are drawn upon to illustrate the findings. Pseudonyms are used for all participating consumers, with carers identified by their relationship to the person and clinicians identified by professional group.

Chapter 8: A system constrained by the biomedical model

This chapter examines the structural components that were maintaining and reinforcing care interactions, approaches and options at the study site. This includes an exploration of the various models of illness and the dominant paradigm that was guiding care. The subsequent consequences of this dominance for consumers on CTOs, the perpetuation of stigma and discrimination, are elucidated with illustrations from the data.

Chapter 9: Discussion

This chapter builds on the analyses from the four findings chapters that have identified and examined the cultural themes and structures that were impacting on care for consumers on CTOs at the study site. Social theories of risk and trust are drawn upon to provide an explanatory framework for the findings and possible means for cultural change. The conflicting concepts of risk and recovery as they were applied and experienced in clinical practice are explored alongside feasible means for change.

Chapter 10: Conclusion

This chapter resituates the research questions and objectives in relation to the conflicting narratives of risk versus recovery in current mental health care service provision. A summary of the key findings from the thesis is presented alongside recommendations for practice, education and research. Recommendations are made based on feasibility and evidence, and aim to improve care planning practices, options and outcomes for individuals with a mental illness who are on a CTO.

CHAPTER TWO
LITERATURE REVIEW

Introduction

Care planning is the process that supports the development of care plans which guide care and treatment in mental health care settings. This chapter presents the relevant literature pertaining to care planning practices with individuals who are on a CTO. Specifically, the objective of the review was to gain an in-depth understanding of multiple perspectives and experiences of care coordination and care planning for consumers on CTOs in community mental health care settings. An integrative review method was selected, as this provided a rigorous method for identifying and analysing the broad range of studies that have been published on this topic. The integrative review methods used in this thesis closely aligned to those of a systematic review and included a systematic literature search, data appraisal and synthesis, and analysis of findings (Whittemore and Knafl, 2005; Joanna Briggs Institute, 2014). The initial integrative review, which was conducted in 2015 and published in *BMC Psychiatry*, is presented in the first section of this chapter. The second section of the chapter presents an update of the literature to ensure currency of knowledge. This includes a synthesis of the findings from recently published studies that met criteria for the initial review objective.

Published paper

Dawson, S., Lawn, S., Simpson, A., & Muir-Cochrane, E. (2016). Care planning for consumers on community treatment orders: an integrative literature review. *BMC Psychiatry* **16,** 394. https://doi.org/10.1186/s12888-016-1107-z

Authors' contributions

S.D., E.M.C., S.L. and A.S. had input into study design, manuscript review and approval of final manuscript. S.D. was responsible for study selection (with input from E.M.C.), appraisal, analysis and manuscript writing.

A note about language: In the initial review, the findings were presented against a framework of case management developed from Ross et al. (2011). On returning to the published review with the aim of updating the literature towards the completion of my research, I found some of the terms taken from the framework challenging, specifically “case management” and “case finding”. Over the course of this thesis, I have become increasingly sensitised to tacit meanings and impacts of language, and acknowledge the powerful impact of language on culture. I acknowledge that the use of the terms “case management”, “case manager”, “caseload” and “case finding” could be viewed as negative conceptualisations of the person as an “object” or “other”. I would have made a different choice today and used language that was more neutral. The second half of this chapter, and the remainder of this thesis, use these terms only within participant quotes.

Furthermore, as a reflexive comment on completion of this thesis, I acknowledge that the following literature review is situated in a biomedical framework. As a researcher, this was my entry into the topic and relates to my experience as a clinician working within the mental health system, as well as the dominant themes in mental health literature.

Abstract

Background: Case management is the established model for care provision in mental health and is delivered within current care philosophies of person-centred and recovery-oriented care. The fact that people with a mental illness may be forced to receive care and treatment in the community poses challenges for clinicians aiming to engage in approaches that promote shared decision-making and self-determination. This review sought to gain an in-depth understanding of stakeholders' perspectives and experiences of care planning for consumers on CTOs.

Methods: An integrative review method allowed for inclusion of a broad range of studies from diverse empirical sources. Systematic searches were conducted across six databases. Following appraisal, findings from included papers were coded into groups and presented against a framework of case management.

Results: Forty-eight papers were included in the review. Empirical studies came from seven countries, with the majority reporting on qualitative methods. Many similarities were reported across studies. Positive gains from CTOs were usually associated with the nature of support received, highlighting the importance of the therapeutic relationship in care planning. Key gaps in care planning included a lack of connection between CTO, treatment and consumer goals, and lack of implementation of focused interventions.

Conclusions: Current case management processes could be better utilised for consumers on CTOs, with exploration of how this could be achieved warranted. Workers need to be sensitive to the "control and care" dynamic in the care planning relationship, with person-centred approaches requiring core and advanced practitioner and communication skills including empathy and trust.

Keywords: care planning, case management, community mental health, community treatment order

Background

The concept that people should have a stronger voice in decisions about their health and care has been a policy goal in health for at least 20 years (Foot et al., 2014) with increased consumer involvement linked to improved care experiences. and better clinical and economic outcomes

(Hibbard & Gilburt, 2014). In mental health care, case management is the established model for care provision and aims to integrate care and support across a broad range of services for individuals presenting with complex needs (Goodwin & Lawton-Smith, 2010). As there is no single definition of case management, for the purposes of this review case management and care planning are explored utilising Ross et al.'s (2011) framework of case management with core components including: case finding; assessment; care planning; care coordination and case closure.

Case finding in this review refers to consumers on a CTO. The care planning process, informed by ongoing assessment, should be personalised to the individual, address the range of issues that may impact upon their health and wellbeing, and be co-produced with the person and relevant others involved in their care (Ross et al., 2011). Care coordination, “the essence of case management”, requires case managers to collaboratively facilitate the above processes, with the care plan the “live” document recording this process (Ross et al., 2011, p. 6). Case managers working with consumers on CTOs have the additional role of managing the CTO requirements, which may include informing the consumer and family about CTO processes, participating in tribunal hearings, initiating recall to hospital and managing discharge from the CTO (Gibbs, Dawson & Mullen, 2006; Mfoafo-M'Carthy & Williams, 2010; O'Reilly, Keegan, Corring, Shrikhande & Natarajan, 2006).

Central to case management in mental health is the therapeutic relationship (Bee, Brooks, Fraser & Lovell, 2015), with positive associations found between “perceived patient involvement, satisfaction and empowerment”(Tambuyzer & Van Audenhove, 2015, p.523). A recent systematic review examining barriers and facilitators to consumer involvement in care planning in mental health found consumer involvement was dependent on consumer capacity, the relational quality between consumers and health professionals, and the organisational context, with the relational aspects of care planning most valued by consumers and their carers (Bee, Brooks et al., 2015). However, despite benefits and policy support of increased consumer involvement, there has been limited progress towards fully involving people in their own health and care (Foot et al., 2014).

In mental health care, a further challenge for clinicians is that forced care sits within service frameworks promoting recovery-oriented and person-centred care. The World Health Organization state that “[p]ersons with mental health disorders should be provided with health care which is the least restrictive” and that “maintaining legal instruments and infrastructures … to support community based mental health care” is central to the implementation of this principle (World Health Organization, 1996, p. 8). Thus legal frameworks have been created to ensure individuals with a mental illness who are considered to pose a risk to themselves or others receive care and treatment through the use of CTOs (Arya, 2012). Although CTOs typically last between 6 and 12 months, in reality many consumers will be on orders for extended periods (Lawton-Smith, Dawson & Burns, 2008) with rates of usage increasing in Australia (Light et al., 2012).

Clearly challenges exist for mental health clinicians engaging consumers on such orders in ways that promote self-determination and empowerment. The issue of care planning with consumers on CTOs is complex, with CTO legislation, service delivery models and resource availability all impacting upon implementation (Brophy et al., 2014). Significant concerns regarding the effectiveness and ethics of CTOs also exist, with a recent review examining CTO effectiveness finding no differences in social functioning, quality of life or service use for individuals on CTOs compared to those receiving standard voluntary care (Kisely & Hall, 2014). Advocates for CTOs cite clinical improvement and its being the least restrictive treatment option as benefits (Atkinson & Garner, 2002; Mustafa, 2015), while advocates against CTOs, often ex- service users, consider forced treatment a major barrier to collaborative, person-centred care (Russo & Wallcraft, 2011). Further ethical concerns have been raised about current legislation for compulsory treatment in Australia where there is a lack of consideration of the individual’s decision-making capacity (Arya, 2012).

In summary, although case management has been used in practice for several decades, there remains a lack of conceptual clarity of what personalised care planning is (Lhussier et al., 2015) and lack of evidence regarding its effectiveness (Ross et al., 2011; Smith & Newton, 2007). In mental health care, compulsory care further challenges concepts of personalised care planning. Over the past 20 years, there has been significant debate in the literature about the purpose, value and stakeholder experience of CTOs. This review explores the impact of CTOs on case management. The intention is to add to the current evidence base with the aim of improving the process and experience of case management for all stakeholders and specifically the experiences and outcomes for those consumers who find themselves on such orders. The integrative review method was the chosen methodology as it allowed for the inclusion of a broad range of studies from diverse empirical sources which was considered important in addressing this complex issue (Whittemore & Knafl, 2005).

Objective

To gain an in-depth understanding of consumers’, carers’ and mental health workers’ perspectives and experiences of care coordination and care planning for consumers on CTOs in community mental health settings.

Methods

Search strategy

The search strategy utilised for conducting systematic reviews aimed to find published, peer-reviewed literature relevant to the phenomena of interest (Joanna Briggs Institute, 2014). An initial search with relevant keywords was conducted, followed by an extensive search from 2000 onwards with relevant keywords and index terms. Databases searched included: CINAHL; PubMed; Medline; Scopus; PsychINFO; and ProQuest (see Appendix A). Reference lists of papers meeting inclusion criteria were checked for additional papers and searches were registered with the databases, allowing for inclusion of papers published during data analysis. Studies of qualitative and quantitative design and opinion papers from any country were sought. Literature published from 2000 onwards was considered for inclusion in order to reflect current mental health care practice and mental health legislation pertaining to CTOs. Non-English papers and studies with forensic patient participants were excluded.

Results

Description of studies

A detailed search across selected databases identified 7459 papers. After removing duplicates, 4283 were examined against the objectives of the review and inclusion criteria by reading titles and abstracts. Eighty-two papers were retrieved for full review, with a further 7 papers identified from reference lists and data base alerts. Forty-one papers did not meet the inclusion criteria and were excluded. A total of 48 papers were included in this review. Of the included papers, 24 reported on qualitative research, 15 on quantitative research, 4 used mixed methods and 5 were opinion papers (see Figure 1).

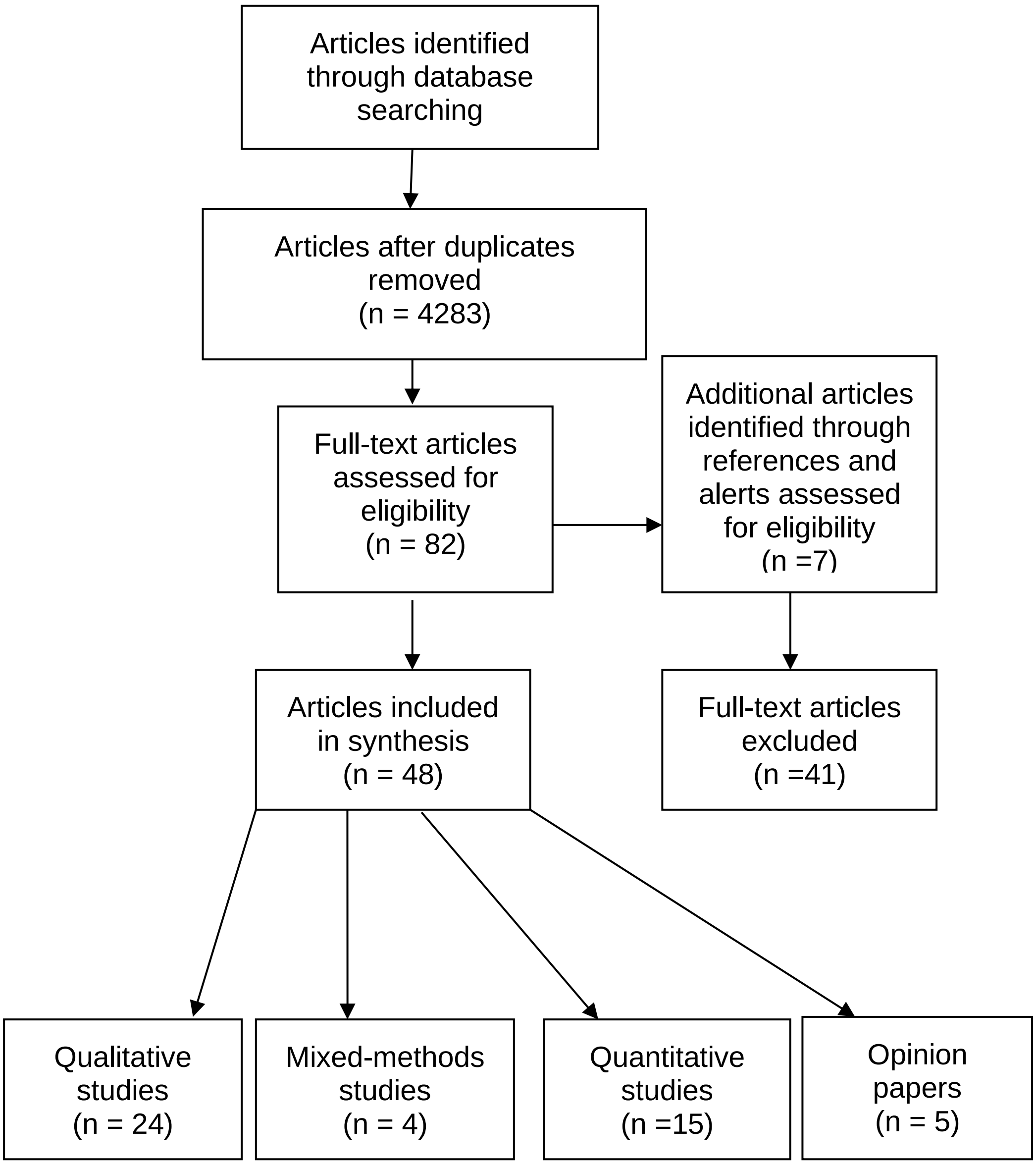


Figure 1. Prisma flow diagram of included studies

There has been a significant increase in publication of papers on this topic in recent years, with 25 of the included papers published since 2013. Empirical studies came from seven countries: New Zealand (6); UK (9); Australia (6); Norway (3); US (4); Canada (3) and Israel (1). Often several papers reported on data from the same study. The highest number was seven papers reporting on a large qualitative study conducted in New Zealand. In this instance, although these papers all had a different focus, findings were considered conjointly when there was congruence across papers.

Studies reported on a variety of objectives although the majority explored the experience of CTOs from different stakeholder perspectives including consumers, carers and mental health clinicians from varied backgrounds. Fewer studies included views of lawyers, advocates and members of mental health tribunals. More recently, authors have reported on more nuanced issues related to care planning, although the majority of papers referenced the current policy environment of recovery-oriented care. Three studies aimed to interview key stakeholders involved in care planning. Gjesfjeld and Kennedy (2011) interviewed consumers and their nominated mental health worker, and a large New Zealand study aimed to interview consumers, their case workers, psychiatrists and carers. Brophy and McDermott (2013) explored the perspectives of people on CTOs, their carers, case managers and doctors, to inform best practice for individuals on CTOs. No study specifically explored the care planning relationship. With the exception of two studies that aimed to interview participants on two occasions (Brophy & McDermott, 2013; Ridley & Hunter, 2013) to ascertain whether participant views changed with time, all other studies collected data at one point in time.

Quality of evidence

Joanna Briggs Institute appraisal tools relevant to study design were used, with key criteria selected from each of the tools (Joanna Briggs Institute, 2014). Studies utilising mixed methods were appraised against qualitative criteria, as results relevant to the phenomena of interest were drawn from qualitative data. Overall, qualitative studies were of good to excellent quality, with good methodology and representation of participant voices. Common gaps were lack of stated philosophical perspective and lack of information about the researchers and their influence on the research.

Of the quantitative papers, only one paper reported on a randomised control trial (Rugkåsa et al., 2015). This study has drawn much debate, although the authors clearly identified various limitations themselves, such as the inability for clinicians to persist with initial randomisation at subsequent stages of clinical decision-making. Also, given the participant group it was not possible for participants to be blinded to treatment allocation or for allocation to be concealed from the allocator. The remaining 15 papers were descriptive or correlational case studies. In most studies the sampling would not be considered robust, with people volunteering to participate and no randomisation. Furthermore, measures used were not always validated, although this was considered appropriate given opinions were being sought.

All included opinion papers were written by individuals considered experts in the field of research regarding CTOs. No papers were excluded following appraisal.

Availability of data and materials

The data supporting the conclusions of this article is included within the article (and in Appendix B).

Data synthesis

Data were extracted from the included papers and coded into categories using NVivo 10. These findings are presented against a framework of case management developed from Ross et al. (2011) and include: case finding; assessment and care planning; care coordination; case closure; benefits of case management and broader issues that support effective case management (see Figure 2). The qualitative research and opinion papers provided rich descriptive data and form the main part of the synthesis, with data from the quantitative papers used to augment the findings.

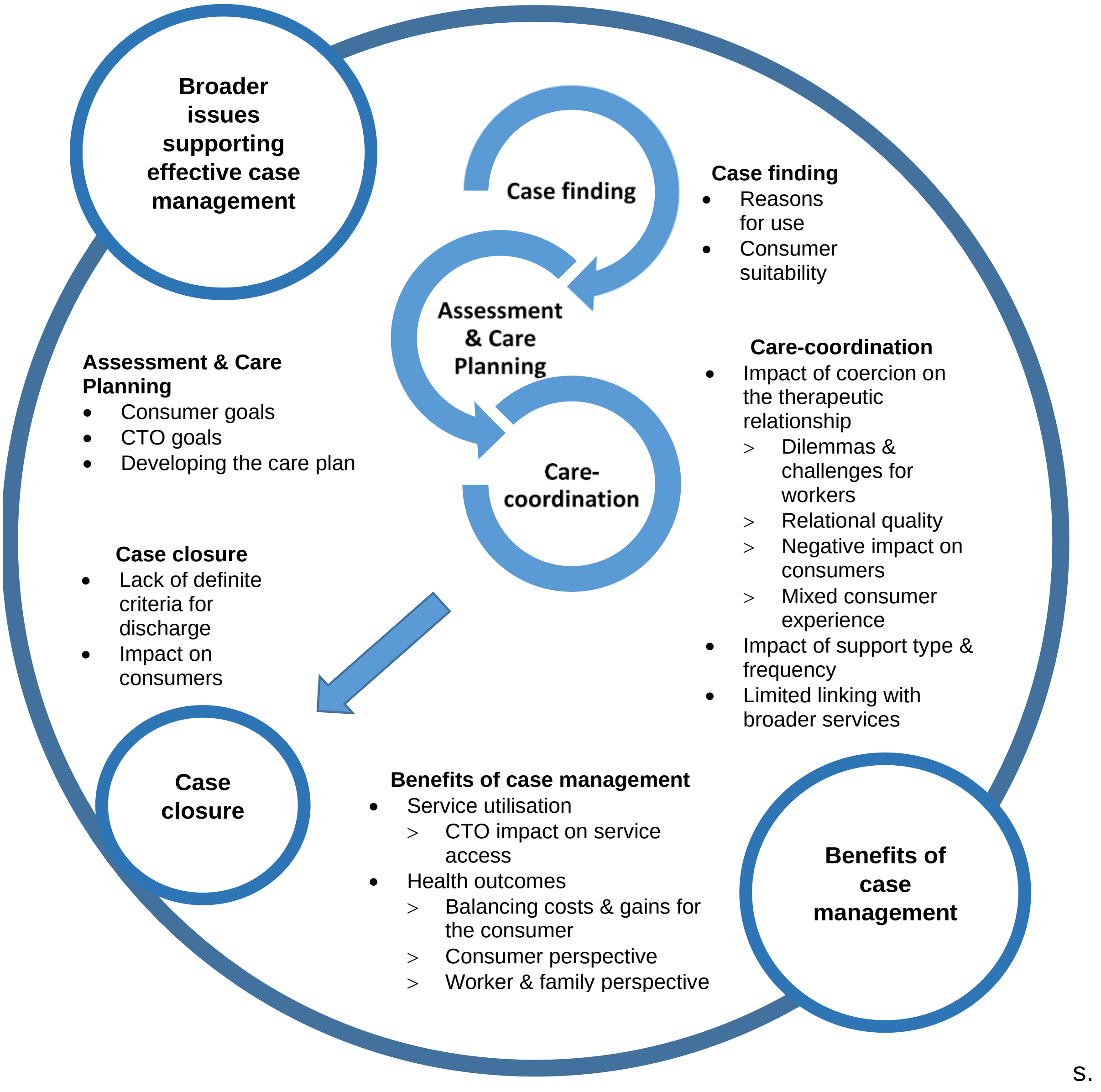


Figure 2. Framework for findings related to case management for consumers on CTOs

Core components of case management

Case finding

Reasons for use (positively and negatively framed)

This review includes individuals who are on a CTO and receiving case management from community mental health services. The reported reasons for consumers being placed on a CTO, from qualitative studies, included risk to self and/or others (Gibbs, Dawson, Forsyth, Mullen & Tonu Tanga, 2004; Schwartz et al., 2010), poor insight, lack of compliance with treatment (predominantly medication) (Canvin, Rugkåsa, Sinclair & Burns, 2014; Schwartz et al., 2010), ensuring treatment (Canvin et al., 2014; Gibbs et al., 2004; Taylor, Lawton-Smith & Bullmore, 2013) facilitating discharge from inpatient services and hospital avoidance (Canvin et al., 2014). Quantitative studies reporting on workers' perspectives on factors governing decision-making of CTO use found the most reported factors to be: ensuring contact with workers; protecting consumers from consequences of relapse; promoting medication adherence; and providing authority to treat (Coyle et al., 2013; DeRidder, Molodynski, Manning, McCusker & Rugkåsa, 2016; Manning, Molodynski, Rugkåsa, Dawson & Burns, 2011; Romans, Dawson, Mullen & Gibbs, 2004). These clinical factors driving CTO use have remained consistent over the past decade and across continents (DeRidder et al., 2016; Romans et al., 2004).

Consumer suitability

Several studies highlighted the lack of usefulness of CTOs to those clients whereby the coercion experienced from being on the CTO cancelled out any gains (Gibbs, Dawson, Ansley & Müllen, 2005; Stroud, Banks & Doughty, 2015) with clinicians reporting the consumers most likely to benefit from a CTO being those with a level of insight into their mental health problems and therefore more likely to collaborate with services (Christy & Petrila, 2009; Stroud et al., 2015). Consumers needed to accept the validity of a treatment order for CTOs to be a viable treatment option (Christy & Petrila, 2009; O'Reilly, Dawson & Burns, 2012) with Mullen, Dawson and Gibbs (2006) suggesting that if good therapeutic relationships were not achieved within a reasonable period of time, they should be discharged from the CTO to voluntary care.

Assessment and care planning

Findings that relate to assessment and care planning are combined as in practice they co-occur, with ongoing assessment informing care planning. Key findings presented include consumer goals, CTO goals, development of the care plan and recommendations to improve assessment and care planning.

The care plan provides the framework for and documentation of the processes of assessment and care planning, although interestingly most studies did not directly reference the care plan. Of those that did, findings indicated consumers on CTOs had little knowledge about their care plan and what was in it, with care plans often out of date and focused on medication (Light et al., 2014; Owens & Brophy, 2013; Ridley & Hunter, 2013). As the care plan is the means for recording the collaborative care planning process, Owens and Brophy (2013) suggested that outdated care plans indicated that such conversations between clinicians and consumers may not be occurring regularly.

Consumer goals

Care plans should address consumer goals in the broader areas of social connection, community engagement and employment (Mfoafo-M'Carthy & Williams, 2010). In practice, however, there was a lack of evidence of supporting consumers in these areas (Ridley, Hunter & Rosengard, 2010). Instead, care plans were reported to be “formal records of deficits, professionally assessed needs, and allocated services” (Ridley & Hunter, 2013, p. 517). Reasons for CTOs were typically referred to as conditions, implying lack of consumer choice, and rarely linked to consumers’ recovery goals. In fact there was little reference to consumers’ goals, with consumers and carers expressing disappointment at the overly medical focus of the CTO and related care package (Canvin et al., 2014; Ridley & Hunter, 2013). Only one study referenced links between CTO and consumer goals (in this case medication compliance linked with regaining a drivers licence) (Stuen, Rugkåsa, Landheim & Wynn, 2015). Brophy, Campbell and Healy (2003) highlighted the benefit of incorporating a more holistic perspective into the CTO process as “offer[ing] a valuable balance against the tendency to “over-medicalise” assessments of mental health problems and risk assessment” (p.161). The same author highlighted the diversity of consumers on CTOs as well as diversity in CTO goals or purposes and stated that guidelines have tended to assume homogeneity among CTO recipients (Brophy & McDermott, 2013).

CTO goals

For the majority of participants in the included studies, the primary purpose of the CTO was medication compliance, which then became the focus of interactions between workers and consumers (Lawn, Delaney, Pulvirenti, Smith & McMillan, 2015; Stroud et al., 2015). Workers and family members often linked the need for medication compliance with poor insight and increased risk of harm (to self or others) (Dawson & Mullen, 2008). Interestingly, perceptions of risk differed among participant groups, with consumers’ and carers’ concerns focused on the distress stemming from mental illness and subsequent social and interpersonal difficulties, and workers focused on actual harm and potential risk (Light, Kerridge et al., 2015). Findings indicated that workers had variable thresholds for risk (Mullen, Dawson & Gibbs, 2006) with a worker in one study questioning what should be considered “normal,” “at risk” or “dangerous” behaviour when informing of the need for a CTO (Lawn et al., 2015). Other reasons or conditions for CTOs included the requirement to stay in specified accommodation (O'Reilly et al., 2006; Stuen, Rugkåsa et al., 2015) and maintain contact with the mental health team (Banks, Stroud & Doughty, 2015; Canvin et al., 2014). Consumer reports of CTO purpose varied, with some unclear as to why they were on a CTO or what was being asked of them by services (Gjesfjeld & Kennedy, 2011; Schwartz et al., 2010), some perceiving they were on orders as a result of diagnosis or previous episodes, and reports of consumers and their mental health workers offering different requirements (Gjesfjeld & Kennedy, 2011; Stensrud, Høyer, Granerud & Landheim, 2015; Stuen, Rugkåsa et al., 2015).

While Banks et al. (2015) warned that broadening CTO goals would be ”ethically unsound”, clarifying the purpose of the CTO and linking CTO goals with consumers’ individual recovery goals were considered necessary and achievable within care planning processes (Brophy & McDermott, 2013; Mfoafo-M'Carthy & Williams, 2010). Mental health workers stated CTO goals and conditions should complement the care and treatment goals set out in the care plan (Taylor et al., 2013), although workers also expressed scepticism and concern that CTOs could undermine the process of developing consumer-led goals (Sullivan, Carpenter & Floyd, 2014). Given these challenges, Brophy and McDermott (2013) recommended mental health clinicians working with consumers on CTOs should have advanced clinical and interpersonal skills.

Developing the care plan

When exploring findings to support collaborative care planning, it was found consumers often reported little or no opportunity to give input into decisions related to the implementation of the CTO (Banks et al., 2015; Brophy & Ring, 2004; Fahy, Javaid & Best, 2013; Lawn et al., 2015; Ridley & Hunter, 2013), although they reported benefits (e.g. increased trust) from “being heard” by clinicians even when their views differed (Banks et al., 2015). Increased input into decision-making was reported by some consumers at later stages of the CTO process, including reviews, as well as other care planning decisions (such as preferences for support options during crisis) (Banks et al., 2015; Riley, Høyer & Lorem, 2014). One study reported on the lack of impact of advance directives as a means for increased consumer participation, with consumers reporting that their statements were ignored (Ridley & Hunter, 2013). Clinicians reported varying levels of consumer involvement in the CTO process, with some stating it was “little or none”, others that it was increased (Brophy & Ring, 2004) and some reporting attempts to offer consumers choice and participation in decision-making (Lawn et al., 2015). To add to the complexity, workers themselves were found to have inconsistent understandings about CTOs (Canvin et al., 2014; Gjesfjeld & Kennedy, 2011).

Assessment of carer needs and input into care planning varied widely, with some carers choosing to “take a step back” and others reporting “being excluded from decision-making” (Canvin et al., 2014, p. 1880). Some carers reported their involvement in care planning as infrequent, which was seen as contradictory given the high level of care they provided (Ridley et al., 2010). Others reported having an increased voice subsequent to the CTO process and feeling that their caring role was more recognised (Stroud et al., 2015). Interestingly, some carers reported increased involvement at the initiation of the CTO with less communication from mental health services over time, which was the opposite to reported consumer experiences of increased involvement with time

(Banks et al., 2015; Mullen, Gibbs & Dawson, 2006). Issues related to confidentiality were cited as barriers to carers receiving information about their relative (Gibbs et al., 2004).Overall, as consumer participation was reported to be low, increased involvement was recommended at all stages of the CTO process to enhance consumer empowerment (Banks et al., 2015). Authors of a recent study found “CTOs were more successful when they were a carefully planned intervention [inclusive of the consumer and their family], rather than where they were made almost as a matter of course” (Stroud et al., 2015, p. 91). Mfoafo-M'Carthy and Williams (2010) went further and suggested mandated treatment could be discussed and presented as an intervention option under an advanced directive with individuals during a period of improved capacity. This approach, however, was recommended on the proviso that the CTO was part of a more holistic care plan and approach. Currently, the provision of services to address consumers’ broader needs is not a statutory requirement of the CTO and is dependent on the individual case manager (Brophy & Ring, 2004), although Brophy et al. (2003) suggested efforts should be made by case managers to address broader identified needs to meet consumer goals and redress the negative experience consumers often have of being on a CTO (Stuen, Rugkåsa et al., 2015).

Care coordination

Care coordination “involves continual communication with [consumers], their carers, and the various professionals and services … fundamental to care co-ordination is the … case manager” (Ross et al., 2011, p. 6). Case managers can have a significant impact on consumers, who can experience the support as either positive or negative, with the potential to “either assist or obstruct recovery” (Lawn et al., 2015; Mfoafo-M'Carthy, 2014). Owens and Brophy (2013), for example, found workers were not making sufficient efforts to manage the risk of recall to hospital or the distress experienced by consumers subsequent to this. Establishing good therapeutic relationships and family involvement are necessary to good care coordination (Brophy & McDermott, 2013). The main findings under the theme of care coordination relate to the therapeutic relationship and impact of coercion on this.

Impact of coercion on the therapeutic relationship

Dilemmas and challenges for workers

Various findings were reported regarding the impact of the CTO on the relationship between the case manager and consumer. Mullen at al. described it as an “apparent paradox that good therapeutic relations seemed to be required for a CTO to be effective” and considered collaborative relationships integral to the success of a CTO (Mullen, Dawson et al., 2006, p. 542). Workers in this study spoke of needing to establish relationships based on trust and encouragement, aware that rehabilitation could not be forced (Mullen, Dawson et al., 2006). In the same study, highlighting the coercive aspect of CTOs, workers admitted to using the threat of return to hospital if consumers were non-compliant with orders (Gibbs et al., 2006). Brophy and McDermott (2013) viewed this dilemma as a daily compromise faced by case managers “between acting paternalistically, in what might be understood as the client's best interests, and a competing requirement to respond to their expressed wishes" (p. 158). Studies show workers were aware of the dilemma of wanting to support a person's "right to self-determination while obtaining the benefits … possible with treatment adherence" (O'Reilly et al., 2006, p. 520). Lawn et al. (2015) framed this as a moral dilemma experienced by staff and found some staff more attuned to the impact of CTOs on consumers and the therapeutic relationship, and others less so. Moral interpretations were found to be made by workers and consumers regarding various issues encountered in the care planning space (Lawn et al., 2015). This included clinicians seeing consumers as "wilfully" stopping medication and consumers reporting the need to overcome a "vice" in order to be discharged from a CTO. These negative framings impacted upon both the care planning relationship (e.g. workers "punishing" the consumer for not taking medication) and the consumer's sense of self. Consumers learnt that to be "perceived as morally worthy" they had to "say the right thing" (Lawn et al., 2015, p. 6). To address this, Lawn et al. (2015) highlighted the importance of worker empathy in engaging consumers on CTOs and the need for workers to consider "the relationship between what is done and how it is done" (p. 15). Interestingly, in another study those workers who viewed CTOs as primarily coercive also reported discomfort in working with consumers on CTOs (Sullivan et al., 2014).

Workers recognised the importance of developing a therapeutic alliance with consumers and reported on the stress that resulted from working in conditions that at times involved "hostility", "manipulation" and "deceit" (O'Reilly et al., 2006), with one case manager describing their role as sometimes more aligned with correctional services than clinical treatment (Sullivan et al., 2014). To redress the balance of power, workers have a responsibility to empower consumers by providing clear information about CTO processes and facilitating as much choice and involvement as possible in decision-making at all stages (Banks et al., 2015; Gibbs et al., 2005; Light et al., 2014). Workers acknowledged the "legal recognition" of care that came with CTOs placing a greater responsibility on them to effectively engage consumers (Stroud et al., 2015), as well as the challenges of effective engagement and the intensive nature of support required of person-centred care (Banks et al., 2015). Brophy and McDermott (2013) considered continuity of care important in providing quality care with this client group and suggested psychiatrists take a more central role as they are typically a more stable team member. In other studies, however, consumers reported more strained relationships with treating doctors, preferring to engage with case managers (Gibbs et al., 2005).

Relational quality

Consumer reports of the impact of the CTO on the relationship with their worker were varied, with some reporting no differences and others remaining angry towards workers (O'Reilly et al., 2006). Consumers reporting positive relationships with workers also appeared to have an overall positive experience of being on a CTO and associated positive outcomes including improved mental health, support, relationships and occupational gains (Mfoafo-M'Carthy, 2014; Schwartz et al., 2010; Stuen, Rugkåsa, Landheim & Wynn, 2015). Relational aspects mentioned by consumers who reported positive rapport included workers who expressed concern, were helpful and supportive, didn’t view them as patients and with whom they met regularly (Gibbs et al., 2005; Gjesfjeld & Kennedy, 2011). Lawn et al. (2015), exploring the nuances of the therapeutic relationship between consumers and mental health workers, highlighted the complexity of developing trust within this dynamic. Interestingly, the authors found that while mental health workers had the expectation that consumers should trust and engage with them, as they had “good intentions” and were “there to help”, consumers experienced that they were not trusted themselves by mental health clinicians. Steun et al. (2015) also discussed the importance of developing reciprocal trusting relationships, with consumers reporting worker availability and support with everyday problems (such as housing, finances and social isolation) enhancing such relationships and positively impacting upon their experience of the “restrictive interventions” of CTOs.

Negative impacts on consumers

While some consumers reported a “blurred distinction between formal and informal coercion” with treatment pressure a usual experience of mental health care (Stuen, Rugkåsa et al., 2015, p. 6), others on CTOs experienced contact with mental health services to be more intrusive and coercive than the same contact had been experienced prior to the CTO (McKenna, Simpson & Coverdale, 2006; Newton-Howes & Banks, 2014; Riley et al., 2014). The use of persuasion was found to be more common for those on CTOs and resulted in significantly higher levels of perceived coercion (McKenna et al., 2006). Issues that negatively impacted upon establishing trusting relationships included lack of information from workers (Banks et al., 2015) and lack of involvement in decision-making, regularly reported as a lack of information and influence on medication (Riley et al., 2014; Stuen, Rugkåsa et al., 2015). Consumers’ feeling of distrust towards workers was linked to the distress that resulted from the impact of CTOs on their liberty and rights, with interpersonal problems, including relationships with workers, linked to a sense of unhappiness (Newton-Howes, 2013). Banks et al. (2015) suggested the issue of choice was further complicated by the fact that consumers often retrospectively viewed restrictions on choice positively. While studies reported increased acceptance of CTOs by consumers over time, often related to positive gains (Mfoafo-M'Carthy, 2014; O'Reilly et al., 2006; Stroud et al., 2015), even those considered to be “generally favourable about the CTO” still identified negative aspects including feeling restricted, stigmatised and untrusted by mental health workers and a lack of control (Gibbs, 2010; Gibbs et al., 2006). Three quantitative studies explored consumers’ perceptions of coercion. Although overall consumers on CTOs reported experiencing greater coercion then voluntary consumers and less satisfaction with care (McKenna et al., 2006; Newton-Howes, 2013), Rugkåsa et al. (2015) found that consumers reported a smaller increase over time in feeling that service pressure could be helpful. McKenna et al. (2006) stated that a small level of coercion may have a positive impact on therapeutic outcome, although they recommended that “the correct amount of coercion is titrated and then sustained” (p.155).

Mixed consumer experience

Of those papers reporting on consumer experience of CTOs in general, the majority reported mixed experiences, with similar numbers of findings referencing positive and negative experiences. This variation highlights the complexity and individual response consumers have to being on a CTO. One paper comparing views of consumers from different ethnic backgrounds (Maori and non-Maori) found few differences (Newton-Howes, Lacey & Banks, 2014). Dawson et al. (2003) found some consumers were “volunteers for compulsion” although they acknowledged that even those “voluntary” consumers often had a complicated relationship to the CTO with variation in experiences over time. CTOs were seen as favourable to most consumers over hospital stays and often seemed to account for their positive view (Gibbs et al., 2004). Reported benefits included increased support, a sense of security, improved access to services and hospital avoidance (Banks et al., 2015; Canvin et al., 2014; Mullen, Gibbs, et al., 2006; O'Reilly et al., 2006; Riley et al., 2014) with some consumers viewing CTOs “as a transitional step from a chaotic to a more stable life” (Gibbs et al., 2005, p. 366). One study found no association for consumers between being on a CTO and recovery beliefs (Patterson, Mullen, Gale & Gray, 2011); however, negative impacts for consumers on CTOs were significant and included “side-effects of enforced medication … an enduring sense of stigma; restrictions on place of residence … limited social and work opportunities; the feeling that others made key decisions about their lives; and not getting better, merely existing” (Gibbs et al., 2004, p. 822). Consumers likened their experience of treatment by others to that of a child or criminal (Canvin et al., 2014; Gjesfjeld & Kennedy, 2011), with some referring to their own home as an institution in the community (Riley et al., 2014).

Impact of support type and frequency

Reported support type and frequency varied. Some consumers reported frequent (daily) contact and support with an emotional focus, practical tasks and social engagement, with this type of support related to positive care experiences (Stensrud, Høyer et al., 2015). Others reported less frequent contact and dissatisfaction when the focus was primarily on medication (Brophy & Ring, 2004). Given the high level of needs typical to consumers on CTOs, it was surprising that there was little evidence of use of specialised interventions (Brophy & McDermott, 2013). Although consumers on CTOs were often unemployed and living in difficult conditions, only a minority were receiving assertive care or input from psychosocial supports (Owens & Brophy, 2013). Brophy et al. (2013) stressed the need for workers to provide psychological, social and occupational interventions and avoid overfocusing on medication. Other interventions proposed to reduce the coercive impact of CTOs and promote consumer participation included the use of advanced directives, shared decision-making (SDM) and increased access to independent advocates (Ridley & Hunter, 2013; Sullivan et al., 2014).

Limited linking with broader services

Although consumers on CTOs typically have complex needs that require linking with various services, there was minimal reference to this in the included studies. Light et al. (2015) found general practitioners (GPs) had a key role with consumers on CTOs as they addressed the person's broader health needs, provided mandated psychiatric treatment (often medication by injection) and "enhanced patient care by … building strong therapeutic relationships and 'normalising' treatment" (p. 487). Interestingly, the authors found minimal reference to GPs in CTO literature and policy. Conversely, references to engaging with families were made in the majority of studies, with family members often study participants. Family members were aware of potential dilemmas and tensions that came with CTO use including differing opinions between them and their relative (Mullen, Gibbs et al., 2006; Ridley et al., 2010), although they often reported positive benefits of CTOs such as increased stability for their relatives and increased connection with services and support for them and their family member (Banks et al., 2015; Gibbs et al., 2006; O'Reilly et al., 2006). While the CTO gave carers evidence that their relative's illness was being taken seriously by services, they remained the primary caregiver with the major responsibility for care. Family members requested increased inclusion from services as they were the frontline support when the system failed to adequately address their relative's needs (Ridley et al., 2010). Clarity around who to contact and how to request an emergency review reassured carers (Stroud et al., 2015).

Case closure – discharge from CTO

An individual's autonomy and rights are impacted upon by a CTO and the aim should be that the person resumes personal control and does not require the CTO (Brophy, Campbell & Healy, 2003), with workers having a responsibility to support consumers towards discharge from treatment orders (Mullen, Dawson et al., 2006). The findings indicated significant confusion around when a consumer should be discharged from a CTO.

Lack of definite criterion for discharge

The majority of qualitative studies did not directly explore discharge. Workers had difficulty identifying optimal indicators for discharging consumers from orders, with differing opinions reported in the multidisciplinary team and factors other than current presentation impacting upon the decision (e.g. the consumer's risk profile and workers' previous experience of discharge) (Gibbs et al., 2006). Factors that facilitated discharge included sustained compliance, clinical improvement, reduced risk, greater stability and insight, taking responsibility for treatment and engaging with the treating team (DeRidder et al., 2016; Gibbs et al., 2006; Manning et al., 2011; Mullen, Dawson et al., 2006; Romans et al., 2004). Brophy and Ring (2004) found medication compliance and improved insight were linked by workers and the primary basis for discharge, although interestingly Rugkåsa et al. (2015), reporting on quantitative data, found no changes in consumer insight or attitudes to treatment (including adherence to medication) between consumers on CTOs and consumers not on CTOs. Dawson et al. (2003) stated the lack of a “definite criterion of success in compulsory community care” results in “the dilemma of discharge” and queried whether long-term use of CTOs resulting in hospital avoidance should be considered “a successful or an unnecessary (and therefore overly coercive) form of intervention” (p. 250).

Impact on consumers

Lack of clarity regarding discharge impacted on consumers, who reported discharge as difficult to obtain (Gibbs et al., 2005). Additionally, lack of certainty about the duration of CTOs was experienced negatively by consumers (Rolfe, Sheehan & Davidson, 2008; Stuen, Rugkåsa et al., 2015), with some reporting becoming dependent on the mental health system subsequent to being on orders for prolonged periods (Gibbs, 2010). Consumers reported reasons for compliance with CTOs included avoiding hospital, to prevent another CTO, fear of relapse, family pressure and seeking to gain greater stability (Gibbs et al., 2004; Greenberg, Mazar, Brom & Barel, 2005; O'Reilly et al., 2006; Stroud et al., 2015). Based on the lack of clarity regarding discharge, workers need to be more transparent with consumers regarding the processes and conditions of discharge (Gibbs et al., 2006).

Benefits of case management

Service utilisation

Case management aims to reduce the need for service contacts, particularly hospital utilisation (Ross et al., 2011). Dawson et al. (2003) reviewed studies claiming CTOs reduced the need for hospilitisation; however, they found those studies had not sufficiently accounted for changes in mental health services, introduction of more effective medications or interventions received in the community. For the purpose of this review, given consumers on CTOs are forced to receive treatment, the data was explored regarding CTO impact on facilitating service access according to individual need.

CTO impact on service access and referrals

In summary, studies often stated CTOs facilitated access to mental health clinicians and services, with easy access reported as benefits of CTOs by consumers and their carers (Light et al., 2014; Stensrud, Høyer et al., 2015). Increased access to accommodation services was also reported, with accommodation staff reporting that they felt more supported by mental health workers when CTOs were in place (Mullen, Dawson et al., 2006). Conversely, some consumers reported that the negative impact of being on a CTO meant that they would avoid seeking help in the future (Mfoafo-M'Carthy, 2014). In other papers, the small numbers of consumers receiving assertive and intensive psychosocial support as well as limited resources in rural areas were highlighted, indicating CTOs do not always enhance access to needed services and supports (Gibbs et al., 2006; Owens & Brophy, 2013). It was often unclear in the studies whether this was a consequence of lack of infrastructure and resources, or poor referral and linking.

Health outcomes

Case management has been shown to have a positive impact on health outcomes, although it is acknowledged that measuring such outcomes is complex. Health outcomes include: “quality of life, independence, functionality and general well-being” (Ross et al., 2011, p. 13). For this theme, data relating to consumer, clinician and family perspectives on the usefulness of CTOs in enhancing the above domains for the consumer was explored.

Balancing costs and gains for the consumer

Consumer perspective

Consumer perspectives on the usefulness of CTOs varied. Some consumers considered CTOs to be a barrier to their recovery and negatively impacting on their sense of self-worth, self-direction and relations with others in the broader community (Gibbs, 2010; Riley et al., 2014; Stensrud, Høyer et al., 2015). Being on a CTO was experienced as humiliating, embarrassing and more stigmatising than having a diagnosis of mental illness (Brophy & Ring, 2004; Light et al., 2014; Riley et al., 2014). Others reported improved self-worth and a sense of empowerment linked to functional gains, improved relationships and success in finding employment (Gibbs et al., 2006; Mfoafo-M'Carthy, 2014). Interestingly, when positive gains were reported there was a lack of consistency regarding what had facilitated improvements, with some reporting medication adherence and others increased support as primary facilitators (Gjesfjeld & Kennedy, 2011). Furthermore, some family members reported that gains such as employment were a result of the individual’s own efforts rather than service support (Ridley & Hunter, 2013).

Worker and family perspective

Although some clinicians reported observing positive gains including risk reduction, relapse detection, hospital prevention and housing stability, they challenged whether being on a CTO enhanced social inclusion, reporting a lack of gain in meaningful occupation and no positive changes in stigma or discrimination (Taylor et al., 2013). Workers were generally reluctant to attribute positive changes to the CTO alone (Brophy & Ring, 2004; Canvin et al., 2014). Similarly, family members thought increased and regular engagement with workers, rather than the powers of the CTO, was what resulted in improved compliance (Mullen, Gibbs et al., 2006). Furthermore, although family members often reported improvements in their relative’s social and occupational functioning, they were critical when the focus of care was symptom amelioration with medication, with one family member describing such care resulting in their child being “simply ‘contained’ at home rather than hospital” (Canvin et al., 2014, p. 1880). Positive impacts for family members included improved family relations, a sense of relief, increased safety (Mullen, Gibbs et al., 2006) and feeling empowered and supported when actively involved in the CTO process (Ridley et al., 2010).

Broader issues that support effective case management

Various broader issues impacted upon the effectiveness of case management and consumer outcomes. These included resources, manageable caseloads, effective linking with stakeholders from different service sectors and continuity of care (Ross et al., 2011). These broader service issues were referred to in several of the included papers. Limited resources and service availability were reported to impact on decisions around CTO use, as well as increased use of CTOs to facilitate early discharge from inpatient services (Banks et al., 2015; Christy & Petrila, 2009; DeRidder et al., 2016) and access to limited inpatient beds (Canvin et al., 2014; DeRidder et al., 2016). Psychiatrists reported high caseloads, insufficient time available to spend with consumers and reduced service options in rural areas (Gibbs et al., 2006).

Few studies reported on links with a broad range of stakeholders. Light et al. (2015), exploring links with primary care, found a lack of integration between primary care and mental health services, although they reported some instances where systems were established to enhance shared care between GPs and mental health services. Gibbs et al. (2004) reported a lack of linking of mental health teams with supported accommodation services. Even within mental health services, workers referred to a “silo-mentality” with poor communication and poor linking between inpatient and outpatient services negatively impacting upon consumers (Christy & Petrila, 2009; DeRidder et al., 2016; Owens & Brophy, 2013). Lack of continuity of care was also found to lead to increased tensions for workers, for example when workers were required to adhere to CTO conditions put in place by others (Banks et al., 2015; Greenberg et al., 2005).

Discussion

The studies included in this review provide rich data that relates to consumers’, carers’ and mental health workers’ perspectives and experiences of care coordination and care planning for consumers on CTOs in community mental health care settings across a range of countries. Models of case management differ in terms of staffing, caseload number, contact frequency, length and availability of service, and treatment options and responsibilities (Mfoafo-M'Carthy & Shera, 2012). Understanding the various issues that impact upon the implementation of CTOs, including service delivery models and resources, is important in order to inform best practice (Brophy & McDermott, 2013).

A key finding of this review is the lack of connection between CTO goals (which are service-driven) and recovery goals (which are consumer-driven), with minimal reference made to care plans documenting the care planning process. Furthermore, given the lack of consumer input and knowledge of care plans, it was difficult to substantiate consumer involvement (Owens & Brophy, 2013). Several papers identified the need to link CTO goals to treatment and consumer goals (Brophy & McDermott, 2013; Mfoafo-M'Carthy & Williams, 2010; Taylor et al., 2013). Such linking would promote collaborative care planning, facilitate care that is person-centred (and not overly focused on service goals of medication compliance) and promote service responsibility and support of the consumer's broader goals, including discharge from orders. Even linking CTO purpose to treatment goals would enhance worker accountability.

Lack of clarity of the purpose of CTOs further complicates linking CTO and consumer goals. Kisely and O'Reilly (2015) questioned whether the purpose of the CTO is to "reduce revolving-door admissions, provide a less restrictive alternative to involuntary admission, prevent violence by people with severe mental illness, or increase stability and promote recovery" (p. 415). The CTO purpose will impact upon both the focus of interventions and expected outcomes including "hospital use, perceived coercion, violent acts and quality of life" (Kisely & O'Reilly, 2015, p. 415). This is important given the lack of clarity regarding discharge from orders. CTO processes of assessment, review and discharge from orders are incorporated into the case management role. In Australia, mental health tribunal reviews are conducted 12-monthly. In addition to these formal reviews, care coordinators are required to regularly review an individual's care (typically 3-monthly). This multidisciplinary review process provides regular opportunities to review changes against both CTO and individual recovery goals, ensure required supports are in place, prompt consideration of discharge and ensure consumers are not left languishing on CTOs. There was little evidence of regular reviews and early discharge from CTOs in the included studies and only three studies that recruited all key stakeholders involved in the care planning relationship. Further exploration of how case management can better incorporate and manage issues related to CTOs is warranted.

A core component of care planning is identifying and implementing relevant evidence-based interventions (Ross et al., 2011), yet none of the included studies specifically examined the usefulness of focused interventions. Studies exploring the use of crisis planning and advanced directives identified in the search specifically excluded individuals on CTOs (Borschmann et al., 2014; Thornicroft et al., 2013). Increased stakeholder participation (of workers, consumers and carers) during mental health tribunals was recommended to enhance decision-making related to CTOs (Brophy & McDermott, 2013), with a particular focus on promoting consumer participation in early stages of CTO implementation (Banks et al., 2015). SDM is a core concept in care planning and builds on person-centredness by promoting mutual expertise and determining the individual's "preferred role in the decision-making process" (Lhussier et al., 2015). In mental health care, SDM is often referred to in the context of supporting consumers to make informed decisions related to medication (Deegan & Drake, 2006; Drake, Deegan & Rapp, 2010). A recent randomised trial of a patient decision aid for individuals with PTSD reported increased consumer knowledge of their condition and reduced conflict regarding treatment choice (Watts et al., 2015). Recent studies aiming to enhance medication compliance of consumers with mental health problems have explored the use of peer workers (Thornicroft & Slade, 2014), motivational interviewing (Barkhof, Meijer, De Sonneville, Linszen & De Haan, 2013) and treatment adherence therapy (Staring et al., 2010), with results indicating some success. Given consumers' dissatisfaction with their level of involvement in care planning, decisions related to the CTO process and overfocus on medication, focused interventions to enhance decision-making and medication compliance for consumers on CTOs are important areas to further explore.

Various recommendations for practice were made in the included studies. Mfoafa-M'Carthy and Shera (2012) considered "CTOs should be a voluntary contractually based community treatment option of last resort" (p. 76) and suggested providing less coercive support options for people with serious mental illness, including intensive case management and use of advanced directives to increase collaborative care planning. Brophy and McDermott (2013) took a more pragmatic approach and, acknowledging CTOs are part of current mental health care, sought key stakeholders' perspectives on how to "do CTOs well". Identified principles of good practice included: taking a human rights perspective (being aware of people's right to self-determination); being transparent regarding CTO goals and purposes and linking these to treatment goals; providing quality services (including continuity of care and evidence-based interventions); facilitating involvement of consumers and their carers in the CTO process; and development and use of direct practice skills (including linking with support staff and development of advanced interpersonal skills) (Brophy & McDermott, 2013). Similarly, Lehssier et al. (2015) emphasised the need for case managers to have advanced practitioner skills such as SDM and motivational interviewing.

Stuen et al. (2015) found an assertive engagement approach with psychosocial interventions was as beneficial as the CTO in engaging "reluctant consumers" in treatment. Similarly, Churchill et al. (2007) conducted a comprehensive review of research of experiences of CTO use internationally and recommended exploring the "potential therapeutic gains [that] might be better delivered by enhancing the quality and assertiveness of community treatment for high risk patients through, for example, ACT". Core elements of ACT include "assertive engagement, small caseloads [and] focus on supporting broad life domains" (Stuen, Rugkåsa et al., 2015, p. 11). While this approach has clear benefits in engaging consumers around their identified goals, referral to services that are able to provide psychosocial support is more widely available and should be considered more often than was evident in the studies (Brophy & McDermott, 2013). In addition to linking with broader services, the recovery literature recommended a focus on linking consumers with their personal and community resources to support everyday connections and reduce dependence on health services (Mezzina, 2014). There was little reference to such linking in the included studies other than with consumers' families and a few reports of links with GPs and accommodation services (Light, Kerridge et al., 2015; Mullen, Dawson et al., 2006).

Most papers made reference to the coercive nature of CTOs and potential impact on the therapeutic relationship, which is key to effective case management. Some authors who have published extensively on involuntary psychiatric treatment have backgrounds in socio-legal research and/or social work. Brophy and McDermott (2013), for example, used critical social work theory to explore best practice with individuals on CTOs and highlighted the role this theory has in “encourag[ing] social workers to be mindful of the imbalance of power that is inherent in all social work practice” (p. 74). In clinical practice, case managers have varied professional backgrounds and may be less sensitive to some of the issues of care and control inherent in the care relationship, as these issues may not be addressed in undergraduate training. Lawn et al. (2015) highlighted the potential for the relationship between mental health workers and consumers to “either assist or obstruct recovery” (p. 14). Key components of the therapeutic relationship in the context of forced treatment included empathic skills and trusting relationships (Lawn et al., 2015). Consumers who trusted health services and workers had better clinical outcomes and reported increased positive care experiences (Meyer & Ward, 2008). Trusting relationships were considered “a prerequisite to the negotiation of reciprocal agreements [which], in turn, lead to patient-centred care” (Slade et al., 2014, p. 886). “[Worker] characteristics that have been shown to encourage patient trust [include] ability (also termed competence), benevolence, integrity, respect, and honesty” (Meyer & Ward, 2008, p. 7). The role these relational factors have in facilitating therapeutic alliance has a longstanding and robust evidence base; however, Davidson and Chan (2014) warned that it should not be assumed that such skills are already being practised, and that empathy skills should be developed and maintained with targeted training, reflection and supervision (Davidson & Chan, 2014; Lawn et al., 2015).

Limitations

Appraisal and data extraction were conducted by only one author, although opinion was sought from a second reviewer to clarify the studies for inclusion. A limitation of qualitative studies is a lack of generalisability to broader contexts, although the integrative review method of synthesising data from different studies conducted in different locations helps address this. Quantitative studies are not reported in detail, with the decision made to utilise this data to augment the more in-depth qualitative findings in order to best answer the research question.

Conclusion

The effectiveness of case management will be influenced by various factors, including the quality of relationship established between consumers and workers, and the type of support offered to consumers. These factors are interrelated and dependent on good assessment of needs, as well as resources available in the community (inclusive of housing, financial security, substance-abuse programs and supports to facilitate social connections) (Mfoafo-M'Carthy & Shera, 2012; O'Reilly et al., 2012). As Davidson (2012) pointed out, “personal choice plays a very limited role … when the person has very limited, if any, choices to begin with" (p. 366). CTO legislation, service delivery models and resource availability all impact upon the implementation of CTOs and need to be considered when exploring best practices (Brophy & McDermott, 2013). Changes at the level of clinical practice, however, can still positively impact on consumers' experiences of CTOs. The conflicting processes of reciprocity, which involves mutual trust, and authority in current mental health practice need to be recognised (Slade et al., 2014), with person-centred approaches requiring core practitioner and communication skills including empathy, trust and hope (Lhussier et al., 2015). Workers should aim to engage in the care planning process in ways that enhance consumer experience (increased consumer involvement and addressing identified consumer needs) while being sensitive to the "control and care" dynamic of the relationship.

An update of the literature

The search for the integrative literature review presented above was conducted in 2015; therefore an update of the literature pertaining to the review is now presented.

The objective of the review restated:
To gain an in-depth understanding of consumers', carers' and mental health clinicians' perspectives and experiences of care coordination and care planning for consumers on CTOs in community mental health settings.

The search strategy developed for the initial review was repeated, with the aim of finding peer-reviewed literature relevant to the above objective that had been published between January 2015 to August 2020 (Appendix C). Those papers published in early 2015 that were included in the initial review were excluded from this update. In total, 23 papers met the criteria for inclusion (see Appendix D for the list of included papers). Empirical studies came from six countries: Australia (6); Canada (4); Norway (5); Netherlands (1); Spain (1); and the UK (2). As with the previous review, papers often reported on data from the same study but with a differing focus.

The included studies were predominantly qualitative in design and reported on a range of objectives, with most studies exploring CTO experiences from different stakeholder perspectives. Three systematic reviews examining the perspectives of consumers, carers and clinicians (Corring et al., 2017; Corring, O'Reilly, et al., 2018; Corring, O'Reilly, et al., 2018), in addition to a paper that provided a comparative analysis of these reviews (Corring, O'Reilly, Sommerdyk & Russell, 2019), also met the criteria for inclusion. Several papers presented critical analyses of CTO use by exploring the ethics of use in practice. The focus of these papers included the role of trust (McMillan, Lawn & Delany-Crowe, 2019), sense-making (Lawn, Delany, Pulvirenti, Smith & McMillan, 2016) and the impacts of CTO use on the person and systems from a sociological perspective (Klassen, 2017). Studies also reported on practice issues that arose for clinicians regarding CTO use, specifically focusing on decision-making (Brophy, Kokanovic, Flore, McSherry

& Herrman, 2019). Finally, broader systems-level issues were addressed in several papers, including understanding the impact of social factors on consumers' CTO care journeys (Haynes & Stroud, 2019), the use, interpretation and role of CTOs within the broader mental health system (Klassen, 2017; Light et al., 2017) and service use post discharge from CTOs (Vine, Turner, Pirkis, Judd & Spittal, 2016).

Data were extracted from the included papers and coded into categories. NVivo software was used to aid in the storage, management, and sharing of data between the research team (QSR NVivo 12). The findings are presented within two main themes: relational issues of CTO use, which explores care planning and participants' experiences and views of CTOs; and systems-level issues related to CTO use. The following section examines recent findings presented in the papers in relation to the initial integrative literature review and alongside other literature relevant to this investigation. Areas of knowledge development, in addition to gaps in knowledge pertaining to care planning with individuals on CTOs, are discussed. The themes of care planning and care coordination that were discussed separately in the initial review have been integrated in this synthesis to align with the interpretation of care planning that has been applied to the remainder of the thesis. Care planning is considered broadly to include communication pertaining to a person's care needs that occurs between clinicians, consumers, carers and other supports, and communication among clinicians.

Relational issues of CTO use

Key findings presented below include the impact of CTOs on consumers and the relational quality with clinicians, involvement of different participant groups in decision-making processes, and care options and focus. These themes are presented according to the perspectives of the differing participant groups, consumers, carers and clinicians. Finally, the broader systems level issues that impact on care planning experiences are presented.

Consumer experiences

Although consumers' experiences of CTOs varied, negative experiences were more frequently reported (Corring et al., 2017; Lawn et al., 2016; Mfoafo-M'Carthy, Grosset, Stalker, Dullaart & McColl, 2018). Corring et al. (2017) conducted a systematic review that included 22 qualitative studies which reported on experiences of individuals who had been on a CTO. The three primary themes identified were: feeling coerced and controlled; medication as the primary purpose of CTOs; and CTOs as a safety net. Each of these themes were identified in the initial review (Dawson et al., 2016). Recent studies found that CTO experiences were found to be linked to the perceived trustworthiness of the clinicians and the quality of the supports, including helpfulness of care coordinators (Haynes & Stroud, 2019; McMillan et al., 2019; Mfoafo-M'Carthy et al., 2018) . The relational quality, and relevance of supports offered, have previously been found to positively influence consumer experiences of CTOs and perceptions of coercion (Stuen, Rugkåsa et al., 2015). When consumers reported benefits from CTOs, it was found that their trust in the potential for CTOs, clinicians and the system was enhanced (McMillan et al., 2019). Conversely, when consumers lost trust with workers and the system, the opportunity for developing trust was often gone (McMillan et al., 2019). Consumers' involvement in decision-making about CTOs, choice of medication and side effects continues to be reported as minimal, challenging the concept that care provision is personalised and recovery-focused (Banks et al., 2015; Brophy et al., 2019; Francombe Pridham et al., 2018).

Many recommendations from the studies focused on enhancing the positive aspects of CTOs, such as offering help with broader needs, and minimising the negative aspects, particularly coercion (Corring et al., 2017). Forced care resulted in consumers reporting feeling stigmatised, controlled and fearful of the mental health system (Brophy et al., 2019). A review of empirical studies suggested that, while CTOs contribute to consumers' perceived coercion, broader contextual factors impacting on a person's experience also need to be considered (Francombe Pridham et al., 2016). Consumers on CTOs are often subjected to a range of formal and informal coercive practices, including financial restrictions (Nakhost, Sirotich, Pridham, Stergiopoulos & Simpson, 2018). Recommendations to minimise coercion included further training for clinicians to support working in ways that are empathic, transparent and recovery-focused in the context of forced care, provision of information about CTO processes and increased inclusion of consumers in decision-making (Banks et al., 2015; Corring et al., 2017; Francombe Pridham et al., 2018). More specifically, Lawn et al. (2016) suggested clinicians engage in dialogue with consumers to understand their sense-making of the CTO experience. Although often negative, for some consumers CTOs were viewed as a “wake-up” to make change (Lawn et al., 2016). Given that the development of trust was found to be possible and to positively influence consumer experiences of CTOs (McMillan et al., 2019), clinicians' engagement with consumers in this space has the potential to facilitate rapport and enhance the care planning relationship (Lawn et al., 2016).

Although there is significant research that has explored consumers' experiences of CTOs, including a systematic review that included 22 papers (Corring et al., 2017), there is minimal research to date that has been led by researchers with lived experience (Brosnan, 2018), which would likely result in very different reporting of experiences. While the possibility of consumer bias in reporting of experiences of CTOs has been acknowledged as a limitation of current research (Corring et al., 2017; Corring et al., 2019), CTO studies have not referred to the survivor literature to provide further context. The user/survivor literature is resoundingly, and consistently, against forced care (O' Hagan, 2012). Several papers from a recent Australian study included an ex-service user in the interpretation of the findings (Lawn et al., 2015; Lawn et al., 2016; McMillan et al., 2019). These papers, and one other recently published paper (Klassen, 2017), explored the ethics and moral undertones to CTO use. Moral inferences that were found to be related to CTO use included the requirement of consumers to adhere to treatment to demonstrate that they had capacity and were therefore “responsible citizens” (Klassen, 2017, p. 367) and the view that CTOs were “promoting the patient’s good” (Lawn et al., 2016, p. 1). To further address this gap of consumer involvement in CTO research, Brophy et al. (2018) recommended more interdisciplinary research that is co-designed and co-produced by individuals with lived experience of mental illness, which would be inclusive of carers. Faulkner (2017), a survivor researcher, stated that to produce knowledge that is not dominated by professional knowledge requires “foregrounding the contribution of experiential knowledge: knowledge that comes from the direct experience of madness and distress” (p. 508).

Carer experiences

Fewer studies reported on carers’ perspectives and experiences of CTOs, compared to those exploring consumers’ and clinicians’ perspectives. Four empirical studies reported on carers’ experiences of CTOs (Francombe Pridham et al., 2018; Light et al., 2017; Stensrud, Høyer, Granerud & Landheim, 2015) and one systematic review reported on the synthesised findings from 12 qualitative studies exploring carers’ views (Corring, O'Reilly et al., 2018), which included the study conducted by Stensrud et al. (2015). Corring et al. (2018) situated their review in the context of the extensive evidence that continues to highlight benefits, and systems expectations, of family involvement in care, alongside families’ ongoing exclusion from services. Corring et al (2018) found that overall carers were in favour of CTOs. Combining the findings from all included studies with carers, reported benefits of CTOs included systems-level factors (improved supports from services) and personal factors (improved family relations, treatment adherence and stability, and hope for recovery) (Corring, O'Reilly et al., 2018; Stensrud, Høyer et al., 2015). Disadvantages included an overemphasis on medication as treatment, lack of rigorous follow-up, overly complex legislative processes and lack of information about medication and CTO processes (Corring, O'Reilly et al., 2018; Stensrud, Høyer et al., 2015).

Experiences regarding input into decision-making and care planning were mixed. While some carers reported increased involvement once the person was placed on a CTO, many carers were critical of CTO decision-making processes (Corring, O'Reilly et al., 2018; Francombe Pridham et al., 2018; Rugkåsa & Canvin, 2017; Stensrud, Høyer et al., 2015). Carers reported feeling “responsible, but still not a real treatment partner” and having to navigate and balance their relative’s needs and clinicians’ expectations with their own experiences (Stensrud, Høyer et al., 2015, p. 585). Overall, the findings highlighted variation in carers’ experiences, which aligns with previous findings (Dawson et al., 2016). Rugkåsa and Canvin (2017) extended the investigation into carer experiences and examined the factors influencing the variation in carer involvement in CTO processes. Although some of the factors were at the relational level, including sensitivity to their relative’s preference regarding their involvement, most factors were related to the mental health service systems. Systems-level factors included lack of access to information and clinicians, and issues regarding confidentiality. Carers were found to hold a range of roles that were based on kinship as well as the role of “expert carer” (Rugkåsa & Canvin, 2017, p. 9). Within these differing roles, carers reported experiencing conflicts, such as “policing” compliance while advocating for their relative who might not agree with treatment recommendations. The authors highlighted the need for services to clarify carer roles to avoid potential negative impacts that may occur in family relationships. This aligns with recommendations from a systematic review that examined the role of carers with relatives with a severe mental illness and their relationships with clinicians (Rowe, 2012). To address any potential ambiguity regarding responsibilities and support more empathic communication, Rowe (2012) proposed the development of a contract that defines mutual roles and responsibilities. Given policies that continue to state the need for services to engage with carers (Department of Health and Ageing, 2017), improvements in this area now need to occur at the clinical interface (Rowe, 2012).

Clinician experiences

Sixteen papers from empirical studies reported on clinicians’ experiences of CTOs, with nine papers published since 2018. Additionally, a systematic review exploring clinicians’ experiences of CTOs included a further 14 papers (Corring, O’Reilly et al., 2018). This systematic review of qualitative studies highlighted that clinicians had ambivalent views about CTO use, including the impact of recovery approaches within the context of forced care (Corring, O’Reilly et al., 2018). Positives included enhanced engagement with treatment, specifically medication adherence, while negatives referred to the need to balance positive gains with the potential detrimental impact on the therapeutic relationship. A repeat survey of psychiatrists’ views in the UK reported that there had been no change in overall endorsement of CTOs over a 10-year period despite the increasing evidence questioning CTO effectiveness (DeRidder et al., 2016). This was considered a consequence of individual, clinician and systems-level issues. Clinicians believed that CTOs were necessary to protect the consumer and others, support development of insight and result in clinical improvement (DeRidder et al., 2016; Lawn et al., 2016). Systems issues included ensuring service access and ongoing contact. These factors were previously found to be used to justify CTO use and discharge (Dawson et al., 2016). Although overall clinicians held favourable views of CTOs, there was also an acknowledgement that broader systems change and investment were required to improve psychosocial factors for individuals including housing and jobs (de Waardt, van der Heijden, Rugkåsa & Mulder, 2020).

Several papers explored the challenges and ethical tensions at the relational level of attempting to provide personalised and recovery-oriented care in the context of forced treatment (Banks et al., 2015; Francombe Pridham et al., 2018; Stensrud, Høyer, Beston, Granerud & Landheim, 2016). Lawn et al. (2016) described CTOs resulting in the pervasive forfeiting of a person’s capacity in all areas of their lives, rather than reduced capacity within focused areas. In this same study, although clinicians did not trust that consumers were able to understand the implications of their illness and need for treatment, they appeared unaware of the impact of the CTO on the consumers’ trust of services, with consumers’ mistrust pathologised and interpreted as a sign of illness (McMillan et al., 2019). Some clinicians, however, were aware of the impact of CTOs on their therapeutic relationship with the person and would advocate against CTO use (McMillan et al., 2019). While clinicians acknowledged CTOs disrupted therapeutic relationships in early stages of use, some reported that, over time, it was possible to develop trust (Mfoafo-M’Carthy et al., 2018). Clinicians referred to the challenges faced when engaging “reluctant patients” and highlighted “respect, empathy … communication skills, patience and persistence” as essential components of successful engagement (Stuen, Landheim, Rugkåsa & Wynn, 2018, p. 6). This type of engagement was consistently reported by clinicians working in assertive community treatment (ACT) teams, which is a service model that provides comprehensive and frequent supports (Mfoafo-M’Carthy et al., 2018; Stuen, Landheim, Rugkåsa & Wynn, 2018; Stuen, Landheim, Rugkåsa et al., 2018; Stuen, Rugkåsa et al., 2015). Clinicians working within ACT teams identified that regular contact, knowing the person and shared team responsibility allowed for greater risk taking and increased personal autonomy (Riley, Lorem & Høyer, 2018). Overall, clinicians emphasised the importance of the therapeutic relationship for providing meaningful care for the person (Haynes & Stroud, 2019).

Several papers focused on decision-making processes related to CTOs (Brophy et al., 2019; Light et al., 2016; Riley et al., 2018), although other papers referred to such processes within the study findings. Decision-making regarding CTO use was based on clinician perceptions of risk, insight, perceived lack of capacity and engagement with services, specifically, medication compliance, with congruence found among all professional groups (Haynes & Stroud, 2019; Lawn et al., 2016; Stensrud et al., 2016). While CTOs were considered a treatment tool for enhancing consumer stability and safety, they were also used to contain risk and prevent harm (Riley et al., 2018; Stuen, Landheim, Rugkåsa et al., 2018). Light et al. (2016) explored consumer, carer and clinician understandings of capacity, a key concept used in decision-making regarding justification for involuntary care, and proposed a new model to conceptualise capacity that incorporates an individual’s “capacities to manage illness, for self-care and to maintain social roles” (p. 40). The authors argued that a capability model extends the narrow medico-legal interpretation of capacity to include those “fundamental capabilities [required] to pursue a ‘good life’” and thereby aligns assessment and treatment with recovery (Light et al., 2016, p. 41). Related to this, Haynes and Stroud (2019) found that while clinicians acknowledged the importance of social factors (housing, employment and relationships) when making decisions about CTOs, lesser weight was given to these factors than to issues related to risk and capacity.

Most of the studies exploring decision-making were concerned with decisions regarding reasons for CTO use; however, the issue of ongoing involvement in decision-making during all care contacts is also important. In an ethnographic study that explored the implementation of CTOs in the UK, clinicians labelled consumers as “actively accepting” or “resisting” CTOs, with personal choice in medication considered central to making a CTO “work” (Jobling, 2014). There is also some evidence to suggest that active engagement of consumers in discharge planning may reduce severity of relapse and need for further CTOs (Vine et al., 2016). Workers expressed support of increased involvement of consumers in decision-making processes related to CTOs (Brophy et al., 2019). Promoting transparent discussions with consumers about their experiences of being on a CTO would help clinicians to understand the possible consequences of CTOs for consumers (Lawn et al., 2016; Riley et al., 2018) and potentially improve consumer involvement in decision-making. While some clinicians were sensitive to the tension between a person’s autonomy and experience of coercion, the majority did not ask consumers directly about this nor consider that CTOs were coercive beyond the enforcement of medication (Lawn et al., 2016; Riley et al., 2018). Clinicians were found to demonstrate varied interest and knowledge regarding the potential impact of CTOs on consumers such as perceived coercion and stigma (Francombe Pridham et al., 2018; Moleón & Fuertes, 2020; Riley et al., 2018). Other studies highlighted the level and impact of coercion that consumers experienced on CTOs (Riley et al., 2014; Stensrud, Høyer et al., 2015).

Although consumer and carer involvement in decision-making was often reported as minimal, workers in the care planning relationship also described differing levels of involvement and consequences in decision-making processes, with support workers feeling disempowered and psychiatrists feeling exposed to blame if any harm were to occur (Brophy et al., 2019). The various relational and structural experiences reported thus far have occurred within systems; key systems-level issues are therefore briefly explored.

Systems-level issues of CTO use

As discussed above, CTOs serve a function within the broader mental health system and therefore need to be viewed in this broader context (Light et al., 2017). CTOs function as a tool to facilitate and ensure timely and ongoing service access, as well as facilitating discharge from inpatient settings. These features were described by participants from all groups as being among the benefits of CTOs. CTO benefits, however, such as acting as a safety net, were found to be used by clinicians to dismiss consumers’ negative sense-making of CTOs (Lawn et al., 2016). Klassen’s (2017) critical analysis of CTOs challenged the notion of reported benefits of CTOs as offering a less restrictive care option and being preferable to being in hospital (Banks et al., 2015; Corring et al., 2017; Nakhost et al., 2018) by highlighting the inherent lack of choice that individuals on orders possess. As Klassen (2017) pointed out, “non-compliant” consumers on CTOs do not have the choice of living in the community without taking medication. Clinicians also reported use of CTOs due to pressure on hospital beds as challenging the ethics of use (Banks et al., 2015; DeRidder et al., 2016). As Light et al. (2017) highlighted, “service deficiencies are a significant determinant in the use of CTOs”, justifying the need for “advocacy to improve policy accountability and resourcing of community mental health services” (p. 352). Light et al. (2017) stated that CTOs should be viewed as “procedural instruments” rather than treatment or intervention.

Previously identified gaps in the CTO literature include lack of engagement and exploration of the impact of focused interventions (including shared decision-making), lack of connection between CTO and personal goals, and lack of linking with community and personal supports (Dawson et al., 2016). In the update of the literature conducted in 2020, several papers reported on CTOs in combination with ACT (Mfoafo-M'Carthy et al., 2018; Stuen, Landheim, Rugkåsa et al., 2018; Stuen, Landheim, Rugkåsa et al., 2018). In these studies, the role and value of addressing consumers' broader needs promoted engagement, with CTOs considered to be a "platform for other interventions" (Stuen, Landheim, Rugkåsa et al., 2018, p. 5). Additionally, there is some evidence to suggest that active involvement of consumers in discharge planning may reduce severity of relapse and need for further CTOs (Vine et al., 2016), emphasising the wideranging benefits of SDM. There were, however, no studies that described specific strategies, approaches or tools to support decision-making. SDM continues to have limited uptake in mental health care despite the identified benefits and policy support (Slade, 2017). Broader exploration of the impact of evidence-based interventions on CTO use and consumer experiences remains an ongoing gap in knowledge.

Summary

Since the introduction of CTOs, there have been 73 papers published that met the criteria of this combined literature review (Dawson et al., 2016 and this update conducted in 2020). These papers have highlighted the complexity of CTO use and, more specifically, the challenge of effectively engaging with consumers in care planning within current mental health care models that promote personalised and recovery-oriented care. Although qualitative studies have found that carers and clinicians report more benefits than drawbacks to CTOs (Corring et al., 2019), the negative impacts of coercive care for consumers are clear and go against care that promotes self-autonomy and development of trust in the system by these consumers. Consumer experiences of CTOs are related to their own recovery and experience of supports. Given the discrepancy in views, increasing usage and acknowledged role of CTOs in mental health service provision, it is important to understand how they are being used in practice in order to make informed recommendations for improvement. While some studies highlighted that change is possible at the clinical interface (Corring et al., 2017; Lawn et al., 2016; McMillan et al., 2019), other studies called for a systems-level transformation that includes changes in values and practice (Brophy et al., 2019), as well as "macro scale social policy interventions" (Haynes & Stroud, 2019, p. 475). Corring et al. (2018) recommended a focused qualitative enquiry into consumers' and clinicians' views on the impact of CTOs on the therapeutic relationship. Care planning, however, occurs within systems; thus, this thesis extends the examination of care planning to include an understanding of systems-level factors that impact on the relational aspects of care planning. Furthermore, this investigation is concerned with illuminating the scope for possible change at these different levels. The following chapter details the methodology that was selected to support and facilitate this examination.

CHAPTER THREE
METHODOLOGY

Introduction

This chapter discusses the methodology that has underpinned the examination of the interpersonal and structural issues that were impacting on care planning processes for consumers on CTOs. In a research endeavour, the methodology is the process or plan of action that informs the choice of methods best suited to meet the desired outcome (Crotty, 1998). Critical ethnography, as developed by Carspecken (1996), is the chosen methodology for the thesis as it provided a clear and rigorous means of examining the culture of care planning, as well as providing opportunities for positive change in practice. Central to Carspecken’s (1996, 2012) critical ethnographic methodology is his adaptation of Habermas’s (1984, 1987) conceptualisation of critical social theory (CST). The first part of this chapter discusses Carspecken’s (1996, 2012) conceptualisation and use of CST and its relevance to this research enquiry. The latter part of the chapter provides an overview of Carspecken’s (1996) five-stage methodology.

Care planning, CTOs and critical ethnography

For the purpose of this study, care planning is considered broadly to include communication among mental health clinicians, and communication between clinicians and consumers and their carers. Communication type includes verbal, nonverbal and written, with the study focus on care planning discussions. Care planning should be an interactional, collaborative process involving the consumer, clinicians and relevant others, including the consumer’s nominated personal supports (often family), GPs and other key services. The literature, however, clearly highlights a disjoint between how care planning occurs in practice and how care planning could and should be done (Brophy et al., 2014; Hannigan et al., 2018). As previously highlighted, in the context of care planning with individuals on CTOs treatment and care should be recovery-focused, although legislation and justification for CTO use are predominantly risk-based (Light, 2019). Hence, this examination of care planning has been specifically concerned with how the concepts of risk and risk management influenced care provision for individuals on CTOs within the context of mental health policies and service frameworks that are recovery-oriented.

Developing an understanding of the culture of care planning has involved an exploration of the relational-level factors, as well as the broader systems-level factors including organisational and policy influences. Ethnography, which is the study of culture, is commonly associated with a range of methodological approaches and theoretical perspectives (Hammersley & Atkinson, 2007; Spradley, 1980). Carspecken (1996) embedded his interpretation of CST within ethnographic methods. Thus, Carspecken’s (1996) critical ethnographic methodology was chosen as it facilitated an examination of the relational and systems-level factors impacting upon care planning with consumers on CTOs within two adult community mental health teams. Additionally, inherent in Carspecken's (1996) critical ethnography is an emancipatory intent whereby increased knowledge through reflection is linked to possible positive change. Criticalist researchers commonly assume that "thought is fundamentally mediated by power relations that are social[ly] and historically constituted" (Kincheloe & McLaren, 2005, p. 304). The CTO literature clearly highlights the coercive nature of CTOs and the need for improved care planning practice for consumers on CTOs (Dawson et al., 2016). Research informed by CST aims to move beyond an increase in knowledge (Kincheloe & McLaren, 2005). In this spirit, this thesis seeks to go beyond providing an exploration of coercive power, already well described in the CTO literature, and to identify ways in which the articulated power relations can be challenged and overcome in situ.

Prior to discussing Carspecken's application of CST, the core concept of culture is addressed, as culture is central to both the methodology and the research enquiry.

The importance of culture

Carspecken (2012) described culture as:

> the milieu through which people communicate with each other … [as well as] the milieu through which people make sense of their situations generally, monitor and explain their own actions (including non-communicative ones) and form and maintain their personal identities (p. 47).

This thesis examines communication among mental health clinicians and between clinicians and consumers on CTOs and carers from the perspectives of all participants.

Communication transmits culture, although when people communicate a significant proportion of knowledge remains implicit (Carspecken, 2012). To address this issue, Carspecken (1996, 2012) adapted and applied Habermas's (1984, 1987) theory of communicative action to develop insights into the "deeper layers of assumptions and beliefs that are not commonly questioned or even noticed" (Carspecken, 2012, p. 47). Mead's theory on communication, as articulated by Mead's student Blumer (1969), informed Habermas's (1987) theory of communicative action and thereby the above definition of culture. Mead considered that human groups should be viewed in the context of social action. In symbolic interactionism, social interaction is considered to be the process that *forms* human actions, rather than being merely the context or means for social expression (Blumer, 1969). Meaning arises in the process of human interactions, with individuals' interpretation of the meaning of another individual's act mediating their own response. Many of Mead's core concepts and views of society and individuals' actions informed Habermas's (1984, 1987) theory, which is presented in more detail below.

The following section introduces CST, which is the methodological context in which Carspecken's critical ethnography is situated.

Critical social theory

Development of critical social theory

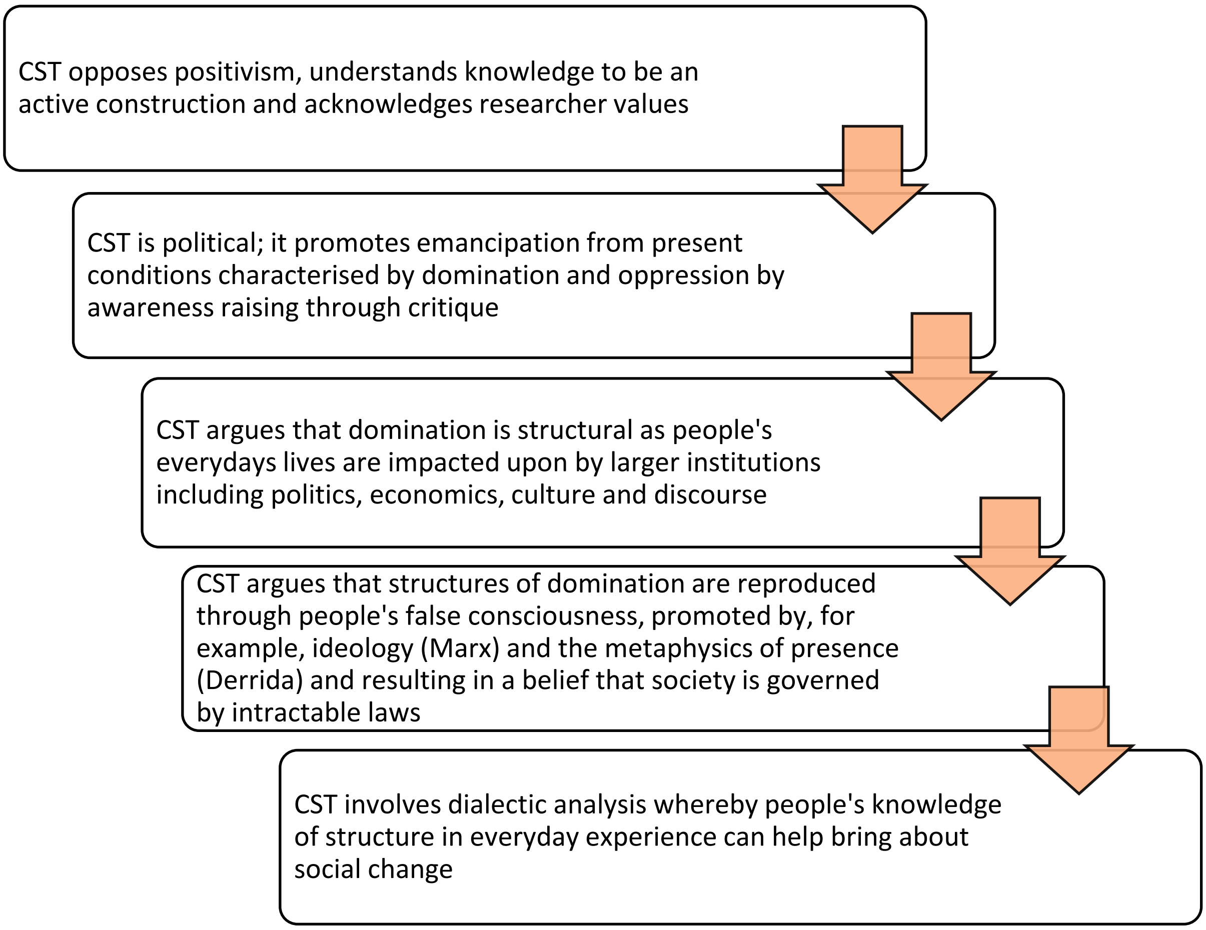
Social critique has occurred throughout human history, although it is Marx (1818–83) who is recognised as having laid the foundation for current critical enquiry (Crotty, 1998). CST, sometimes referred to as "Western Marxism", refers to those theorists who, while drawing on a range of sources, were all influenced by Marx (Crotty, 1998). Agger (2013) identified the critique of positivism as one of the most central and enduring features of CST, with this critique "address[ing] positivism's metaphysical view of history" (p. 7) and thereby resulting in the conceptualisation of social patterns as being historically fluid rather than a "static representation of a lawful social universe" as they had been viewed previously (p. 6). Aligned with this, Marx described a dialectical reality that could potentially result in liberation, referred to as the *relations of production* (Crotty, 1998). Production is central to Marx's analysis, whereby he believed people become fully human through action (Crotty, 1998). Marx highlighted that the *forces of production*, or ways in which people "produce their means of subsistence", differ according to the historical and geographical context, as do the social relations which are created by these forces of production (Crotty, 1998, p. 119). The crux of this is the belief that economic forces determine how people think, with those holding economic hegemony having influence over the perceptions and views of others in society. In stating this, Marx is describing an oppression at the level of thought, whereby a "false consciousness and … corresponding ideology or system of beliefs and values" is assumed by a cultural group to be the truth (Crotty, 1998, p. 121).

While these concepts were drawn upon by critical theorists that came after Marx, Marx's description of economic determinism was eventually rejected (Kincheloe & McLaren, 2005). Marx conceptualised a *base-superstructure* model of society whereby the *base* (social and technological production) determines the *superstructure* (political, legal and religious structures) (Carspecken, 1996; Kincheloe & McLaren, 2005). A major shift that occurred with Western Marxism was the emphasis on the *superstructure*, or culture, rather than the economic substructure. This is important in this enquiry as it highlights the influence of culture on all social acts.

Core tenets of critical social theory

CST informs Carspecken's methodology and has thereby shaped the collection, analysis and presentation of data for this research enquiry. While it is not possible to present a summary of a unified critical theory, as it is represented differently by different theorists, there are core tenets that are generally collectively adhered to by critical social theorists (Agger, 2013; Carspecken, 1996; Held, 1980). The two main branches of CST are first the thinking that was linked to the Frankfurt school of social theory established in the early 1920s and latterly that which was centred around Habermas (Held, 1980). Held (1980) examined central critical theorists including Horkheimer, Adorno, Marcuse and Habermas and identified common aims and motivations. Common to critical theorists is their interest in understanding the meaning of culture, the relations between individuals and their cultural context, and the conditions that reproduce and transform culture.

Agger (2013) referred to CST as a *theory cluster* and presented a synthesis of the core tenets of CST which includes the following features, as depicted in Figure 3 (pp. 4–6):



CST opposes positivism, understands knowledge to be an active construction and acknowledges researcher values

CST is political; it promotes emancipation from present conditions characterised by domination and oppression by awareness raising through critique

CST argues that domination is structural as people's everydays lives are impacted upon by larger institutions including politics, economics, culture and discourse

CST argues that structures of domination are reproduced through people's false consciousness, promoted by, for example, ideology (Marx) and the metaphysics of presence (Derrida) and resulting in a belief that society is governed by intractable laws

CST involves dialectic analysis whereby people's knowledge of structure in everyday experience can help bring about social change

Figure 3. Core tenets of critical social theory

Both Held’s (1980) and Agger’s (2013) syntheses of CST align with Carspecken’s interpretation of CST. Basic tenets of Carspecken’s critical social research include:

> the realist social ontology; the combination of reconstructive analysis with systems analysis; the importance for all people to have and maintain a valid identity; the dependence of such identities on cultural milieu and the concept of cultural production (Carspecken, 2005, p. 24).

The application of these core tenets, as summarised by Carspecken (2005), will be elaborated upon in more detail throughout this chapter. Although there are many commonalities among criticalists, Carspecken (1996) went further and developed a tight methodological theory to guide research design which was inclusive of methods for data collection and analysis (Carspecken, 1996).

The specific methodological tenets of CST developed by Habermas (1984, 1987) and then adapted and utilised by Carspecken (1996, 2005, 2012) are now discussed.

Habermasian critical social theory

While Carspecken drew on various theorists, it is his interpretation of Habermas's own recasting of critical theory which is central to his methodology and of particular relevance in addressing the enquiry presented in this thesis. Carspecken (1996) identifies Habermas's critical epistemology in *The Theory of Communication* (1984, 1987) to be the most rigorous formulation of CST available. Two complementary concepts central to Habermas's critical theory, *communicative action* and the reconceptualisation of the social system as the *lifeworld* and *system*, inform Carspecken's (1996) methodology and are elaborated in the following section. The application of these concepts provided a rigorous means to investigate and understand both the relational and systems-level factors in care planning in this study.

The theory of communicative action

For Habermas, "communication provides an ethical basis for critical theory" (Agger, 2013, p. 91). Habermas (1979) stated the basic intention (or goal) of communication as "coming to an understanding … to bring about an agreement that terminates in the intersubjective mutuality of reciprocal understanding, shared knowledge, mutual trust, and accord with one another" (p. 3). Habermas assumed that all forms of social action, including actions resulting in conflict, are intended to reach a mutual understanding (1979). Based on this assumption, Habermas "reformulates socialism as the ideal speech situation" whereby people's opportunities for dialogue are equal and governed by the aim of achieving consensus (Agger, 2013, p. 94). This relates well to the concept and goal of person-centred, collaborative and recovery-oriented care planning.

Habermas's communicative paradigm involves the reconceptualisation of knowledge and social action with "the subject as inherently intersubjective" rather than in terms of a "duality between subject and object" (Agger, 2013, p. 93). Thus, knowledge is embedded within action (Carspecken, 2005). Rather than becoming truly human through labour (as presented by Marx), Habermas argued that it was through social interaction that people become human (Agger, 2013). Thus, people can influence systems and societal change through self-reflection and communication. This interpretation of the goal of communication has provided the theoretical basis in which the care planning relationship was explored.

Lifeworld and system

Habermas reconceptualised the social system as the *lifeworld* and *system*. The *lifeworld* refers to "culture, or that which is intuitively known" by individuals when engaging in face-to-face interaction (Dennis, Carspecken & Carspecken, 2013, p. xi). *System* refers to the dynamic processes, or coordination of action between different social sites, that are able to be located in space and time (Carspecken, 1996).The *lifeworld* and *system* are viewed as a complementary concept to communicative action and as the background to all communicative situations from which people draw upon to collaboratively process interpretations (Habermas, 1987). Habermas (1987) claimed people move within the horizon of their *lifeworld*, which can be viewed as being intersubjective, as it is a shared "intuitively familiar, pre-interpreted reality" (Habermas, 1987, p. 132).

Communicative action is the medium through which culture and society are constantly reproduced (Habermas, 1987). Habermas (1987) identified and named the processes by which these structural components of the *lifeworld* (culture, society and person) come into being as "cultural reproduction, social integration and socialisation" (p. 138). These structures serve to connect new situations with existing conditions in the *lifeworld* in the semantic dimension of meanings (culture), the dimensions of social space (socially integrated groups) and time (across generations) (Habermas, 1987). While the *lifeworld* and *system* are viewed as interacting elements, Habermas (1987) believed that there has been an uncoupling of the *system* and *lifeworld*. In complex and modern societies, systems become increasingly detached from the social structures through which social integration occurs, resulting in increasingly autonomous organisations that are mostly disconnected from norms and values (Habermas, 1987). Thus, in organisations the *system* colonises the *lifeworld* and prevents people from developing shared unique meanings from everyday experiences (Agger, 2013). Carspecken (2010) adopted this interpretation of the function of modern and complex societies:

> Complex, nuanced and non-quantifiable forms of social relationship have been replaced by instrumentalised relationships, practices and corresponding ideas as societies have become more institutionally complex and differentiated (Carspecken, personal correspondence, date unknown, 2010).

The use of risk assessment tools to inform CTO usage could be viewed as an example of this uncoupling. Risk assessment in mental health is known to have limited predictive accuracy, yet can have a profound impact on a person's liberty if assessment leads to involuntary (or forced) treatment (Large, Ryan, Singh, Paton & Nielssen, 2011). Coffey et al. (2017) found that mental health clinicians used "accepted fictions" in their risk assessment and management practices, with accepted fictions referring to the fact that "risk status is ambiguous, outcomes uncertain and consequences significant" (p. 479). The authors found that as a consequence of the perceived risk and possible consequences, mental health clinicians legitimised service intervention and "prioritise[d] the procedural aspects of assessment" over more nuanced relational aspects of care planning (Coffey, Cohen et al., 2017, p. 471). Despite the important function of the risk assessment, consumers were not involved in the process, with clinicians viewing it as a separate function within care planning (Coffey, Cohen et al., 2017; Mustafa, 2015).

Habermas theoretically differentiated the coordination of *lifeworld* activities and *system* phenomena, viewing “institutions as the switching place between the *lifeworld* and the *system*” (Dennis et al., 2013, p. xix). In this enquiry, a community mental health centre (CMHC) in Adelaide was the selected institution where care planning with consumers on CTOs was examined. Social integration occurs at both the relational (*lifeworld*) and *systems* levels. Thus, the relational level, what is occurring within the *lifeworld,* must first be understood in order to identify the systems-level processes and phenomena that are underpinning cultural reproduction (Carspecken, 1996; Dennis et al., 2013). In relation to this research, this meant first developing an understanding of care planning at the relational and service levels (communicative actions and organisational culture) and latterly at the systems level (policy, legislation, professional models and social theories).

Understanding the micro and macro levels of care planning

Carspecken’s (1996, 2012) critical ethnography involves two forms of analysis: reconstructive-hermeneutic and systems-theoretic. These theoretical concepts are utilised by Carspecken (1996) to understand and articulate what is occurring in the *lifeworld* and *systems* particular to the study, as well as to understand the broader cultural influences. The theory underpinning these analyses is discussed below. The various methods for investigating these methodological concepts are then elaborated upon at the end of this chapter, with a presentation of Carspecken’s (1996) five-stage methodological framework.

Reconstructive-hermeneutic analysis

Critical epistemology of communicative action

Reconstructive-hermeneutic analysis is underpinned by Habermas’s theory of communicative action and reconceptualisation of societies as *lifeworlds* and *systems*. Carspecken (1996) posited that critical epistemology uses a “holistic, preconceptual, and communicatively structured experience” as the core metaphor (p.188) rather than visual perception, meaning that perception itself, and thereby meaning, is structured communicatively (p. 19). In critical epistemology, there is delineation between the intention and meaning of social acts, with intention considered a ”secondary explanatory term for routine social interactions” (Carspecken, 1996, p. 78). The primary category instead relates to shared meanings, whereby people are aware of how others might interpret a social act. Carspecken (1996), however, clarified that interactions involve only *possible meanings*, as privileged access makes it impossible to make claims of an absolute truth. Thus, in critical social research, truth claims are translated into validity claims of possible meanings.

To reconstruct meanings of communicative acts, Carspecken (1996) adapted Habermas's ontological categories, described in more detail below, which explain the structure of communicative action, namely, the objective, subjective and normative realms, and associated truth claims (see Figure 4 for a diagrammatic representation of these concepts). Such analysis is critical as it seeks to identify "an underlying reality missed in everyday modes of awareness and interpretive schemes" (Carspecken, 2005, p. 23). The next section describes the ontological categories as they have been applied by Carspecken (Carspecken, 1996, 2012). Carspecken (1996) stated that truth claims are validated by the "consent given by a group of people, potentially universal in membership" and drew on Habermas's theory of communication to provide the means to achieve this (p. 21). Since Carspecken published his detailed methodology in 1996, he has developed and changed his application of several of the concepts presented below. Thus, any relevant change will be integrated into the discussion that follows.

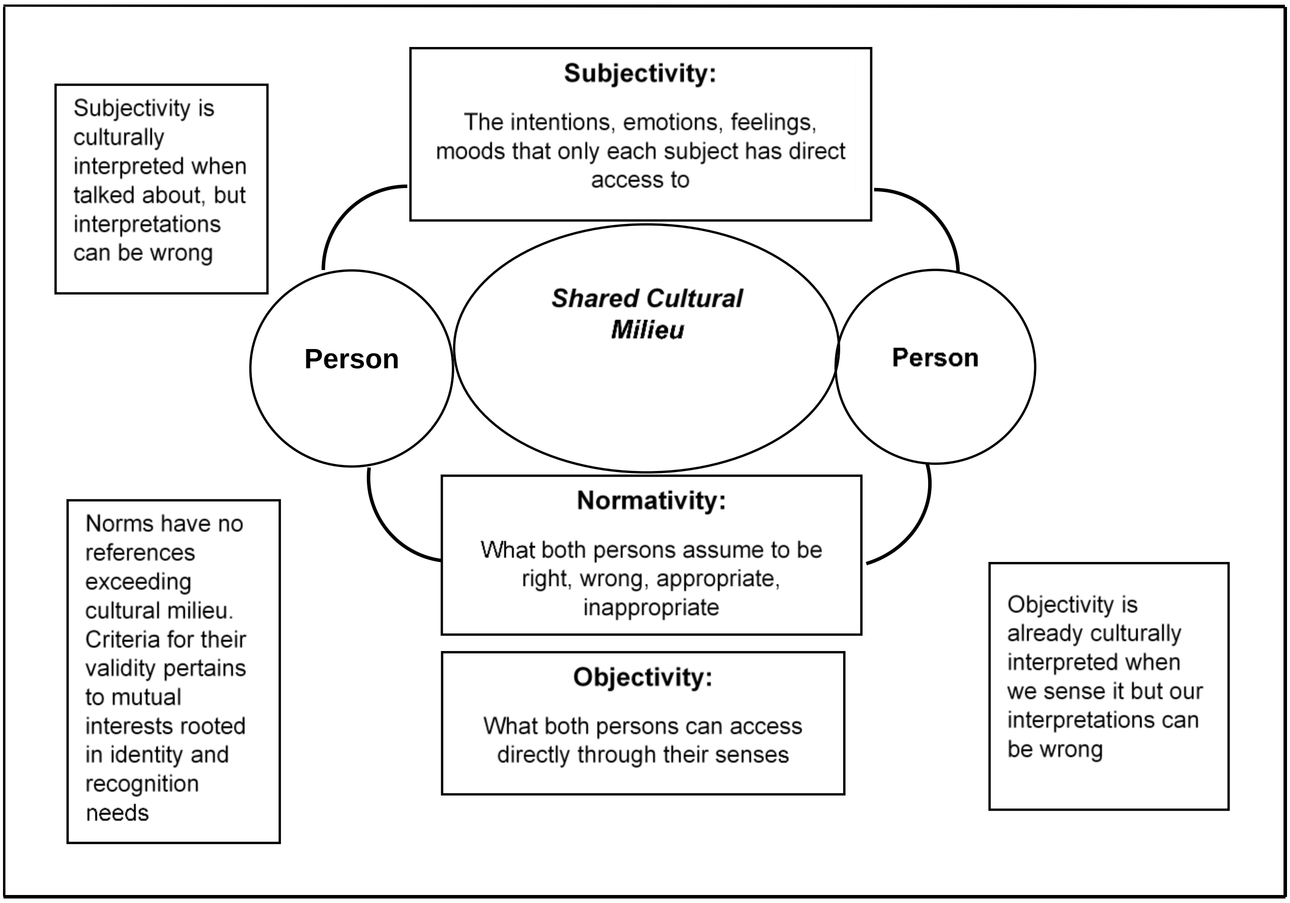


Figure 4. The basic communicative situation (Carspecken, 2012, p. 48)

Defining the ontological categories

Carspecken (1996) defined ontologies as "theories about existence [that make] it possible to formulate diverse truth claims" (p. 20). Each of the ontological categories are structured according to levels of access. The objective ontological category (the world) is structured according to the principle of multiple access. This means that objective-referenced truth claims are those which all actors can, in principle, access through their senses (p. 65). Subjective truth claims (my, her, your world) are structured by privileged access and refer to emotions, intentions, aspirations and awareness that only the individual themselves can ever directly access (p. 69). The third ontological category refers to normative truth claims (our world). This category is structured by tacit position taking that occurs in order to understand the possible meanings of all social acts (p. 81). Normative truth claims (norms) are about what is “proper, appropriate and conventional” (p. 83).

Carspecken (1996) initially presented the third truth claim as the normative-evaluative claim; however, more recently he has made a distinction between normative and value claims (Carspecken 2009, 2012). Carspecken (2012) posited that while objective, subjective and normative truth claims are found in all communicative acts, values, which are closely related to norms, are usually although not always present in all communication. This distinction between norms and values is applied to this thesis. Value claims refer to what is “right, wrong, good and bad” (Carspecken, 1996, p. 83) and, when made explicit, provide additional information about a culture (Carspecken, 2012). Carspecken (2009) stated that normative and value claims relate to our need for positive regard from others, as well as from ourselves, and will be affirmed or rejected by others based upon our values.

Carspecken’s (1996) operationalisation of Habermas’s ontological categories has provided a rigorous framework for ensuring that the truth claims produced in the research are valid and well supported. Alongside reconstructions of the various ontological claims, Carspecken (1996) introduced the concept of horizons, which provide a more subtle understanding of communicative acts than would be achieved if exploring only the ontological claims. The following section discusses Carspecken’s use of horizons in the identification and articulation of possible meanings. Incorporating the concept of horizons has helped clarify both the explicit (or intended meanings) during care planning discussions as well as deeper assumptions and beliefs evident within the cultural context. Although these deeper layers are often implicit, they impact upon the care planning process.

Defining validity horizons

Carspecken (1996) extended his theoretical framework and increased rigour in his methodology for reconstructive analysis by relocating the concept of *horizons* from phenomenology into Habermas’s theory of meaning. For phenomenologists, *objects* are understood within perceptual experience against a background (*horizon)* that is perceived simultaneously (Carspecken, 1996). Carspecken’s (1996) conceptualisation of horizons, however, regards action, rather than perception, as primary in a person’s experience. Carspecken (1996) explained how the meaning of any communicative act has a horizon structure which is constituted by intersubjective assumptions, that is, assumptions from a first, second and third position. Validity claims, according to the three ontological categories – objective, subjective and normative – are considered an articulation of truth on the horizontal horizon, whereas those that are distinguished between highly foregrounded and highly backgrounded are considered articulations of the vertical horizon (Carspecken, 1996, p. 110). Carspecken (1996) claimed that reconstruction of validity claims at the various levels along the vertical horizon of backgrounding and foregrounding provides a more subtle analysis of any communicative act. Validity claims in the foreground provide the meaning intended by the actor, whereas backgrounded claims usually involve assumptions and beliefs that are characteristic of the culture of the enquiry and cultural discourse (Carspecken, 2012). Reconstruction of meaning in a validity horizon (previously referred to by Carspecken (1996) as *pragmatic horizons*) makes explicit the cluster of claims made by actors.

A fourth claim that is made with all meaningful acts is the identity claim. Although Carspecken (1995, 1996) referred to this claim in his earlier work, in more recent publications he has written more extensively on the importance and function of identity claims as detailed below (Carspecken, 2009, 2012).

Identity claims within the validity horizon

Identity claims are also present in validity horizons (Carspecken, 2009). For this additional claim, Carspecken (2012) drew upon the theory of identity claims as originally conceived by Mead (1934) and later adapted and refined by Habermas (1987). Identity claims refer to the “kind of person the actor claims to be” and are present in all communicative acts at various levels of foregrounding or backgrounding (Carspecken, 2012, p. 52). Carspecken (2012) claimed that humans “desire and even need to maintain stable, respected social identities” (p. 54). “Identity claims are made and understood through cultural structures that actors understand holistically” and involve individuals “taking the position of a generalised other to monitor and judge the self” (Carspecken, 2012, pp. 53–55). Individuals internalise other generalised positions, including positions from different groups as well as broader cultural sources. Identity claims are therefore a combination of subjective and normative claims (Carspecken & Cordeiro, 1995).

Understanding the identity claims and concerns of actors facilitates the understanding of routine social action, culture and the power relations that are occurring (Carspecken, 2009; Carspecken & Cordeiro, 1995). Cultural themes that are accessed in the construction of validity claims “will usually reflect cultural beliefs about the differences between groups” (Carspecken & Cordeiro, 1995, p. 88). Identity claims, therefore, have been an important means of understanding the cultural system in this enquiry. It was anticipated that mental health clinicians’ identity claims would likely relate to their different professional knowledge and roles, as well as service culture and mental health policies. For participants with lived experience of mental illness, it was anticipated that their identity claims would likely be impacted upon by personal, service, cultural and societal structures. Self-stigma among people with a mental illness (Corrigan, Larson, & Rüsch, 2009), as well as stigmatising views often held by mental health clinicians (Lebowitz & Ahn, 2014), are well documented in the literature and needed to be considered during data collection and analysis in this research.

Power and truth

A core tenet of CST is the acknowledgement of power and oppression as a constraining feature on all communicative acts. This was also of relevance to this enquiry, as the consumer participants on CTOs were in receipt of care that was enforced by mental health legislation. Carspecken (1996) warned that “unequal power distorts truth claims” (p. 21). When exploring power, Carspecken (1996) drew on Giddens (1979), who linked the concept of power analytically to action by explaining how all actions, small or large, intervene and make an impact. For Giddens (1979), “all acts are acts of power” (Carspecken, 1996, p. 128). To understand the types of power at play, Carspecken (1996) further drew on Weber’s (1978) typology of power relations, whereby types of authority are described as being ”charismatic, legal-rational, [or] traditional” (Carspecken, 1996, p. 129).

Carspecken (1996) highlighted the need to consider power within the cultural milieu and identified that “coercion is usually employed within normative frameworks of cultural origin that legitimate it” (p. 131). Understanding how power relations were being enacted, and impacting on the identified truth claims, particularly when implicit, was of particular relevance to this enquiry, as consumers on CTOs report experiencing significant levels of coercion in their contact with mental health services. Unequal power relations between different mental health professions has also been highlighted in the literature (Tang, Chan, Zhou & Liaw, 2013). As this study is interested in understanding and increasing participants’ awareness of the types of power that may be operating at the relational level (communicative action), the systems level (the culture and structures of the organisation) and the macro systems level (policies and legislation), an in-depth understanding of the cultural milieu was required.

Before discussing the systems-level analysis, the theory of hermeneutics, which is applied in the first stage of reconstructive-hermeneutic analysis, is briefly presented.

The hermeneutic circle

Hermeneutics is a theory on how to understand meaning and thereby articulate, or make explicit, that which is already known implicitly (Carspecken, 2009). Hermeneutics therefore describes the “how to” of the reconstructive analysis by explaining the process by which the researcher reconstructs and recognises meaning in different settings and groupings (Carspecken, 1996). The hermeneutic circle is the process whereby the researcher uses their “preunderstanding of an observed act … to then modify this same preunderstanding to make certain novel features of the act comprehensible” (Carspecken, 1996, p. 101). This process acknowledges, and incorporates, the researcher’s prior knowledge, understandings and prejudices, which shape the interpretative process (Denzin & Lincoln, 2011).

As a communicative being, the researcher can position-take to formulate possible meanings. Position-taking is intersubjective, as individuals employ cultural typifications to make meaning of any social situation. The researcher’s inference of possible meanings, based on their own cultural typifications, therefore may be inaccurate. To increase rigour, knowledge is garnered through reconstructions as understood through Habermas’s communicative action theory (Carspecken, 2009). Carspecken stated the purpose of the hermeneutic circle is to:

> broaden bias horizons so that an interpretation will win consent of as large and diverse ‘a community as possible’ and in this way produce ‘non-biased’ or ‘objective’ knowledge (Carspecken, personal correspondence, date unknown, 2010).

Thus, Carspecken referred to the important concept of objectivity in two different ways: the first being “objectivity as claims about objects and events open to multiple access”, described above in the articulation of objective validity claims; and the second, “objectivity as non-biased forms of knowledge”, as articulated through hermeneutic inference (Carspecken, personal correspondence, date unknown, 2010). “Hermeneutic inference is based on recognition, not perception”, with the researcher’s own cultural horizons altered through contact with the cultural horizons reconstructed in the study (Carspecken, 1996, p.144). It is through the hermeneutic process that cultural power can be identified when the researcher, having developed an insider’s view of normative claims through position-taking, identifies normative (and value) claims that do not meet the interests of all group members (Carspecken 1996).

As previously stated, communication transmits culture, although communication is also informed by the broader cultural milieu of both the present and past. Thus, Carspecken (1996) broadened the analysis and incorporated concepts that facilitate understandings which go beyond those garnered through reconstructive analysis.

Systems-theoretic analysis

Systems-level analysis, or structural analysis, is what has specifically provided the critical focus to the research enquiry (Carspecken, 1996). Carspecken (1996) described this broader level of analysis as an attempt to ”explain cultural formations in terms that may go beyond the culture of a specific group”, with the focus of the analysis on identifying structures or relationships that are related to systems factors (p. 189).

Habermas (1987) highlighted the need to connect the *system* and *lifeworld* and warned of the limitations of exploring only one concept exclusively:

> Individuals' goal-directed actions are coordinated not only through processes of reaching understanding [as uncovered in reconstructive analysis], but also through functional interconnections that are not intended by them and are usually not even perceived within the horizon of everyday practice (Habermas, 1987, p. 150, as cited in Dennis, 2013, p. 409).

From this, Dennis (2013) clarified that it is the analysis of structures that provides a means of naming the implicit "functional interconnections" that impact upon social life (social integration), although outside individuals' awareness. Social integration, articulated through hermeneutic-reconstructive analysis, "refers to the coordination of action on one site through face to face interactions", whereas system integration, as articulated through systems analysis, is "the coordination of action between social sites separated in space and time" (Giddens 1979, p. 74, as cited by Carspecken, 1996, p. 190). Structural analysis starts from the participant's own experience, as identified through hermeneutic-reconstructive analysis. For this thesis, understanding the structural elements of care planning was important as these impacted upon the care planning process at the relational level, although they were often outside the participant's awareness.

When discussing systems-level analysis, Carspecken (1996, 2012, 2013) referred to several concepts that require further clarification in order to understand their use within his methodological framework (and this thesis). The first is to distinguish between systems and structures.

Defining systems and structures

"Systems are dynamic processes located in space and time" whereas structures "do not exist in space and time" (Carspecken, 2012, p. 57). When referring to cultural structures, Carspecken (2012) drew on Gidden's (1979) concept of *structuration* and defines structures as "ways in which reasons for acting implicate more … and other reasons" (p. 57). In this way, structures are determined from the identified validity horizons by examining the formation and linking of the different validity claims (Carspecken, 2012). Carspecken (2012) explained that the layers that exist in a culture determine the cultural structure, with the surface layer, inclusive of cultural themes and beliefs, implicating deeper layers, of which cultural members remain unaware. Structures therefore are a phenomenon of the lifeworld, with each social act reproducing cultural structures (Dennis et al., 2013).

Defining conditions of actions and action consequences

Two further related concepts are conditions of actions and action consequences. Carspecken (2012) acknowledged that actions have multiple consequences that may be intended or unintended, with the social system created from the relationship between action conditions and consequences. Cultural conditions of action both "resource and constrain the volition of the actor"

(Carspecken, 2012, p. 190). So while an individual’s volition is dependent on cultural structures, with culture a necessary resource, culture in itself does not determine social actions (Carspecken, 1996). Culture constrains actors when they draw on cultural themes that are used more frequently and have greater currency in the group. Thus, cultural power can be identified, recognising that it may be fully intended, partially intended or unintended with regards to effects.

Dennis (2013) linked objectivity (multiple access to truth claims) to intentionality (volition) when she clarified that to act with intention, it must be done within contexts that are taken to be objectively agreed. This is based on the premise that there are “a set of conditions that structure people’s interactions and that must be invoked if one’s intentions are to be met or taken as sensible” (Dennis, 2013, p. 410). Thus, Carspecken (1996) stated that “epistemologically, systems analysis foregrounds universalising claims to multiple access” (p. 189).

Carspecken (1996) specifically sought to examine and identify the cultural, economic and political conditions that may be impacting upon and structuring participants’ actions, as he considered that these three categories identify the majority of action conditions that are occurring within the lifeworld (Dennis et al., 2013). More recently, Carspecken (2012) presented four categories of action conditions (see Table 1) whereby he distinguished between action conditions that are internal or external to an individual’s volition. Cultural conditions of action are considered internal to volition because when an actor’s position on them changes, the conditions themselves also change (Carspecken, 2012).

Table 1. Conditions of action (adapted from Carspecken, 2012, p. 12)

CONDITIONS OF ACTION			
Objective: external to volition	Subjective; external to volition	Cultural and internal to volition; directly intersubjective	Institutionally mediated; internal to some, external to others
1. Physical environmental (e.g. interview rooms at the CMHC) 2. Socially constructed but uncoupled from culture (e.g. market conditions)	1. Emotions (e.g. anger, anxiety) 2. Action compulsions, habit energies 3. Some types of mental imagery 4. Processes of denial and misrecognition 5. General capacities (e.g. intelligence)	1. Norms 2. Values 3. Beliefs 4. Interpretative frameworks 5. Identity structures	1. Laws 2. Regulations 3. Policies 4. Formal rules

As well as examining cultural conditions of action, this thesis is specifically interested in political conditions of action, which are institutionally mediated through laws, policies and formal rules (Carspecken, 2012). Carspecken (1996) linked political conditions to culture as it is culture that determines political relations to be legitimate and fair. Furthermore, culture informs individuals' political actions by facilitating or hindering personal motivations to act politically. This thesis seeks to understand and explore the impact of the various policies and laws (e.g. the South Australian Mental Health Act), various regulatory assessment tools (e.g. risk assessment) and the interpretation of the Clinical business rules which govern community mental health service provision, on care planning.

Carspecken's (1996) inclusion of systems-level analysis in his critical ethnographic methodology addresses several criticisms of Habermas that were highlighted by Agger (2013). For example, Agger (2013) referred to the exclusion of a broader discourse, as well as limited acknowledgement of the impact of culture, by Habermas's paradigm of communicative action. Additionally, utilising ethnographic methods has provided further means to include the broader cultural discourse of care planning beyond a detailed account in situ. The following section details Carepecken's (1996) operationalisation of his critical ethnographic methodology.

Research design

Carspecken (1996) developed a clear methodological framework for conducting critical qualitative research, although he suggested that his methodology should be used flexibly as opposed to applying it in a rigid mechanistic way. The five stages, as detailed below, first facilitated an in-depth exploration of social actions at specific sites and then sought to explain identified actions through examining these in relation to locales and social systems. This provided a clear structure for this enquiry, which included examining the care planning relationships and processes within a CMHC in Adelaide, as well as the impact and influence of other related sites (acute inpatient wards, mental health tribunal hearings) and relevant policy, legislation and broader (societal) views of mental illness and mental health care.

Applying ethnography

Ethnography is the study of culture and is inclusive of a broad body of knowledge, research techniques and cultural texts (Spradley, 1980). Carspecken (1996) embedded his methodology in ethnography to facilitate an in-depth understanding of culture through the application of ethnographic methods. Ethnographic research typically involves fieldwork that studies people's actions and accounts in everyday contexts by gathering data from a range of sources including participant observation, interview and document review (Hammersley & Atkinson, 2007). Ethnographic studies can range in scope from macro-ethnography (studies of societies) to micro-ethnography (studies of single social situations), with research questions concerned with broad *surface investigations* or alternatively focused on specific domains, to facilitate *in-depth* *investigations* (Spradley, 1980). This research was micro-ethnographic in its scope, as it has sought to develop an in-depth understanding of care planning practices occurring within a single setting, a CMHC in Adelaide.

Carspecken (1996) combined ethnography with CST to develop a rigorous methodology for understanding specific cultural practices, applied in this case to understanding care planning with consumers on CTOs. Ethnography involves “intepret[ing] the meanings, functions and consequences of human actions and institutional practices” at both the local and wider levels (Hammersley & Atkinson, 2007, p. 3). Common ethnographic methods informed each stage of the research design, with CST providing the theoretical lens through which the data was collected, analysed and presented. Figure 5 provides a figurative summary of Carspecken’s (1996) five-stage methodology.

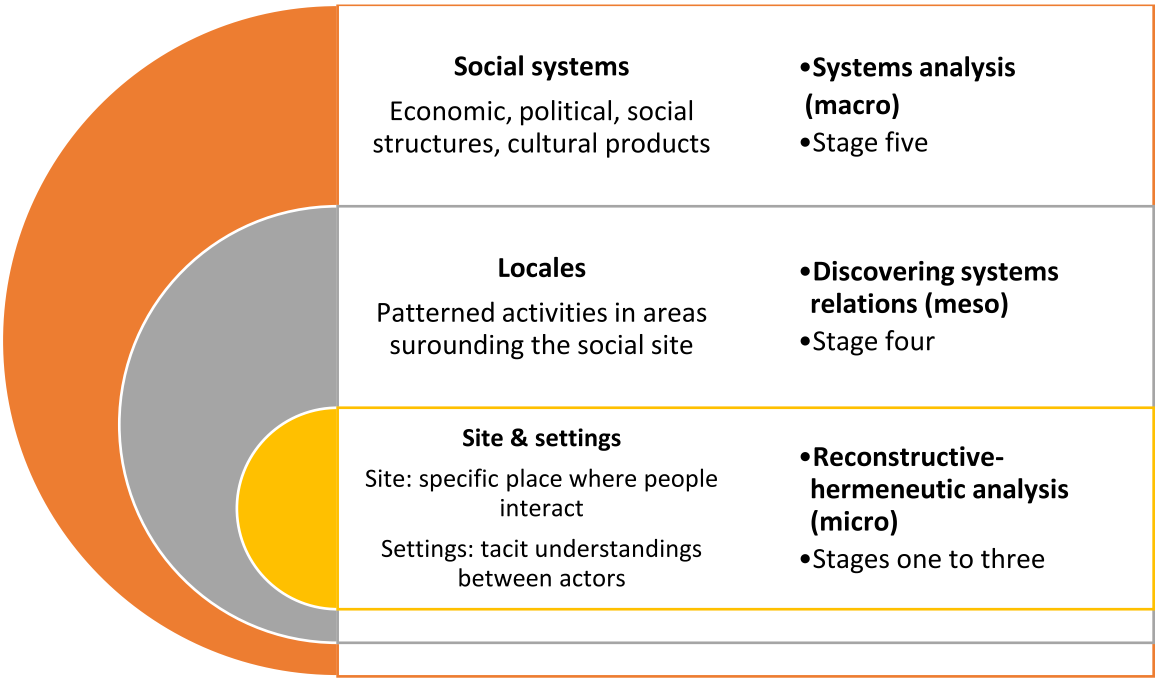


Figure 5. Carspecken's (1996) five stages of critical qualitative research enquiry

Stage one: Compiling the preliminary record

During this stage, the researcher observed interactions within the social site of enquiry to build a primary written record. Carspecken (1996) referred to the information collected at this stage as *monological* in nature as the observations are from the researcher’s perspective alone and, more specifically, from the stance of a third-person position as an uninvolved observer.

Stage one prioritised objective validity claims that were structured by multiple access to the setting. Carspecken (1996) suggested employing various strategies to support the objective claims made which included the use of: multiple recording devices and observers; a flexible observation schedule; prolonged engagement; low-inference vocabulary (to avoid normative and subjective referenced claims); peer debriefing; and member checks.

Inherent in qualitative research is the impact the act of research has on the participants, referred to as the Hawthorne effect. Carspecken (1996) minimised concerns about the Hawthorne effect by highlighting that although participants will change their actions in the presence of an observer, these changes will be made within the same cultural frameworks that they are accessing in everyday situations. Additionally, prolonged engagement in the field and member checks assist in addressing this phenomenon (Carspecken, 1996).

Stage two: Preliminary reconstructive analysis

Stage two primarily prioritised normative validity claims and, to a lesser extent, subjective claims, particularly as referenced by nonverbal communication. Carspecken (1996) detailed methods for reconstructing cultural themes and system factors not usually observable or articulated by the actors themselves. Preliminary reconstructive analysis involved initial meaning reconstruction, low-level coding and horizon analysis. As previously discussed, this analysis is considered *reconstructive* as it articulates meaning, in this case, cultural and subjective factors which are usually only experienced tacitly. Initial meaning reconstruction involved the researcher articulating holistic impressions of selected observations (Carspecken, 1996).

Carspecken (1996) advocated using the various strategies outlined in stage two in a cyclical manner. Low-level coding was used to identify both usual/recurring events and unusual events, with the purpose of informing which portions of text were selected for initial meaning reconstructive analysis. Similarly, initial meaning reconstructions, which assist in identifying biases and gaps in understanding, helped inform and lay the groundwork for horizon analysis.

During stage two, the researcher made use of the hermeneutic process as she moved between initial holistic understandings towards more explicit understandings and then back to the holistic. By articulating what Carpsecken (1996) referred to as the *meaning field,* the researcher through position-taking formulated possible objective, subjective, normative and identity claims on a continuum of foregrounded and backgrounded layers. This process provided information about identity claims, subtle meaning negotiations and tacit efforts that were occurring in order to hide concerns from others (Carspecken, 1996, p. 119). Carspecken (1996) highlighted that through the hermeneutic process, “normative inferences are based on recognition rather than observation” (p. 145).

While it was impossible to absolutely validate reconstructions of meaning fields, Carspecken (1996) proposed various techniques to strengthen support of the analysis. These included: being familiar with the culture of the subjects (through prolonged engagement); ensuring initial reconstructions were at a low level of inference; conducting member checks; and using peer debriefers (Carspecken, 1996). Additional techniques that were employed to strengthen validity included strip analysis (checking segments of the primary record against reconstructions of interest/high frequency) and negative case analysis (explanations for incidents that did not fit the identified cultural themes).

Stage three: Dialogical data generation

Stage three was concerned primarily with the subjective ontological category and is described as the stage whereby the research enquiry is democratised. Carpecken (1996) referred to this stage as dialogical data generation, as participants actively contribute to the process through participation in interviews and/or facilitated group discussions. Stage three built on the previous two stages whereby the researcher further explored, with the participants themselves, cultural themes identified during the preliminary reconstructive analysis.

Validity requirements for stage three included: consistency checks (between observed activity and what was said in discussion, as well as what was stated within an interview); repeat interviews; peer debriefers; member checks; and encouraging use of participants' own terminology.

In summary, stages one through three emphasised *social integration*, whereas stages four and five emphasised *system integration*. For this thesis, social integration involved the coordination of action that occurred face to face at the site of enquiry (the CMHC). Action that occurred at this level was, as defined by Habermas (1994, 1987), the "*lifeworld* culture, or that which is intuitively known" (Dennis et al., 2013, p. xi).

Stages four and five: Discovering system relations and using this to explain the findings

Although reconstructive analysis was the predominant means of exploring the data, in order to locate and make meaning of the findings at a macro level the results from the reconstructive analysis were considered against data from other related settings, as well as social theories. During stage four, the social site of interest – the various care planning contexts – was examined against other related sites as well as relevant cultural products. For this enquiry, other sites included local acute inpatient settings, the mental health tribunal, and relevant cultural products including relevant service documents and policies. Carspecken (1996) also suggested considering the broader cultural context, which included current opinions of individuals with a mental illness and psychiatric care (e.g. as expressed through the media).

Stage four aimed to identify systems relations between specific social sites by building on the reconstructions from stages one through three and identifying possible origins of the identified cultural typifications/themes. In order to identify the cultural themes that were present, Carspecken (1996) suggested the researcher examine the distribution, frequency and currency of cultural themes (Dennis, 2013). Thus, systems analysis commenced with participants' experience, then extended the analysis beyond the study site and cultural group (Carspecken, 1996). Stage five involved the examination of findings in relation to pre-existing social theories. This was achieved by building on stage four and linking the identified cultural themes and systems relations to existing social theories that provided an explanatory framework for the findings.

In summary, stages one to three (reconstructive-hermeneutic analysis) provided a clear and rigorous means to understand the factors impacting upon the care planning process at the relational level by identifying and articulating cultural typifications within the site of interest. Stages four and five (systems analysis) broadened the analysis and linked reconstructive analysis with existing systems theories to gain a broader understanding of issues impacting upon the care planning process and suggest ways for positive change.

> Lifeworld critique [was] facilitated by examining relations of claims to truth made [between] actors negotiate[ing] meaning … [and] system critique [was] facilitated by examining the ways consequences and effects exceed the intentions of the actors, contradict one another, or limit the potential for understanding (Dennis et al., 2013, p. xii).

Knowledge and values

Carspecken's (1996) critical ethnographic methodology clearly addresses the relationship between knowledge (facts) and values in the research process. This includes the acknowledgement that critical researchers share a value orientation – the belief that oppression is typical in contemporary culture, but that it can and should be challenged and changed through the research process. Therefore, while the researcher's value orientation is important and may drive and inform the research questions, the essential characteristics of the research methodology are epistemological (Carspecken, 1996). Thus, the value orientation of the critical ethnographer did not determine the empirical findings and outcomes of the study (Dennis et al., 2013; Kline, 2013).

Summary

In summary, Carspecken's (1996) critical ethnographic methodology has informed this research. Carspecken (1996) combined aspects of CST with ethnography to develop a rigorous framework for enquiry into the culture of interest, in this case two community mental health teams. Habermas's CST, as interpreted by Carspecken, has provided the theoretical perspective informing the methodology of this research and thereby provided a theoretical lens and method to understand the phenomena of interest (Crotty, 1998). Carspecken's (1996) critical ethnographic methodology sensitised the researcher to power imbalances and equity, and placed the enquiry within a cultural context. Care planning as an institutional practice is influenced by service culture, frameworks, policies and legislation. Carspecken's (1996) five stages for conducting critical qualitative research have informed the study design, with detailed reconstructive analysis of social interactions at the relational level allowing for broader interpretations to be made about influences at the systems level on care planning. Hermeneutic-reconstructive and systems-theoretic analyses were used in combination to understand and interpret the data at the different levels. The next chapter describes how this methodology was applied in practice to answer the research questions.

CHAPTER FOUR
METHODS

Introduction

Carspecken's (1996) five-stage framework for critical qualitative research draws primarily on ethnographic methods. The previous chapter focused on Carspecken's (1996) interpretation and application of CST, which has provided the theoretical lens to the study. This chapter clarifies the relationship between Carspecken's (1996) methodology and the methods applied to generate data to answer the thesis research questions. The chapter begins with a discussion of concepts central to the methods and rigour of an ethnographic study, namely, the centrality of participant observation and the related concept of researcher reflexivity. Additionally, ethical considerations that ensured ethical conduct was maintained throughout the study are presented. The latter part of the chapter details the application of Carspecken's (1996) five-stage research framework as it was applied to this study, with illustrations of the different stages presented and discussed.

To locate myself as the researcher, I use first-person language at different stages in this chapter.

Application of ethnographic methods

This thesis has sought to understand the culture of care planning for individuals on CTOs within a public community mental health care setting. Ethnography is the study of culture, with extended participant observation a common core feature. Participant observation requires the researcher to immerse themselves in the field and thereby "use the culture of the setting (the socially acquired and shared knowledge available to the participants or members of the setting) to account for the observed patterns of human activity" (Van Maanen, 1979, p. 38). Ethnography draws on data from a range of sources, with commonly used ethnographic methods applied to this thesis during all stages of data collection, analysis and presentation of findings. Culture is understood, or learnt, by individuals making cultural inferences through observation of others' behaviour, observation of the use of cultural artefacts and listening to what is said (Spradley, 1980). In this research, extended time in the field enabled the researcher to observe and study many different interactions related to care planning and thereby develop an in-depth understanding of the process in situ. In addition to studying people's actions and accounts through participant observation and interviews, relevant cultural artefacts were examined, which included the service model and operational plan, service reviews and mental health policy and legislation.

Ethnographic analysis emphasises the centrality of the "interpretation of the meanings, functions and consequences of human actions and institutional practices" (Hammersley & Atkinson, 2007, p. 3). In this thesis, Carspecken's (1996) interpretation of CST has provided the theoretical lens for the analysis and presentation of the findings. Furthermore, ethnography and Carspecken's (1996) framework are relevant to the implications of the thesis findings both locally and more broadly. Regarding the presentation of findings, although Carspecken (1996) did not discuss this in detail, his analytical framework serves as a guide for this process. In an earlier text, *Writing Culture*, Marcus (1986) discussed the presentation of findings that situate the ethnographic study within macro-level theories (as is done in Carspecken's methodology) and defined the construction of the ethnographic text as:

> the crucible for integrating the macro into the micro, combining accounts of impersonal systems into representations of local life as cultural forms both autonomous and constituted by the larger order … [with the role and challenge of the ethnographer to] … construct the text around a strategically selected locale, treating the system as a background, albeit without losing sight of the fact that it is integrally constitutive of cultural life within the bounded subject matter (Marcus, 1986, pp. 170–172).

Increasingly, ethnography is being viewed as a useful way to understand the complex scenarios that often arise in health care (Pilgrim, 2009). Ethnography allows for the in-depth exploration of care delivery, practices, approaches and experiences from the multiple perspectives of patients, carers and clinicians (Reeves, Kuper & Hodges, 2008). Ethnographic studies commonly focus on a single setting or group of people, with the focus of this thesis an in-depth exploration of care planning at one location. In this thesis, ethnography has provided the means to investigate the "polyvalent concepts" of both recovery and risk, as conceptualised in policy and understood among different professional groups, consumers and carers (Pilgrim, 2009). As ethnographic researchers are required to immerse themselves in the field and become a part of the study context (Van Maanen, 1979), the researcher's position and reflexivity, two related and important concepts, require elaboration.

Locating the researcher- "Insider" and "Outsider"

Locating the researcher refers to the positioning and involvement of the researcher in relation to the study participants and study setting. Researcher positioning is most typically defined as the researcher being either an *insider* (taking an emic position) or *outsider* (taking an etic position). An alternative description is that of *membership type*. Interestingly, in earlier ethnographic studies it was assumed that seeing and understanding primarily arose from being an outsider, whereby being less familiar with a social situation, or culture, was considered to make it easier to identify tacit cultural rules and meanings (Spradley, 1980; Van Maanen, 1979). Over the years, however, it has become increasingly common for researchers to study their own culture. Benefits, as well as risks, of studying a culture with which the researcher is already familiar will be further elaborated below.

In practice, researcher positioning is usually complex and nuanced, and the typologies *insider* and *outsider* and *membership type* are presented with various gradations. Banks (1998), for example, proposed a typology of cross-cultural researchers that included: indigenous-insider; indigenous-outsider; external-insider and external-outsider. Similarly, Adler and Adler (1987) detailed a continuum of ethnographic field research involvement which identified the researcher as being a peripheral, active or complete member of the group. Certainly, in any specific social context individuals will have multiple group affiliations and social positions impacting upon their behaviour and perspectives, which contributes to the fluidity on the part of the researcher who, depending on the context, may be both an insider and outsider (Acker, 2001; Banks, 1998)

Perhaps, therefore, it is more useful to consider any typology as "a heuristic guide, with plenty of allowances for work at the borders" (Acker, 2001, p. 9). Dwyer and Buckle (2009), for example, challenged "the dichotomy of insider versus outsider status" and conceptualised the researcher position as occupying "the space between" (p. 60). In this thesis, although the researcher was an insider to the culture at study inception, an ethnographic study constantly challenges the researcher to simultaneously identify with and maintain distance from the phenomenon of enquiry (Van Maanen, 1979). This challenge is aptly described by Hammersley and Atkinson in the following quote:

> [T]he essence of ethnography is the tension between trying to understand people's perspectives from the inside while also viewing them and their behaviour more distantly, in ways that may be alien (and perhaps even objectionable) to them (Hammersley & Atkinson, 2007, p. 11).

The degree of researcher involvement, which is not dependent on being an insider or outsider, can be linked to participation type, with the highest level of involvement experienced by the complete participant (Spradley, 1980) (see Table 2).

Table 2. Types of researcher participation (Spradley, 1980, p. 58)

DEGREE OF INVOLVEMENT	TYPE OF PARTICIPATION
High	Complete
	Active
	Moderate
Low	Passive
(No involvement)	Non-participation

In this thesis, as the researcher, at the outset of the study and during data collection I was employed as an occupational therapist (OT) at the study site. Thus, as an ordinary group member, I was a complete participant at the outset of the research process. The aim, however, was to minimise my involvement to that of passive participant, particularly during the observation stage. This meant informing participants when I was taking the role of researcher rather than clinician and thereby observing rather than partaking in care planning discussions. In later stages, when conducting interviews and focus groups I was required to be more active through the process of engaging in and facilitating dialogue, although I still aimed to maintain as neutral a stance as possible to the themes being discussed. The purpose of this was to encourage others to feel comfortable to elucidate their viewpoints, as well as to remain open to views that differed to my own. On occasion, later in the research process, I did resume the role of complete participant. This occurred when it was felt that to not engage in dialogue relating to a consumer's care would be unethical. Two examples of this are: advocating for a young woman with a history of trauma to be seen by a female doctor during a clinical review meeting; and requesting a newly allocated care coordinator to provide a family who had participated in the interviews with information regarding non-government support options.

In summary, my position in the broad sense, and more specifically in relation to the clinician sub-group, was predominantly that of an insider, with my participation level assumed during the research process moving between passive and active participant. Interestingly, there was no significant difference noted in my communication with clinicians from different professional backgrounds during the interviews or focus groups. It was more challenging to identify my position with consumers and carers. Although I was an outsider to this sub-group, I was likely viewed by consumers and carers as an insider to the professional sub-group. In this space, while actively engaging in dialogue, I aimed to be genuinely inquisitive, neutral and empathic to facilitate trust. It was important to create a space where consumers and carers felt safe to critique current service practices.

> Should qualitative researchers be members of the population they are studying, or should they not? (Dwyer & Buckle, 2009, p. 54).

This is an important question and arguments have been put forward advocating both the strengths and weaknesses of the insider and outsider positions. Benefits of being an insider may include easy access to the field, enhanced understanding from unique insights of the cultural group from prior socialisation (Banks, 1998) and openness from participants (Adler & Adler, 1987). Furthermore, complete membership, and the subsequent knowledge and expertise, can be potentially beneficial in identifying relevant topics of enquiry (Adler & Adler, 1987). Disadvantages of being an insider include the possibility of being reluctant to criticise typical practices (Acker, 2001) and pressure to present the group favourably (Adler & Adler, 1987). Additionally, being closely aligned with a specific group in any setting may limit access to the perspectives of other groups within the setting and challenge the researcher to create a researcher role in a setting in which they are already known (Adler & Adler, 1987). Related to this, the complete member researcher is exposed to the possibility of role conflict, whereby the researcher may experience themselves as more separate from members due to their research interest and focus (Adler & Adler, 1987).

The researcher’s positioning, as an insider or outsider, can be linked to values (Banks, 1998). Insiders are generally perceived to share the same knowledge, values and beliefs, or have alliances to subgroups of the community being studied. An insider, therefore, may be bound by loyalties to the group, challenging their objectivity and resulting in findings that support and promote the dominant values, knowledge and practices of the community. Thus, there is the potential for the researcher to unintentionally promote existing power distortions. To address these issues, Carspecken (1996) encouraged an exploration of the researcher’s own values and beliefs, and the possible impact of these on the study, at the outset and throughout the research process.

At the completion of data collection, as the researcher I needed to transition back to being a clinician (only) within the setting. Adler and Adler (1987) highlighted that when the researcher is already a member of the group, their pre-existing role changes significantly during the research process, with a transitional process of disengagement required when leaving the field. As data collection occurred over an extended period of 18 months and I continued with usual work duties while conducting the research, there was no abrupt disengagement from the field that many ethnographers are required to manage (Hammersley & Atkinson, 2007). Furthermore, Carspecken’s (1996) methods include analysis alongside data collection, which also meant that in practice the process was more iterative and fluid than staged.

In summary, the two main concepts that were relevant to locating the researcher at any time within the research process were: researcher position and participation type. In this thesis, I was predominantly an insider to the culture, or complete member, which as discussed above can be “both an aid and a hindrance to researchers*”* (Adler & Adler, 1987, p. 77). In practice, being an insider appeared to have more benefits than disadvantages during the research process. The main challenge was related to participation type whereby the change in my participation (or role), from that of complete participant as a member of the treating team to the role of researcher, and moving between passive and active participant, needed to be navigated and monitored. Thus, my role within the study setting was continuously considered throughout this project through the process of reflexivity. This included locating myself (as the researcher) at different points in the research process and exploring the potential impact of my positioning and values on data collection, analysis and presentation of the findings. The next section discusses the closely related concept of reflexivity which facilitated this process.

Reflexivity

Reflexivity is important to all qualitative research as it acknowledges the influence of the researcher’s own culture, and self, on the research process:

> The concept of reflexivity acknowledges that the orientations of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them (Hammersley & Atkinson, 2007, p. 15).

Recognition and acknowledgement of the influence of researchers’ values on all stages of the research process was identified by the Chicago School (Blumer, 1984) and brought to the fore in the 1960s and 1970s by the postmodern, women’s and ethnic studies movements, which challenged the neutrality of the social sciences (Banks, 1998). Although pure objectivity was considered unobtainable in social science research, objectivity was still considered the ideal (Banks, 1998). Thus, to get closer to this ideal and thereby increase the rigour of the research, understanding the influence of the researcher on the research process was required. This process, known as reflexivity, is a central element to all social research, including ethnography (Hammersley & Atkinson, 2007).

In practice, reflexivity was an ongoing process of being aware, critical of and reflecting on the impact of my own biases throughout the research. This meant acknowledging the potential impact of my age, gender, values, previous experiences and usual clinical role in my relations with others. Feedback that I received from my supervisors was that over time I increasingly took on the perspective of researcher, rather than clinician, when discussing and analysing data. As an insider, it was certainly initially challenging to see the data in ways that were different to my usual experience as a clinician. This process is described well in the following quote:

> Reflexivity can be seen as opening the way to a more radical consciousness of self in facing the political dimensions of fieldwork and constructing knowledge … Reflexivity becomes a continuing mode of self-analysis and political awareness (Callaway, 1992).

To increase understandings of the culture under enquiry, the ethnographic researcher is encouraged to view themselves as a research instrument and become increasingly introspective (Spradley, 1980). Researcher reflexivity, also termed ethnographic ethic (Altheide & Johnson, 2011), is promoted throughout all stages of the research process (Altheide & Johnson, 2011; Carspecken, 1996). In addition to locating the researcher, this meant providing narrative evidence of the entire research process, including problems and solutions experienced during all stages of data collection, analysis and interpretation (Altheide & Johnson, 2011).

Various methods are suggested to help the researcher to identify their own biases, both prior to commencing and throughout the study (Carspecken, 1996). In this research, dialogue between myself and my PhD supervisors assisted me to determine my own value orientations and biases. As an OT I believe that occupation is a health determinant and value the role of engagement in meaningful activity as integral to a person's recovery. Additionally, having worked in UK settings prior to the introduction of CTOs, I was somewhat critical of CTO use. Additional methods that I used to facilitate reflexivity throughout the project included maintaining a subjective journal, undergoing regular peer debriefing with supervisors, conducting member checks and presenting strips of data coding and analysis in the thesis. These processes, which are detailed further in the stages below, allowed for ongoing reflexive practice throughout the collection, analysis and presentation of the research data.

Ethical considerations

Ethics approval was sought and granted from the Central Adelaide Local Health Network (CALHN) Human Research Ethics Committee and the Social and Behavioural Research Ethics Committee at Flinders University. The ethics application was informed by the *National Statement on Ethical Conduct in Human Research* (2007) (National Health and Medical Research Council, 2007), which outlines issues relating to access, recruitment, risk, risk management, confidentiality and consent. In brief, the ethics process required the researcher to demonstrate "the values of respect, research merit and integrity, justice, and beneficence" of the research (NHMRC, 2007, p. 9). See Appendices E, F and G for the ethics application, letters of consent, and participant information and consent forms.

As the research has sought to obtain individuals' perspectives on, and experiences of, usual practice relating to care planning for individuals on CTOs in community mental health services, it was assessed to be low and negligible risk research, which is described as "research in which the only foreseeable risk is one of discomfort" (NHMRC, 2007, p. 13). Minimal risk to all participants was anticipated due to the voluntary nature of participants' contribution to the research and the nature of the questions. Furthermore, it was considered that participants might experience some benefit from their involvement in the project; for example, in previous research people who had received treatment under a CTO were found to value the opportunity to talk about this experience (Russo & Wallcraft, 2011). For mental health clinicians whose actions and processes were observed, as well as for those who were interviewed, participation could provide an opportunity to be reflective about their role and the CTO process generally.

In practice, various situations arose during the phase of data collection that illustrate how the study promoted reflection among clinicians. Some clinicians specifically commented during individual interviews that the interview allowed them the opportunity to reflect on the issue of CTO usage and specifically their practice in relation to this. It was particularly evident during the focus groups held with clinicians that differing staff opinions and experiences prompted reflection in situ. Following one of these groups, a junior doctor spoke about subsequently initiating a conversation with a consumer she was seeing who was on a CTO, to explore early termination of the order. Several clinicians also proceeded to present the researcher with various news articles relevant to the research theme after their involvement in data collection.

Ethics ensures that there are procedures in place to protect participants. If, for example, a participant became distressed during an interview or focus group, they would be asked if they wished to terminate the interview/focus group and offered appropriate support (linking with care coordinators or the team duty worker for consumers, state/national telephone support numbers for carers and employment assistance program for clinicians). This situation did not arise at any point during the research process.

As mentioned, during data collection I was a member of one of the integrated community teams located at the site. Therefore, none of the staff members with whom I had supervisory relationships and responsibilities for were recruited in order to prevent any of these staff feeling coerced into participating. Additionally, none of the consumers with whom I had care coordination responsibilities or had been involved with directly in my clinical role as an OT were asked to participate, to avoid potential perceived coercion. Potential biases resulting from being a member of the team were addressed and resolved through regular PhD supervision.

Any potential risks to my safety was assessed and managed by utilising existing team practices. Participants were given the choice between meeting at the CMHC or a location of their choice. When interviewing participants away from the office site, I used the usual service safety protocols, which included the electronic in/out board and vehicle booking system. This system both located me and provided an expected return time. If recent clinical risk assessments (recorded in the electronic recordkeeping system) indicated any potential issues regarding risk to others, the opinion of care coordinators or treating doctors was sought and the interview was conducted either on site at the mental health centre or in a public setting of the participant’s choosing. With consumer participants, this included a public park and café. Carer participants selected to meet at the site, their own home and an office at the university. Staff participants chose between meeting on site or at a local café.

Information sheets detailing the project were provided to all participants and signed consent forms were obtained for all those participating in interviews. Verbal consent was obtained for observation of team meetings (such as clinical reviews), as well as doctor’s appointments, with the requirement that I clarify the purpose of my attendance at each meeting. Verbal re-consent was gained from participants at all subsequent interactions to allow for continued consent, as well as to provide the opportunity for participants to opt out of the process at any stage should they wish.

Participants were informed that all information would be de-identified to maximise confidentiality. Additionally, consumer participants were informed that in the possible scenario where there were concerns for their safety or the safety of another person, or if there was any suggestion of professional malpractice, these concerns would be need to be discussed with the participant themselves and their medical team. On one occasion, information regarding a consumer’s delusional beliefs about their care coordinator which were extremely distressing to them was shared with the care coordinator and clinical coordinator. A brief entry was made in the medical notes detailing the content of the conversation; however, it was decided that it was not in the best interest for this to be disclosed to the consumer, as the therapeutic relationship had already irreparably broken down and the consumer’s relationship with services was already conflictual. Instead a new care coordinator was allocated in an attempt to improve relations. I am aware that this process could be viewed as an example of an imbalance in power relations whereby the consumer participant was excluded from some of the decision-making process. This situation highlights some of the challenges around engagement that present on a day-to-day basis in clinical practice.

In the case of participating clinicians, it was explained that, as the research would have a relatively small participant sample, it may be possible that some people could be identified by other team members. When this was likely, identifiers by professional group were modified in the data to the more generic role of allied health clinician. In the case that poor practice was observed, given mandatory reporting requirements as a practising health professional relating to this, it was decided that if any concerns arose, this was to be explored in the first instance with the relevant team manager. This was not needed over the duration of the research process.

Setting and access

The study site for the project was a CMHC located in suburban Adelaide where two adult community mental health teams were co-located.

The issue of access to the field in an ethnographic study can be problematic and involves various ethical considerations including: permission to conduct the study; provision of information about the study to participants; and issues related to consent (Hammersley & Atkinson, 2007). Access therefore can be viewed at two levels: initial access to the site; and ongoing access and engagement with participants. For this study, initial access involved seeking formal ethics approval (as discussed) and gaining permission to conduct the study from senior mental health service staff who would not be directly involved in the study. To facilitate this, permission was sought from the Clinical Director and Clinical Co-Director. Support was readily gained at this level from both individuals, with the Clinical Director agreeing with the importance of the enquiry and contributing various ideas around recruitment that were included in the ethics application. Following executive-level approval, verbal and written information (the research proposal) about the project was given to the sector manager, both team managers and clinical leads at the CMHC. Support from senior staff at the research site was crucial to progressing data collection.

The second level of access involved actual entry to the field and recruitment of participants. Hammersley and Atkinson (2007) identified access as being much more than simply gaining approval to conduct the study and discuss various complications that can arise when approaching the field. Being an insider to the team facilitated both levels of access. These processes are discussed in more detail in the following section.

Participants

Consumers

Selection criteria

Individuals who were on a current CTO who had capacity to provide consent were recruited. A person has capacity to give informed consent to a decision if they understand the information that is given to them about the decision, can remember the information, can use and weigh the information and can communicate the decision. The issue of consent is somewhat contested as individuals who are on CTOs are all living in the community, with varying degrees of support, and therefore make decisions about their own life on a day-to-day basis. In reality, the issue of capacity to consent very rarely came up, with only one doctor declining to approach those individuals he was working with who were currently on CTOs due to his view that they were not “well” enough to participate at the time of data collection. There may, however, have been other clinicians who did not suggest any potential consumer participants for similar reasons of which I was unaware.

Recruitment

Recruitment occurred through care coordinators or doctors, who approached individuals with information about the project regarding participation. As per the selection criteria, care coordinators were asked to approach those consumers on CTOs whom they considered had the capacity to provide consent for participation. Consumers considered unable to provide consent were not included. While being on a CTO did not in itself exclude the person from competence to participate in the project, the opinion of care coordinators and treating doctors was sought as those most likely to understand the person’s current mental state and therefore their capacity to participate and provide consent, as well as any possible risks involved with their participation. Many clinicians offered to look over their client list in my presence to help identify possible consumer participants. To further reduce bias in consumer participant recruitment, permission was sought and granted to identify all consumers on CTOs at the site by accessing the service electronic mental health records reports that listed current consumers on CTOs (n=92). This meant that I was able to approach clinicians directly working with individuals on CTOs to discuss possible recruitment. In practice, I was introduced to potential consumer participants through attendance at multidisciplinary care meetings and during face-to-face contacts (appointments with doctors). Many consumer participants were recruited for the second stage of the study (observation of care journeys and interviews) following the first stage involving observations of care contacts and discussions. Additionally, after some months of data collection, several doctors would approach me to let me know when they were meeting with a consumer who was on a CTO. Recruitment of consumer participants was clearly facilitated through face-to-face contact during these appointments.

To further assist in recruitment, I met with the Coordinator of the Lived Experience Workforce Program to provide information about the project and to seek their support in recruitment of consumers and carers. Consumer participants were offered a $30 gift voucher to compensate them for their time and travel. This was funded via Higher Degree student research maintenance funds.

Carers

Selection criteria

For the purpose of this study, carers were defined as individuals who provided care and support to a family member or friend who in this instance had a mental illness. Caring roles and activities are broad and may include assistance with a variety of daily living activities and providing emotional, social and financial support (Carers Australia, n.d).

Recruitment

Carers were recruited via various methods. In the first instance, consumer participants were asked to nominate a family member/or carer whom they considered provided them with emotional and/or practical support. Care coordinators were then asked to approach those nominated carers and provide them with the information sheet and consent form. If carers agreed to participate, the plan was for the researcher to make contact by phone to set up a time for interview. In practice, the recruitment of carers varied a little to this description. I met some of the carers at the same time as the consumer participants (e.g. when attending outpatient appointments with doctors). In this case, with the consumer participant’s agreement, I approached carers directly, by phone or face to face, and in some instances consumer participants approached their family members themselves and told them about the project. Several consumer participants did not want their family members contacted or did not have anyone whom they identified as having a caring or supportive role. As there were fewer carer participants recruited via the above means, further carer participants were recruited independently via care coordinators and through the local carer forum. In this instance, carers were not related to consumer participants.

Mental health clinicians

Selection criteria

All clinicians working at the centre with care coordination responsibilities, including nurses, OTs, social workers, psychologists and treating doctors, as well as those who had input into clinical reviews and care planning (team managers and clinical coordinators), were potential participants.

There were two teams co-located at the community mental health centre, with a pool of approximately 70 clinical staff (full-time equivalent).

Recruitment

Information about the project purpose and aims was presented to the clinical staff at several team meetings. The first stage of data collection involved participant observation, so it was important that the focus and purpose of the observational component of data collection were understood, particularly as I required clinicians to assist in approaching potential consumer participants. As an additional non-obtrusive prompt, my research project title was added to the minutes of the morning handover meeting that was held daily for both teams. This prompt remained in place for at least six weeks. Interest in the project among clinicians was observed to increase over time. This was partly a consequence of my confidence as a researcher in the clinical setting gradually developing and subsequently raising the research project purpose with a broad range of clinical staff. Initial interest came from my colleagues who were seated close to me in the office area, as well as those that had an interest in research or had previously partaken in research and/or further tertiary education. On direct approach, most clinicians were very open to participating and supporting data collection, with some clinicians remaining more wary. Following the observation stage, all clinicians who were working at the site were invited to participate in focus groups where early findings were presented and discussed. By this stage there was significant interest among a growing number of clinical staff, with two focus groups requested to discuss early data.

Carspecken’s five-stage research design

Stage one: Compiling the primary record

Compiling the primary record, or “thick” record, required extended participant observation and detailed recording of what was observed through the taking of field notes.

Participant observation

In ethnographic studies of organisations, “patterns of interest” are usually those activities where people “do things together in observable and repeated ways” (Van Maanen, 1979, p. 38). As this study focused on care planning with consumers on CTOs, this required identification of the various contexts where care planning occurred most frequently, both between clinicians and with consumers and their carers. As I was already working at the study locale, and therefore familiar with the sites and settings relevant to care planning, the process of identifying as well as accessing relevant settings for data collection was expedited. The various care planning contexts included clinical review meetings attended by clinicians, meetings between clinicians, consumers and their carers (usually in the context of the outpatient doctor’s appointment) and informal discussions between clinicians. During the observation stage, the participant observer needs to learn to become explicitly aware of that what is typically only known tacitly by participants and to develop a wide-angle lens to gather information (Spradley, 1980). Carspecken (1996) recommended that during this stage of data collection the researcher should be a passive observer and commence as unobtrusively as possible.

As I was already a member of the clinical team, this meant alerting colleagues at the outset of clinical review meetings, or outpatient review meetings, that the role being taken was that of researcher, and therefore observer, rather than clinician and active participant in the discussion, as would typically have been the case. This was more straightforward in the clinical review meetings as they were typically attended by at least six staff members. The outpatient appointments were smaller, with sometimes only the doctor and consumer present, and at other times with the presence of a family member and/or care coordinator. In these settings, I was a moderate participant (Spradley, 1980), as it was important to maintain rapport within the setting and to observe without any contribution would have gone against typical social norms.

Field notes

Constructing a valid and accurate account when compiling the primary record was important, as further analysis was based on this early data (Carspecken, 1996; Van Maanen, 1979). Early data is first-order concepts, “the ‘facts’ of an ethnographic investigation” (Van Maanen, 1979, p. 38). Typical ethnographic methods were utilised for data collection during the observation stage (such as those described by Spradley (1980)). This included recording details about the context including noting of time, participants’ speech acts, body movements and postures, and use of a low-inference vocabulary, whereby facts were presented without judgement or interpretation (further detailed below) (Carspecken, 1996). To further increase rigour, Carspecken (1996) encouraged a flexible observation schedule to limit any unnoticed biases. In practice, this meant that I observed multiple clinical review meetings and doctors’ outpatient appointments across both teams, which allowed for the opportunity to observe most clinicians working at the site in various groupings.

To capture first-order concepts, Spradley (1980) suggested applying three principles to avoid prematurely condensing what is being observed and writing in what is referred to as the amalgamated language of the ethnographer. The first principle involves identification of the speaker and therefore “the language used for each field note entry” by bracketing or using parentheses for each individual speaker (p. 66). The second principle requires the ethnographer to record verbatim what people say and the third principle involves “describing observations us[ing] concrete language*”* rather than generalities (p. 68). These three principles were applied to produce thick data and reduce the likelihood of the cultural meanings being distorted in the process of recording the observations.

Notebooks were used for this stage of data collection, with the thick data typed into Word documents for later review and analysis. In the first instance, I attempted to document the thick record during actual observations to provide as much detail as was possible (as recommended by Carspecken (1996)). When this was not possible, a condensed account was recorded in situ and then expanded upon as soon as possible after the event (as recommended by Spradley (1980)). The latter technique was also utilised to record the not-so-thick data. When normative or subjective inferences were made, these were written in terms such as “it seems” or “appears to be”, with the code “OC” used to reference observer comments.

In addition to the field notes, which were the ethnographic record of what was being observed, I also kept a fieldwork journal. Ethnographers typically maintain a journal to record “experiences, ideas, fears, mistakes, confusions, breakthroughs, and problems that arise during fieldwork” (Spradley, 1980, p. 71). The fieldwork journal was kept throughout all stages of data collection and was a large part of the ongoing reflexive process, as it was used to assist in identification of my own biases, values and subsequent influences on the research process (Spradley, 1980). Occasionally I would present segments of the fieldwork journal for discussion in supervision. Several excerpts from my fieldwork journal are provided below as illustrations of the reflexive process, with further examples provided in Appendix H.

29/12/2018
After listening to a few podcasts on the topic of coercive care, I realise that I am becoming more aware of the broader discourse around coercive care and how this is enacted in day-to-day clinical practice.

19/01/2018
I’ve just sent out an email to all staff inviting them to participate in a focus group to discuss early data. I’m just noticing how nervous I feel about presenting early findings. What will they think of it? Will they feel criticised? Will this impact on future and ongoing participation? Will they think the data and research is irrelevant?

15/02/2018
The focus group went well today and in the end we had a lively discussion. Several staff who were unable to attend approached me to see if we could arrange an alternate time to get together. There did not seem to be any surprises for staff in the data that was presented and it seemed to provide a space for people to reflect on practices and problems around CTO use.

At the completion of stage one, thick (detailed) records were produced of multidisciplinary clinical review meetings and outpatient appointments with doctors, consumers and care coordinators. These meetings involved care planning discussions between clinicians, both with and without the presence of consumers and their family members. Not-so thick records were made of other related activities, including the morning handover meeting (where work was allocated) and informal conversations. This primary record provided the basis for the next stage of the research process: Preliminary reconstructive analysis.

Stage two: Preliminary reconstructive analysis

The second stage, preliminary reconstructive analysis, involved three procedures: initial meaning reconstruction; low-level coding; and validity horizon analysis. Each of these processes informed the others and were also used throughout the third stage to both analyse data generated from individual interviews and check that analyses at the observational and interview stages matched. The overall aim of this early analysis stage was to begin to speculate about and identify possible normative themes that were only tacitly referenced by participants (Carspecken, 1996). In reality, stages one and two occurred concurrently. Details of each of the analyses are presented below.

Initial meaning reconstruction

The purpose of articulating initial meaning reconstructions included making explicit the researcher's early impressions of meaning and informing validity horizon reconstructions (Carspecken, 1996). Both initial meaning reconstruction and validity horizon analysis involved the application of hermeneutics, the theory of which was discussed in detail in the previous chapter. In practice, to construct initial meaning reconstructions the hermeneutic process required me to articulate possible meanings by *"*mov[ing] from the tacit (intuitive and undifferentiated) toward the explicit (delineated and differentiated), and then back to the holistic*"* (Carspecken, 1996, p. 95). At the stage of initial meaning reconstruction, I articulated possible meanings that others in the setting may have been inferring, overtly or tacitly (Carspecken, 1996). To achieve this, the primary record was read to identify possible patterns and unusual events, with possible meanings then entered alongside the text. The code MF (meaning field) was recorded within the text to identify these initial meaning reconstructions.

Although initial meaning reconstructions could not be absolutely validated, my familiarity with the setting, peer debriefing, member checks and regular discussions with supervisors all enhanced validity. Feedback from these processes also promoted reflexivity, as it facilitated discussions of my possible bias. Initial meaning reconstructions were done in conjunction with low-level coding, which assisted in identifying commonly occurring as well as less usual events. It was noted that over time and through the above processes, I was able to become more of an observer than participant and to become increasingly sensitive to more tacit meanings evident in communication that were previously unnoticed.

Low-level coding

Low-level coding remains very close to the primary record with minimal abstraction, resulting in codes that predominantly reference objective features that would be open to multiple access (Carspecken, 1996). Early codes were allocated against the preliminary record, both before and after initial meaning reconstructions. Below in Table 3 is an example of initial meaning reconstructions and low-level coding from an excerpt of an observation of a doctor's appointment. Field note entries have also been added.

Table 3. Example of early data analysis

TRANSCRIPT	LOW-LEVEL CODING
Excerpt 1	
Jim: I'm looking to getting my drivers licence back. There's people on the bus and I like that. I don't like being alone.	Consumer goal
Doctor: Do you take your phone on the bus?	
Jim: Yep.	
Doctor: So driving is boring, you can't look at your phone while you're driving.	Minimising/patronising/ doctor as the expert
[OC: It seems that the doctor is minimising the problem Jim is raising about his licence being suspended, though it is done with humour and rapport is maintained, it could be viewed as patronising or making light of/or the best of a situation that Jim can do nothing about at present.]	
Excerpt 2	
Doctor: How's your mood been?	
Jim: I'm happy if I'm around people, and sad if I'm on my own. The fact that I have to take medication is a bit saddening too, to be honest. I just hope I don't get any side effects.	Consumer experience/side effects
Doctor: I'm putting a lot of faith in you putting you on orals.	
Jim: The sodium valproate is a bit high.	Minimising consumer experience, expectation to follow advice/ lack of trust
Doctor: I need you to get a blood test.	
Jim: There won't be any trace in my blood as I haven't taken it for some time.	Honesty/transparency
Doctor: You need to restart it.	Lack of shared decision-making
[MF: I'm not expecting you to be compliant with medication. I'm giving you a chance and you need to take it up.]	
[OC: The doctor was smiling and easygoing when he said this to Jim. It seemed that engagement was superficial and that this was a missed opportunity to engage further in discussion about pros and cons of medication.]	

Both low-level and higher level coding link to the reconstructive process (Carspecken, 1996). Low-level coding assisted in the identification of commonly occurring and usual events, which were then selected for validity horizon analyses. Higher level coding was undertaken after several validity horizon analyses were articulated and involved increased abstraction based upon these analyses (Carspecken, 1996).

Validity horizon analysis

The epistemology of validity horizon analysis was discussed in the previous chapter. This section therefore details the specific process of analysis. To conduct validity horizon analysis, I was required to position-take in order to articulate truth claims that were objective (open to multiple access), subjective (subject to privileged access) and normative (structured by tacit position-taking). The interpretation informing validity horizon analyses was hermeneutic and allowed me, as the researcher, to locate the claims as being more immediately referenced (foregrounded) or more remotely referenced (backgrounded) (Carspecken, 1996). Validity horizon analyses thus provided a more detailed and precise meaning reconstruction by articulating impressions through language (Carspecken, 1996). In addition to developing an in-depth understanding of setting negotiations (communication between actors), Carspecken (1996) highlighted how implicit (or tacit) theories may also become evident through this process.

Below in Table 4 is an example of a validity horizon analysis developed from the initial meaning reconstruction and low-level coding as presented above. This process helped capture the conflicting clinician views (some of which are presented in parentheses), as well as to begin to understand cultural themes that were only tacitly referenced.

Table 4. Example of validity horizon analysis

POSSIBLE OBJECTIVE CLAIMS	POSSIBLE SUBJECTIVE CLAIMS	POSSIBLE NORMATIVE-EVALUATIVE CLAIMS
Most foregrounded Nicola is not likely to continue taking medication. Non-compliance and drug taking will result in a relapse/deterioration in her mental state. Renewal of the CTO is required to ensure treatment.	**Most foregrounded** I'm fed up. The doctor and I attempted to engage but it is not leading to treatment adherence. I've exhausted all options around engagement with services. We need to offer more assertive case management. We either take responsibility and control, and apply for a CTO, or take a laissez-faire approach and give back control to Nicola.	**Most foregrounded** She's making the wrong/poor choices.
Less foregrounded Drug use is driving the problems.	**Less foregrounded** She's not taking any responsibility and she is going to stop taking medication.	**Less foregrounded** The service/system needs to be flexible (doctor).

A more coercive stance needs to be taken.	Nicola should engage in what has been offered by mental health services (NGO supports, therapy groups). I have attempted to work with Nicola by changing her depot to orals while she is on a CTO and prescribing in dialogue with her.	Care coordination needs to be more assertive (doctor). Everything that could be done has been done (care coordinator).
Background/remote There is poor engagement with mental health services.	**Background/remote** We need to more assertively engage with Nicola (doctor). Drug-driven behaviour is frustrating and not what we should be focused on. The consumer has a choice to engage and improve her life.	**Background/remote** The expectation is that consumers engage with services: Consumers need to engage with our services. She’s being a ‘bad’ patient.

Stage three: Dialogical data generation

Stage three involved actively conversing with the participants through interviews, group discussions and focus groups. This stage was commenced after I had performed preliminary reconstructive analysis on the primary record. Interviews and discussion groups were a means to democratise the research process and provided me with the opportunity to clarify cultural themes that had been identified from early analyses (Carspecken, 1996). There is significant literature on how to conduct qualitative and ethnographic interviews (e.g. Spradley, 1979). In general, the process can be conceptualised as: interviewer questions; interviewer responses; and data analysis (Carspecken, 1996).

Focus groups

Prior to the interviews, a summary of findings from the first stage of data collection was presented to two lived-experience advisers and two focus groups of clinicians who were working at the site (n=3 and n=6) (Appendix I). The early findings, feedback on these (member checking) and discussions of early analysis in supervision meetings informed the themes to be further explored during interviews. Data from the clinician focus groups were analysed and incorporated into the larger body of data. The lived-experience advisers reviewed the interview schedule that was developed through this process.

Interviews

Interviewer questions

An interview protocol was developed based on the research questions and early findings from the preliminary data analysis. Broad themes explored in the interviews included: insight/capacity/understanding; risk; shared decision-making; engagement; and trauma. The inclusion of trauma came from the feedback process as described above, whereby both groups raised this as a potential issue for all participant groups. Separate interview schedules that covered these themes were developed for each participant group (Appendix I).

Interviews were semi-structured and typically lasted between 20 and 60 minutes. Most interviews were transcribed verbatim and entered into NVivo 11 to assist with coding. Two participants (one clinician and one carer) did not want the interview recorded, so extensive notes were written in each case. As previously mentioned, due to lower carer participant numbers a focus group was conducted with the local carer forum. Four carers attended this, with three actively participating and one carer choosing to observe. The carer interview schedule was used to facilitate this focus group discussion.

Interviewer responses

General techniques for conducting qualitative interviews were applied including active listening, adopting a non-judgemental stance, focusing on questions that were non-leading and using low-level paraphrasing. These techniques were applied to support the development of rapport and encourage the interviewee to express their views and opinions on the research topic. Techniques more specific to the methodology of this study included the use of medium- and high-inference paraphrasing (Carspecken, 1996). Both these techniques, although used cautiously, provided an additional means to begin to articulate the participants' possible implicit beliefs, with medium-inference paraphrasing articulating more foregrounded beliefs and high-inference paraphrasing articulating more backgrounded beliefs. Below is an excerpt from a focus group that demonstrates how more backgrounded beliefs were articulated through this process, in this instance differing staff views around the role of a CTO and the lack of opportunity for change and recovery for some individuals on CTOs. This example relates to an organisational level of care delivery which then impacts upon the individual in receipt of the care.

> Nurse: Obviously on CTOs you have the more enduring and chronic client, for want of a better word. I think CTOs for this enduring group you might see once a month, or once every three months these days … in the depot clinic, for medication. But what happens in between all that? Where's the recovery in that? What's in between?
>
> Researcher: Yes, so the focus becomes very narrow.

> Doctor: But you can’t get a CTO for anything else, CTO is about medication.
>
> Researcher: Yes, and so it reinforces the medical model.
>
> Nurse: What opportunity do the clients get to improve when they are seen once a month by a care coordinator or one of the doctors? [What opportunity do they get] to show they can improve in a number of areas so they don’t need to be on a depot once a month?

Data analysis

The same techniques that were used to analyse the preliminary record (meaning reconstructions, low-level coding and validity horizon analysis) were applied to data generated from the interviews and involved the reviewing and checking of earlier analyses alongside newly generated data for congruency and difference. A deeper exploration of trauma and stress as experienced by consumers, carers and clinicians occurred because of this process. This theme was highlighted in the meetings with the lived-experience advisers and focus groups with clinicians. Higher level coding, abstracted from the validity horizon analyses, was then conducted with identified core themes and used to inform the fourth stage of analysis: Discovering systems relations. Appendix K provides an example of the process of data analysis.

Stage four: Discovering systems relations

Discovering systems relations and the possible origins of the identified cultural themes required the examination of the cultural reconstructions articulated from the first three stages of the research process (Carspecken, 1996). This involved broadening the focus beyond the study site to other relevant sites and settings: inpatient units, community-based services (health and non-government), mental health tribunal hearings and conjointly run community and inpatient ward rounds. Additionally, relevant local and national policies were reviewed to determine possible influences on care planning. Examination of the above helped to determine possible cultural, economic and political conditions and structures that were impacting upon the care planning process as observed and described by participations at the study site.

Stage five: Systems relations to explain findings

Stage five involved situating the thesis findings within relevant macro-sociological theories. The cultural themes that were identified through stages one to three were used to inform the selection of sociological theories. This final stage of analysis provided an in-depth and critical understanding of the broader (economic and political) influences on the care planning relations and culture at the study site, which for this study was inclusive of care planning practices, approaches and care options. It is this final stage that Carspecken (1996) believed provides the “critical bite” to the research.

Limitations of the study

Ethnographic studies often focus on a single setting, which may raise questions regarding the generalisability of study findings. As previously mentioned, however, ethnography is also concerned with the implications and meaning of the study findings more broadly (Carspecken, 1996). The rigorous methods that were theoretically informed by Carspecken's (1996) methodology has meant that the thesis conclusions could be drawn with confidence. Additionally, situating the findings in macro-sociological theories has provided a broader context beyond that of the study site (Carspecken, 1996).

There were both constraints and benefits of my position as an insider-researcher. The constraints of this research being conducted as a doctoral study meant that I was the only researcher present for all participant observations and interviews. Different researchers with different values, prejudices and experiences would likely have influenced data collection. The benefit of a doctoral study, however, was the high level of rigour (including reflexivity) that was applied throughout the research process. This included regular debriefing with my supervisors (one of whom is a carer for a person with a lived experience of mental illness) and member checks (by presenting early data to lived-experience consultants and my peers). As I was a member of one of the mental health teams, consumers known to me and staff members with whom I had supervisory relationships were not recruited to prevent risk of coerced participation. It is still possible, however, that some people may have felt unable to decline participating in the study, particularly in the various group settings that were observed. Finally, being a member of the culture meant that it took me some time to see communications related to care planning more objectively. Conversely, being an insider also put people at ease and enhanced access to different settings.

A final limitation is that there were more male consumer participants. It is unclear if this was due to clinicians being more reluctant to suggest possible women participants or if women were less likely to participate. The findings, however, do not appear to significantly diverge based on gender.

Summary

This chapter has provided a detailed account of Carspecken's (1996) research process as it was applied to this thesis, including: locating myself as the researcher; ethical considerations; and data collection and analysis. Ethnographic methods have facilitated an examination of tacit cultural processes that would have been challenging to garner through interview alone. Data collection and analysis occurred concurrently, with findings from early observations explored in greater detail during the interviews. The application of this process has provided a rich account of the culture of care planning as experienced by consumers on CTOs, their family members and mental health clinicians.

The findings of this thesis are presented over the next four chapters. The following chapter provides an ethnographic account of the context in which care provision for consumers on CTOs occurred at the study site and an introduction to the study participants.

CHAPTER FIVE
SETTING THE CONTEXT: CARE PROVISION AT A COMMUNITY MENTAL HEALTH CENTRE

Introduction

This chapter provides an ethnographic description of the context in which care delivery for individuals on CTOs occurred at the study site. To provide an in-depth understanding of the context, this required situating the study site within the broader mental health service context, inclusive of mental health legislation, policy influence and recent reviews of community mental health services in metropolitan Adelaide. The broader context informs current community mental health services structure and delivery. Furthermore, the community mental health centre (CMHC) is situated within a larger system that includes a range of hospital and community-based mental health services. Relations between these services further impacted on care provision at the study site and are therefore also briefly presented and discussed. Finally, an ethnographic account of care planning processes that were occurring for individuals who were on a CTO at the study site is provided, including details of the study participants.

Situating the study site

The study site was a CMHC in metropolitan Adelaide where two community mental health teams were co-located. Governance of the teams fell under a local health network (LHN) which had governance and oversight of several hospitals, rehabilitation units, mental health care, primary health care and several specialist statewide services. The Mental Health Services Directorate top-level clinical structure comprised of a Senior Psychiatrist, appointed as Clinical Services Director, and Senior Nurse, appointed as Clinical Services Co-Director (see Figure 6). The latter position was established during fieldwork in 2016.

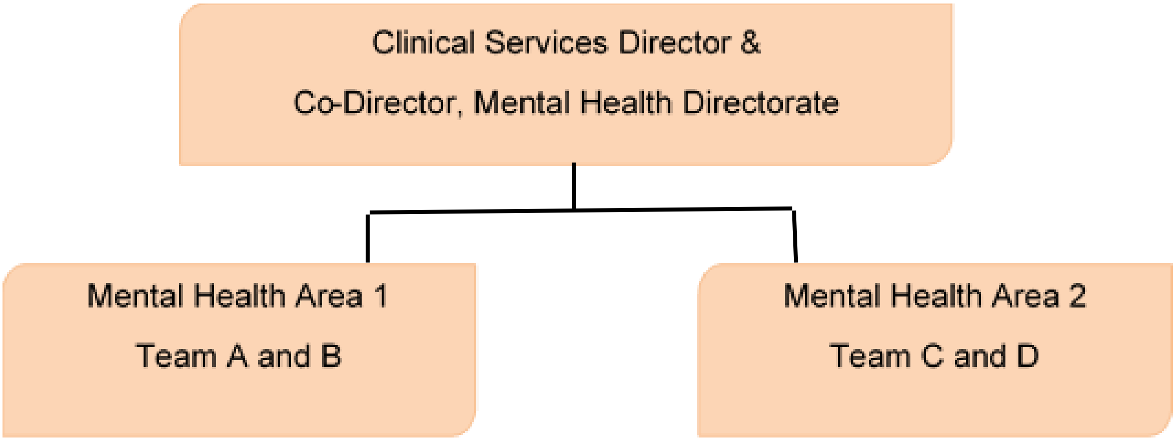


Figure 6. Governance of mental health teams

Legislative and policy framework

Various national and state mental health policies inform current service delivery. Refer to Table 5, which provides a summary of legislation and policy informing current community mental health services. Central to the development of the listed policies and service frameworks were various mental health service reviews that have been conducted over the past decade. These reviews, as listed below, were conducted at both the national and state levels. Additionally, there have been several industrial reviews conducted more recently in South Australia that have further impacted upon current service reforms in community mental health services. Consistently, reviews at the national and state levels have found that mental health services continue to fall short of providing care that is person-centred, inclusive of families and recovery-oriented. Consequently, significant and ongoing reform has been part of the local mental health landscape for more than a decade. The author also acknowledges that mental health care reform has been occurring for many decades in the Australian context, with deinstitutionalisation beginning in the late 1980s. Consideration of policy and subsequent reform over the past decade, however, is the focus of this study due to its immediate relevance to current community mental health service structures and care provision.

Table 5. Policies informing community mental health service provision

YEAR	POLICY DOCUMENTS
	South Australian mental health legislation
2009	*Mental Health Act 2009*
	Commonwealth policy
2018	Fifth national mental health and suicide prevention plan 2017–2022
2013	National framework for recovery-orientated mental health services
2012	Roadmap for national mental health reform 2012–2022
2010	National standards for mental health services
2009	Fourth national mental health plan: an agenda for collaborative action in mental health (2009–2014)
2009	National mental health policy 2008
	Commonwealth reviews
2014	Contributing lives, thriving communities, national review of mental health programmes and services
2012–2018	National report cards

	South Australian policy
2017	South Australian mental health strategic plan 2017–2022
2010	South Australia’s mental health and wellbeing policy 2010–2015
	South Australian health service policy
2013	Clinical business rules
2010	Adult community mental health services model of care
	South Australian health service reviews
2008	A review of community mental health services in South Australia 2008
2015	Community mental health report, Deloitte (conducted in 2015, released in 2016)
2007	Stepping up: a social inclusion action plan for mental health reform 2007–2012
	Industrial reviews
2015/16	• Public Service Association • Australian Nursing and Midwifery Federation (SA Branch)

South Australian mental health legislation

Mental health legislation is core to mental health service delivery and is of specific relevance to the focus of this study. Within Australia, each of the states and territories have individualised mental health Acts. The South Australian (SA) *Mental Health Act 2009* (Government of South Australia, 2009) provides the legislative framework and basis for care and treatment of individuals with a mental illness and informs ongoing mental health care reform. The Mental Health Act allows for services to provide compulsory care and treatment to individuals within inpatient settings and the community. Treatment is generally considered necessary for the individual’s own protection from harm (including further deterioration of their mental health condition) or harm towards others, and is considered when the person is assessed as having impaired decision-making capacity. Use of a CTO means that there must be no less restrictive alternative option available for the provision of treatment, with the more restrictive option being an inpatient treatment order (ITO). Several amendments were made to the SA Mental Health Act during the fieldwork, including the need for a psychiatrist to sign the treatment care plan and an increased duration for a CTO Level 1 from 28 days to 42 days.

Guiding principles of the SA Mental Health Act provide direction regarding the use of and application of the Act (Office of the Chief Psychiatrist, 2017). This includes recommendations that mental health services should provide high-quality therapeutic interventions that promote recovery and community participation, align with international human rights frameworks, provide voluntary services wherever possible, and ensure service provision is always the least restrictive option and as close to the individual’s home as possible and informed by a collaboratively developed treatment and care plan (Office of the Chief Psychiatrist, 2017, p. 14).

The South Australian Civil and Administrative Tribunal (SACAT)

The South Australian Civil and Administrative Tribunal (SACAT) structure is based in law and it is the body that considers applications and reviews for consent and treatment orders.

CTO hearings, appeals and revocations

CTO hearings are the formal context in which designated panel members of SACAT make decisions about applications for treatment orders, usually made by a treating doctor, based on the evidence presented and the Mental Health Act. Individuals who may attend hearings include the person the application is about, any interested parties including mental health clinicians and guardians, and other persons including family supports and legally recognised advocates. If the person that the application is about chooses not to attend, provided there is evidence that they were invited and chose not to be present, the Tribunal can proceed in their absence.

The hearing process itself is very formal and legalistic, with all people in attendance presenting their case to the panel members. The seating arrangement is also formal, where the panel members sit at the front of the room behind a table, with others in attendance seated in front of them. Hearings can last for up to an hour and are usually held at the SACAT office, although there is some flexibility with this based on geographical and individual factors. When participants are unable to attend in person, video-conferencing is most commonly used. Hearings are all recorded and transcribed, with transcriptions available on application (South Australian Civil and Administrative Tribunal, n.d.). During data collection, it was possible to observe a SACAT hearing with permission from a consumer participant. For this hearing, the consumer and their family attended the SACAT building and the doctor and mental health clinicians attended via video-link from the local acute inpatient unit. The seating was much the same as described above, with all parties facing the panel member. This meant that the consumer and their family had to turn around in their seats to view the video screen when anyone spoke from the community team.

An additional issue for consideration is CTO appeals and revocations. Somewhat surprisingly, few appeals occurred during the study period of which I was aware. One of these was made by a consumer and was successful, while the other was a request for a revocation of the order by the treating doctor, which was refused. A consumer participant in the study told the treating doctor that there was no point in attending their SACAT hearing as they believed the outcome would go against their wishes (to not be on a CTO) regardless. Lack of consumer attendance at hearings, as well as few appeals against CTO applications, points to a lack of consumer voice in the CTO process.

During the fieldwork I did not observe any discussions regarding early revocation of CTOs for any individuals. One of the junior doctors however, mentioned to me during the research interview that she had discussed the option of CTO revocation with a consumer who she felt no longer met the criteria for the order. This discussion occurred shortly after one of the staff focus groups that had involved the presentation of, and reflection on early data. The consumer declined revocation of the order as they reported being pleased with the care and treatment that they were being provided. Most doctors however, stated that they made the decision to not pursue a further CTO at the point of the CTO lapsing, rather than initiate an early revocation. Some clinicians appeared to consider that letting the CTO run its course was an active decision regarding CTO termination. Data from the Office of the Chief Psychiatrist supports this observation and indicates that allowing CTOs to lapse is a state-wide practice. More specifically, in the Annual Report of the Chief Psychiatrist, (2015- 16), it was found that "90.3% of orders [were] being made for the maximum duration and 98.7% of orders [were] remaining in place until they expired" (Office of the Chief Psychiatrist, 2016, p. 23).

Office of the Chief Psychiatrist

The Chief Psychiatrist is an independent statuary officer who has oversight for monitoring the mental health services administration of the Mental Health Act and promoting improved mental health service delivery. The holder of the position is a senior psychiatrist appointed by the South Australian Governor.

Policy relevant to current SA mental health service provision

Prior to the current team structure of integrated community mental health teams, each geographical area in metropolitan Adelaide had multiple smaller community-based teams with separate governance and disparate and discrete functions. These team functions broadly included: crisis response; assertive outreach; continuing care; and hospital at home. Services were fragmented, which impacted negatively on both service access and responsiveness. Thus, there was an identified need for service change and in 2005 the Premier of South Australia mandated the SA Social Inclusion Board to review mental health policies and services, and advise on a redesign of SA's mental health care system. In response to this, the SA Social Inclusion Board produced the report: *Stepping Up: A Social Inclusion Action Plan For Mental Health Reform 2007–2012* (South Australian Social Inclusion Board, 2007). This review found mental health services to be out of balance, with a clinical focus rather than a recovery-focused orientation. Additionally, consumers and carers were found to have to navigate the system, rather than the system being responsive and flexible to their needs. Following the *Stepping Up* report and a further review of community mental health services (SA Health, 2008), there has been significant reform in public mental health services structure and function in SA.

The *Stepping Up* report detailed a 5-year action plan of reform that aimed to “provide better, more responsive services and an integrated system of care” (South Australian Social Inclusion Board, 2007, p. viii). Key recommendations of the report included that the SA mental health system become more people-orientated and fully adopt a recovery orientation to service delivery. These principles were further espoused in the *Fourth National Mental Health Plan* (Department of Health and Ageing, 2009) and *South Australia's Mental Health and Wellbeing Policy* (Government of South Australia, 2010), which were also drawn upon to guide reform and identify key actions. As part of the reform, community mental health teams were endorsed with a more central role within a stepped system of care. In 2010, the Adult Community Mental Health Services (Metropolitan Regions) Model of Care was published (SA Health, 2020). Core objectives included development and provision of an integrated service model across all metropolitan areas, improved consumer and carer experiences of services, improved consumer outcomes and implementation of recovery-focused approaches. This resulted in the various community-based teams in each area integrating, a process which took several years. Figure 7 provides an overview of the most relevant mental health care philosophies, policies and service documents informing care provision at the study site. The Clinical business rules (2013) were developed to provide the framework for the functioning of the integrated teams:

> Clinical business rules underpin the successful implementation of the Adult Community Mental Health Services Model of Care. The Clinical business rules have been developed in consultation with clinicians across the Metropolitan Adelaide community mental health services. The clinical business rules aim to set the parameters within which integrated community mental health teams will operate; and are based on accepted best practice approaches to effective assessment, risk management, clinical interventions and quality community mental health service delivery (SA Health, 2013).

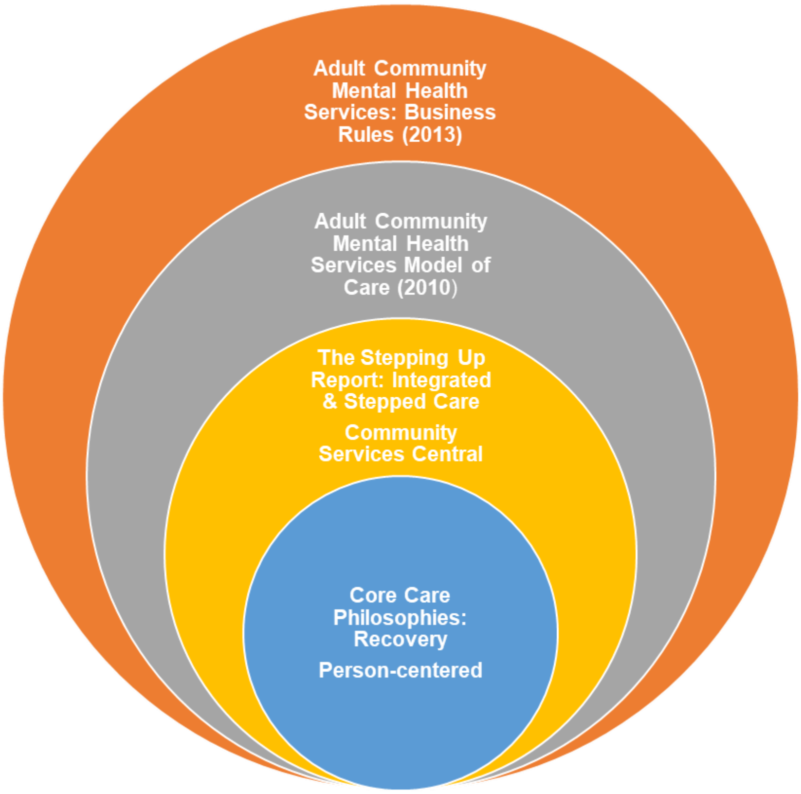


Figure 7. Care planning context

Further reviews and service reform

At the completion of fieldwork, a further large reform had commenced to redesign community mental health services. This was informed by the Deloitte Review (2015), of which key objectives included to "analyse the efficiency and effectiveness of community based mental health services with the aim to maximise mental health consumer *flow* and support; and identify options to improve the *capacity, flow* and *effectiveness*" of services (Deloitte, 2015, p. 1). SA Health accepted the various recommendations, which included the development of new models of care and service plans, although the Royal Australian and New Zealand College of Psychiatrists was critical of the review, highlighting the lack of focus on recovery-oriented care (Royal Australian and New Zealand College of Psychiatrists, 2017). Each of the three Local Health Networks in metropolitan Adelaide conducted the redesign process independently, with no overall oversight or collaboration. Furthermore, separate review processes were simultaneously occurring through industrial relations processes. Overall, during fieldwork community mental health services were undergoing a significant overhaul with the aim of improving consumer outcomes, experiences, service processes, staff morale and team culture. At the time of thesis completion, the new community mental health services model of care (SA Health, 2020) had been endorsed; however, the service plan was still undergoing consultation with staff and unions.

Prior to detailing the study site, care planning processes and study participants, it is important to briefly present and discuss the broader service context that impacted upon, and influenced the care provided at the community mental health centre.

Other locales impacting on care provision

Acute inpatient units

There was a large public hospital in catchment areas for the teams that included a 20-bed acute unit and 6-bed short stay unit. Consumers linked to the teams would be preferentially admitted to these local units, although this was dependent on bed availability. During the study period, it was observed that consumers would often be placed on Level 1 or 2 CTOs while admitted to an acute inpatient unit. For those consumers who were considered “transient”, unless there was an acute clinical need identified, it was usual practice for the community teams to defer referrals for two weeks, to establish some permanency regarding the person’s address. These referrals caused conflict between the inpatient and community treating teams. While the inpatient teams likely perceived their actions as being in the best interests of the consumer, in practice, it was often not possible for the community team to implement the recommended treatment plan upon an individual’s discharge as the person would often not remain at the place of discharge (typically a boarding house where they had no connections).

The literature highlights the potential for siloing within mental health services (Henderson & Fuller, 2011); however, there were several processes in place locally to enhance communication between the acute units and community setting. Care coordinators were expected to in-reach to the acute units, attend the inpatient ward round, meet with the consumer and liaise with the acute unit staff. Input from the community team into care decisions, including discharge planning, was reported as variable from community-based clinicians.

To further enhance communication between settings and facilitate shared clinical decision-making, a community ward round was held weekly at the centre. This was attended by multidisciplinary staff from the local acute unit, intermediate care centre (ICC) and community teams. Discussions focused on consumers who were close to discharge, potential referrals and consumers who had particularly complex needs. These meetings highlighted the different pressures that each setting was experiencing, including length of stay (flow) and team capacity. In this context, conflicting views arose between the inpatient and community-based teams (such as described above in the instance of people who were known to be itinerant and being discharged on Level 1 CTOs to boarding houses). At other times, the teams collaboratively advocated for care pathways for individuals. Overall, the intention of the meeting was to share information and facilitate SDM between the treating teams, with the overall aim to ensure good care and as smooth a transition as possible for consumers back into the community.

Intermediate care centre

ICCs were established to provide the option for step-up/step-down services for individuals who were becoming unwell in the community or required additional support to transition back home following hospitalisation. The model of care reflected subacute care needs, with 24-hour support that was high level recovery-focused and staffed by a multidisciplinary team that included psychiatry. During the fieldwork period, the option of accessing care from the community was rarely available due to bed pressure, with consumers required to present at the emergency department (ED) to facilitate an admission. Clinical coordinators across sites participated in a daily teleconference to facilitate movement of consumers between the ED, acute, subacute and community settings.

Rehabilitation services

Community rehabilitation centre

The community rehabilitation centre (CRC) focused on supporting individuals to better manage their illness, develop skills for independent living in the community and facilitate meaningful linkages with the person’s community. The unit was staffed 24 hours by a multidisciplinary team (excluding medical staff). Individuals were voluntarily admitted to the unit, although they could be on a CTO. All residents at the CRC were linked to the community teams, which resulted in duplication of many administrative tasks for clinicians as both teams had separate clinical review processes occurring simultaneously. Collaborative care planning meetings were held regularly at the unit with consumers and clinicians from the community teams and CRC present.

Inpatient rehabilitation services

There was a 40-bed state-wide inpatient rehabilitation unit that provided specialist services for individuals whose needs could not be met by less intensive community-based mental health services. Individuals referred to this service had moderate to severe and enduring complex mental health conditions and generally faced significant challenges living in the community. The unit was staffed by a multidisciplinary team (including psychiatry). Referral to the unit was being considered for one consumer on a CTO during the period of fieldwork.

Psychosocial supports

Various non-government organisations (NGOs) worked in partnership with mental health services to provide psychosocial supports. For many consumers, these support workers provided more frequent contact than their care coordinator. Support focus was meant to be consumer-led and based on the development of another care plan, known as an individual support plan. The development of this plan was led by the NGO. Supports could cover broad domains including assistance with accommodation, lifestyle and daily activities, and participating in meaningful occupation. Contact type and frequency were agreed upon by the consumer themselves, the care coordinator and the NGO support worker, and reviewed three-monthly.

Since the completion of fieldwork, further significant reform and change have occurred in this space with the introduction of the National Disability Insurance Scheme (NDIS). The NDIS is a major reform in the provision and funding of support services in Australia for individuals living with a disability. The aim of the scheme is to increase choice and control to people living with a disability through the provision of increased funds for disability services and increased personal control over the design and delivery of care to individuals living with a disability (Warr et al., 2017).

Emergency services

There was a memorandum of understanding between SA Health and emergency services, specifically, the SA Ambulance Service and SA Police, with regular meetings between all services to facilitate communication. Emergency services were at times used to support the enforcement of a CTO, either by providing additional safety to clinicians who were seeing consumers in the community where there were significant concerns regarding risk, or to provide transport for consumers to the nearest treatment centre for further assessment and/or administration of medication.

South Australian legal system

State-wide forensic mental health service

Consumer involvement with the SA legal system was not frequent, with only two of the nine consumer journey participants linked to forensic services at the time of data collection. Consumers could have open episodes with both the forensic and community mental health teams at any one time, with a joint decision between services made regarding which team was considered the primary team.

As detailed, the CMHC was part of a broader system of care. Each of the teams and processes described above impacted upon the care planning processes, including decision-making and care options for consumers on CTOs at the study site. Local care planning processes are further elaborated upon on below.

The study site

The integrated community mental health teams provided assessment, assertive care and ongoing psychosocial support to individuals with a diagnosable mental illness. Individuals seen by the services often had serious, complex and enduring mental health disorders, including drug and alcohol comorbidities. The most common principal diagnoses were psychotic and mood disorders. Additionally, within the study site catchment area there was significant ethnic diversity and low socioeconomic status. A complicating factor for the community mental health teams was that there was no formal clearly defined “core business”, although there was general consensus that individuals presenting with a high degree of acuity, as well as those with an established serious mental illness, were the priority for services. Potential or defined risk often triggered pick-up by community teams.

The community teams would frequently receive referrals from the primary health sector (typically from GPs) and EDs for individuals who were not considered core business. A high number of referrals came to the teams where the primary issue was drug use. These referrals were in the context of diminishing drug and alcohol services, and caused some frustration among clinical staff at the site. Additionally, there was a view that staff in the ED were over-referring in a context of risk aversion and lack of knowledge of alternate referral pathways. The clinical coordinator would investigate each new referral and then correspond with the individual themselves, and referrer, with alternate options for those who did not align to current service pathways.

The study site had two clinical teams: Team A and Team B. The team functions included: assessment (urgent and non-urgent); “case management”; out-patient psychiatric review appointments; and clinic services (for administration of medication by injection (depot) and clozapine monitoring). Clinical services were provided as required: short term (crisis management) and longer term (rehabilitation), with four levels of focus of care: acute; functional gain; intensive extended; and maintenance. Specialist services provided included individual and group dialectical behaviour therapy, various other psychological therapies, occupational therapy assessment and interventions, and individual placement and support (IPS), an evidence-based supported employment program that commenced during the study period. At the outset of data collection, consumer numbers were Team A (n=530) and Team B (n=600). Additionally, there were between 30 and 50 new consumer registrations per team monthly, highlighting the pressure around flow. Table 6 shows the number of consumers on CTOs at the commencement of data collection, with significantly more men than women on orders.

Table 6. Consumers on CTOs at the study site

	Team A	Team B	Total
Male	24	40	64
Female	14	14	28
Total	38	58	92

Clinical team members included medical staff (psychiatrists, specialist GPs, psychiatric registrars and registered medical officers), OTs, psychiatric nurses, social workers and psychologists. Nursing staff were the largest professional group, with total clinical staff numbers Team A (n=30) and Team B (n=35). The numbers provided are for full-time equivalent staff. Clinical staff worked across three shifts that covered 8:00 am to 22:30 pm seven days a week, with the bulk of clinical staff working between 9.00 and 17:00 during Monday to Friday.

The team leadership structure consisted of the following:

- Team manager, who could be an allied health professional or registered nurse level 4, with responsibility for management of the operational business of the team
- Psychiatrist lead clinician, with responsibility for oversight and delegation of clinical work to medical staff
- Clinical coordinator, who could be an allied health professional or registered nurse level 3, with responsibility for managing clinical business processes for the team including new referrals, transfers, planned discharges and overnight contacts
- Professional clinical leads, inclusive of nursing, occupational therapy, social work and psychology (all at level 3), who were responsible for identification and support of best clinical practice according to professional guidelines, and participation in usual clinical duties

There were various team functions, articulated in the Clinical business rules, that supported the operation of the team. These included the morning handover meeting, clinical review, duty work, interagency working, clinical supervision, outcome measurements and health information system for documentation (Community Based Information System – CBIS). The various functions that facilitated care planning will be presented in more detail below. Electronic client documentation used to record these discussions was drawn on to illustrate frequency and type of contact. However, as the focus of this exploration was on care planning discussions, it was decided that a detailed review of documentation was not required for this study. Previous studies have found there was a paucity in documentation, particularly related to care plans (Simpson et al., 2016).

Care planning contexts

Care planning, as defined in this study, is focused on communication between clinicians, consumers and their carers or other supports, and communication among clinicians that pertained to an individual’s care. The various care planning contexts at the study site included clinical review meetings (both routine and urgent), held face to face between clinicians, and discussions with consumers, other support services and family members. Communication could be face to face, on the telephone or written. While it was not possible to observe all contact types, for example phone contacts, there were many opportunities to observe both formal and informal care planning discussions. The focus was on care contacts that occurred at the centre due to the variation of care planning contexts and high number of contacts occurring on site. For further variation in settings, I offered to attend home or community visits with clinicians if appropriate; however, this was only taken up on two occasions by two different clinicians. Table 7 presents a summary of the various care planning contexts that were occurring at the study site. As shown in the table, care planning occurs both with and without the presence of the consumer. Carers may or may not be included in the process depending on a variety of factors including the consumer's choice not to have their family members to be part of care discussions or clinicians not actively including carers in the process. Other treatment or care agency predominantly refers to the NGOs who have formal partnerships with mental health services and are contracted to provide individual psychosocial rehabilitation and support services. It was rare for any other support agency to attend any appointments or meetings on site, although it would be expected that the care coordinator or treating doctor would liaise with other relevant services as required, including GPs.

Table 7. Care planning contexts

Participants	**Care coordinator**	**Treating doctor**	**Multidisciplinary team members**	**Consumer**	**Carer**	**Other treating or care agency**
Contact type						
Clinical reviews (3-monthly and/or when urgent)	Y	Y	Y	N	N	N
Outpatient appointments with doctors	P	Y	Y	Y	P	P
Other contacts (face to face or by phone)	Y	P	P	Y	P	P

Y	**Present**
P	**Not present**
N	**Possibly present**

As highlighted in Table 7, shared decision-making, central to promoted care practices, was immediately challenged by current mental health team processes that were in place for care planning. Any decision-making occurring at formal clinical reviews, for example, which were held exclusively among mental health clinicians, excluded the consumer, their family members and other support services. This alone challenged the concept of the consumer being central to their care. Other key issues to consider regarding the various care planning contexts included the frequency, purpose and quality of the contacts and discussions. These issues will be further elaborated on from the perspectives of individuals on CTOs, their family members and clinicians in the following two findings chapters. The perspectives from the different stakeholder participants, and ethnographic observations, are drawn upon to understand care planning for consumers on CTOs in a community mental health setting.

The following team structures and processes were the settings in which care planning occurred at the study site.

Morning handover

The daily handover meeting was held at the beginning of each day. During the week, the teams met separately; however, as staff numbers were low on the weekend, clinicians across both teams came together for the handover. These meetings started promptly and usually lasted between 15 and 30 minutes. The functions of the morning meeting, as articulated in the Clinical business rules, included allocation of tasks, coordination of flow, informing staff of sick leave or student placements, providing a forum to raise concerns and ensuring transparency of caseloads (SA Health, 2013, p. 26). Both team handover meetings met all the above functions, except for ensuring transparency of caseloads, which was not within the scope of the meeting.

The focus on flow during these meetings was evident in various ways. The agenda included lists of those individuals waiting for assessment in any ED, individuals waiting for an acute bed and individuals who were inpatients (with pending discharge dates identified). Other agenda items which linked to flow and care planning included identifying individuals who were going to be discussed in the urgent and routine clinical review meetings to be held that day.

Risk and the management of this was also addressed in the morning meeting. Risk management strategies included identification of individuals requiring a second worker and a list of consumers overdue for depot medication. One team identified individuals who were on a CTO, to further inform any “management plan”, which generally was more assertive follow-up for those individuals on orders. Other tasks allocated at the meeting included: acute assessments (which required two staff); home visits to oversee medication supervision; and phone calls to consumers who either did not have an allocated care coordinator or for whom the care coordinator was unavailable. At the conclusion of the meeting, additional information deemed relevant for team members to know was provided, for example, accreditation requirements, union activities and broader service issues. In one team this space was also used to share good news stories, for example, celebrating when a consumer commenced work via the supported employment program.

The climate of the two teams was observed to be different in various ways during these meetings. Team A was quicker to allocate work, for example, a request for a second worker. In Team B there were often longer pauses before a staff member volunteered to take on the required task. There were various issues likely impacting on this. Team A predominantly managed allocation of acute assessments and second workers outside the team meeting. Additionally, some consumers in Team B were not allocated a primary care coordinator, which meant that there were more unallocated consumers that the team was then required to collectively support. Additionally, Team B had higher consumer numbers, which could also have been impacting on actual and perceived team capacity, and ultimately team culture.

Urgent clinical reviews

Urgent clinical review meetings were held each weekday to discuss urgent clinical issues, as well as consumers new to the team who had been seen and assessed within the preceding 24 hours. The urgent reviews were typically for consumers who were assessed as deteriorating in mental state and who required immediate decisions to be made regarding their care. It was also a forum that could be used to discuss care needs for complex consumers, as the meeting was attended by several doctors and senior clinical staff from different professional backgrounds.

Urgent clinical reviews were often attended by between eight and twelve clinicians from the multidisciplinary team. Students from different disciplines and occasionally police cadets could also attend these clinical discussions. As can be seen in Table 7, many care planning discussions were occurring without the consumer or their carer being present, while at the same time involving clinicians who may or may not have personally met the person being discussed but were still partaking in the decision-making.

Discussions were often thorough in this setting and usually guided by a clinical problem or issue that the care coordinator wanted support in decision-making. These meetings were generally a supportive context for clinicians to seek advice and support from the broader team regarding clinical care. Often decisions about more assertive care were made in this meeting, including decisions to step-up care to an acute inpatient admission.

Clinical reviews

National standards state that a basic clinical review for all consumers occurs every three months. In SA, the ISBAR (identify, situation, background, assessment and recommendation) mnemonic is used to convey relevant information for clinical handover, including clinical reviews. The Clinical business rules outline various aims of the clinical review which included:

> review of assessment, outcome measures, care plan, identification of consumer status and current issues, review of congruency between outcome measures and care plan, identification of risk issues, shared care arrangements with GPs and NGO input for psychosocial rehabilitation (SA Health, 2013, p. 27).

Clinical review meetings were attended solely by clinicians working at the centre, although it was expected that clinicians were having discussions with the consumer, their carer and other care and support agencies, and providing feedback to the GP. Clinicians were allocated to a specific clinical review group. This was to promote consistency by increasing commitment and accountability to attend, facilitate staff knowledge of a broader consumer group, ensure multidisciplinary input into care planning discussions and promote development of trust between staff. Although this structure meant that the treating doctor was not always involved in the care planning discussion and it was challenging for clinicians working a seven-day roster, there was flexibility, with clinicians able to present at other clinical review meetings. Clinical review meetings were cancelled if there was no psychiatrist or senior doctor available to attend. Each clinical review was typically allocated approximately 15 minutes, although in many settings this was insufficient time and the discussion went over this time. Some discussions were robust and thorough, although others were brief with the ISBAR copied from previous reviews. Small changes in the person's circumstances were easy to miss.

The list of administrative tasks that were associated with the clinical reviews was significant and was not met by either team at the study site. As per national and service standards, this included updates of service outcome measures, risk assessments and care plans. Care plans were recorded in CBIS and included the person's relapse prevention plan, wellness plan, goals and means to address these, physical wellness plan and information about medications. Additional sections of the care plan included identification of carers' and children's need and the service plan (which was often a summary of the most recent clinical review). The care plan was meant to be collaboratively developed with consumers; however, audits indicated this was often not occurring, aligning with the international literature regarding poor use of care plans (Coffey, Hannigan et al., 2017). Under the Australian Health Care Agreements, routine consumer outcome measurements must be collected by public mental health services nationally. Those mandated in SA include clinician-rated measures of the severity of a person's problems (the Health of the Nation Outcomes Scales – HoNOS) and the person's functioning (Life Skills Profile – LSP-16) and a consumer reported questionnaire that measures the person's level of psychosocial distress and functioning (the Kessler Psychological Distress Scale- K10+). Refer to Appendix L for copies of the service risk assessment, care plan and outcome measures. A snapshot taken for one month (November 2018) illustrates the challenges that staff were experiencing in completing the required administrative tasks. Averages from combined reporting of both teams included: current risk assessments (37.5%); current care plans (33.5%); completed HoNOS (34%); completed K10+ (16%). Overall, the administrative duties were significant, with the Deloittes (2015) report highlighting the need to reduce and streamline processes, including overhauling the current care plan.

Outpatient doctors' appointments

While the main focus of medical appointments was to formally review an individual's mental state and the impact that medication was having, most doctors considered broader factors, including the person's functioning in their day-to-day life and their physical health. Frequency and purpose varied based on clinical need, appointment availability and the treating doctor. Additionally, doctors experienced pressure to discharge consumers and thereby support flow.

> From the head clinician, the junior doctors are told we need to create capacity for new people, so at the end of our placement we need to have a document of all the patients that we've closed/discarded. Because new people keep on coming in, which is fair, but when I look at the sixty patients on my list, there are only two people who could maybe close in the next three months. Maybe, if things went really well.
> [Junior doctor, Interview]

The treating doctors were observed to welcome the presence of care coordinators at these appointments. This appeared to be especially valued by those doctors who were on rotation. The rotations were training positions for junior doctors who might or might not be progressing their studies in psychiatry. The rotations, which were between 3 and 6 months, were disruptive to consumers and did not facilitate continuity of care. For some consumers, there was further lack of consistency with changes with their allocated care coordinator. Experiences of this staff movement on all participant groups will be elaborated upon further in Chapter 7, which explores care planning practices and experiences.

Other care contacts

These included phone contacts, as well as face-to-face contacts, at the centre or in the community, including the individual's home or other public settings. Additionally, clinicians frequently had contacts with other services that involved care planning. This could include the services discussed above, as well as the person's carers, primary health care, other health services and housing.

Fieldwork: Observations of care planning

This study occurred over 18 months between May 2017 and November 2018. Data collection occurred in two stages, commencing with six months of observations of care contacts followed by 12 months of focused observations of care contacts with eight consumers and interviews with all participants involved in their care planning.

Stage 1 of data collection involved focused observations of care planning discussions at the study site. This was inclusive of the various settings described in detail above including clinical review meetings attended by multidisciplinary team members, outpatient doctor's appointments and informal conversations between clinicians. In summary, more than 44 observations of different settings were conducted and recorded, providing approximately 28 hours of focused observations. This included observations of multiple combinations of members from the multidisciplinary teams (n=75). Table 8 provides a detailed summary of these observations, including details of setting type.

Table 8. Summary of ethnographic observations

CONTACT TYPE/SETTING	TEAM	NUMBER	DURATION (hours)	CONSUMER PRESENT	TOTAL DURATION (hours)
Urgent clinical review	Team A	5	3.3	No	6.8
	Team B	4	3.5	No	
Clinical review	Team A	11	6.8	No	14.8
	Team B	11	8	No	
Supported residential facility medical review	Team A	2	30 mins	Yes	.5
Outpatient medical appointment	Team A	8	3.5	Yes	5
	Team B	2	1.5	Yes	
Informal discussion	Team A	Multiple	30 mins	No	.5
	Team B	Multiple	20 mins	No	.3
					27.9

Care journeys: Interviews and further observations

The second stage of data collection involved a further 12 months of focused observations and interviews. This involved following eight consumer participants' care journeys at the CMHC. During this stage, fieldwork included a further 42 observation contacts that were relevant to care planning. Additionally, individual interviews were conducted with the participating consumer, their treating doctor, care coordinator and, if permission was given, any family members whom the consumer identified as providing them support. Table 9 presents a summary of the fieldwork relevant to the eight consumer care journeys. A total of 34 interviews were conducted including 8 interviews with consumers, 6 interviews with relatives (identified as carers) and 20 interviews with mental health clinicians.

The focus of the study was on care planning processes; therefore selective descriptive details are provided about the three participant groups to provide further context to the findings. To maintain confidentiality but also provide sufficient contextual information, consumer participants whose care journeys were observed are identified by pseudonyms throughout the findings chapters, with their carer(s) identified by their familial relationship to them. Clinicians are identified by professional group.

Table 9. Summary of ethnographic interviews and observations

Consumer participants	**Contacts**										
Caleb **Team A**	Medical review 22.11.17	Clinical review 29.11.17	Medical review 21.03.18	Medical review April	Consumer interview April	CC interview (SW) 11.05.18	Doctor interview 19.09.18				
Wu **Team A**	Clinical review 6.09.17	CC interview (SW) prior to a home visit for detention	Medical review 27.11.17	Medical review 18.12.17	Medical review Jan 2018	Urgent clinical review Feb 2018	Consumer interview 15.05.18	CC interview (SW) 21.05.18	Doctor interview 25.05.18	Medical review 23.08.18	
Sam **Team A**	Medical review 4.08.17	Medical review April 2018	Consumer interview 1.05.18	CC interview (nurse) 28.05.18	Doctor interview 12.06.18	Medical review July 2018	Medical review 27.09.18				
David **Team A**	Medical review 6.12.17	Medical review Feb 2018	Clinician interview following involvement in a detention (SW) 2018	Consumer interview 31/05/18	Carer interview (mother) 08/06/18	Urgent clinical review 18.06.10	Doctor interview 30.07.18	Medical review 16.08.18	CC interview (nurse) 9.10.18		
Mark **Team A**	Medical review 4.08.17	Medical review 24.11.17	Urgent clinical review	Urgent clinical review	CC interview (nurse)	Medical review 25.07.18	Doctor interview 30.07.19	HV with CC 31.07.18	CTO hearing 2.08.18	Consumer interview 13.09.18	Medical review 13.09.18	Carers interview (mother

			17.05.18	30.05.18	19.07.18							and father) 28.09.18
Tom **Team B**	Medical review 23.1.18	Consumer interview 18.04.18	CC interview (nurse) 16.05.18	Brief meeting while waiting for depot June 2018	Doctor interview 20.07.18	Carers interview mother and father 14.08.18						
John **Team B**	Medical review 21.11.17	Medical review 12.12.17	Medical review 12.04.18	Medical review 24.05.18	Consumer interview 3.08.18	CC interview Jane 27.09.18						
Amanda **Team B**	Medical review 23.02.18	Consumer interview 6.03.18	Carer interview (mother) 20.03.18	CC interview (nurse) 28.03.18	Medical review 13.04.18	Email correspondence form care coordinator to lead clinician	Clinical review 8.05.18	Medical review 15.06.18	Doctor interview 20.07.18			
Sally **Team B**	CC interview (SW) 27.09.18	Doctor interview 27.09.18										

Rachel **Team A**	Clinical review 15.06.17	Urgent clinical review 22.03.18	Urgent clinical review to discharge May 2018	Doctor interview 25.05.18								
Jack **Team B**	Clinical review 2017	Doctor Interview 27.09.18										
Jim **Team B**	Medical review 04.01.18	Doctor informal interview Jan 2018	CC interview (nurse) 30.07.18									

Legend for Table 9

Medical review	🟦
Clinical review	🟦
Urgent clinical review	🟦
Consumer interview	🟨
Care coordinator interview (CC)	🟧
Carer interview	🟨
Doctor interview	🟧
Home visit with CC and consumer	🟩
CTO hearing	⬜

Participants

Consumer participants

All eight consumer participants agreed to be interviewed. Seven of the consumers were men, ranging in age from 28–49 years with a median age of 40 years. The female consumer participant was 19 years old and had been in contact with youth mental health services for the previous five years. All other consumer participants had more than eight years contact with services, with the majority having had contact for 20 or more years. All consumers had been on multiple ITOs (maximum 15) and CTOs (ranging between 3–8), with many of the CTOs being consecutively implemented. Six consumer participants were admitted to hospital during the study period, with one participant having two admissions and another participant three admissions. One participant was admitted to the community rehabilitation centre following an acute inpatient admission during the fieldwork period. Four consumers had been linked to a forensic team, with two linked during fieldwork. [Note: the electronic client data system commenced in the year 2000, so any admissions, care episodes and treatment orders prior to this date would not be captured on the current system, indicating the likelihood of under-reporting in the above data.] Five consumers lived alone with four receiving a moderate to high level of psychosocial supports, one consumer lived with their family and one with their partner. At the conclusion of the study, one participant had been incarcerated in the prison system.

During fieldwork, only one consumer participant had the same care coordinator and treating doctor. Five consumers had a change in doctor, ranging between one and six changes, with the typical number being three different treating doctors over a 12-month period. There were fewer changes with care coordinators, with five consumers having between two and three different workers during the 12-month period.

Carer participants

Four consumer participants agreed for their parents to be interviewed (n=6), two consumer participants did not want their family to be involved in the research and two consumers did not identify as having a carer. Four additional carers were recruited to provide a broader carer perspective. All carers reported providing regular support to their relative, with three families maintaining daily contact. Several carers were in employment, although two relatives (both mothers) reported terminating their employment prematurely to provide care.

Clinician participants

Clinicians interviewed came from three professional backgrounds, including social work (n=3), nursing (n=6) and medical (n=7). Medical staff included two psychiatrists, two senior medical officers, one registrar and two registered medical officers (RMOs). The three professional groups interviewed were representative of those professions with the highest staff numbers within the teams. Psychologists did not have any care coordination duties and no OTs were interviewed due to my supervisory responsibilities (as discussed in the section – Ethical considerations). Clinicians ranged in age from 25–65 years with a median age of 49 years. There was a significant range in years working in mental health, with the RMOs having 3–6 months' experience and 11 clinicians having worked for between 15 and 30 years in various mental health care settings. Fifteen in-depth interviews were conducted at a prearranged time, with a further five brief interviews conducted opportunistically in response to real-time events. This included repeat interviews with clinicians who were involved in detaining consumers for assessment for an acute inpatient admission, as well as clarifying ideas and experiences relevant to care planning issues with the consumer participants.

Data collection for another four consumer participants was initiated; however, due to different reasons, there was no opportunity to conduct a range of observations and interviews with this group. The data was incorporated into the thesis findings, as it captured the complexities of clinicians attempting to engage and work with consumers who were being forced to receive care and treatment to which they were opposed.

Figure 8 depicts the cultural themes of care planning that were further explored during the interviews. These themes were developed following the first stage of analysis that involved data from observations of care planning discussions in clinical review settings and medical appointments, and then further ratified through discussions with two lived-experience advisers and two focus groups of clinicians working at the study site. These themes will be further elaborated upon from the different stakeholder perspectives over the next two chapters to provide an in-depth illustration of care planning practices, approaches and care options for individuals on CTOs in a community mental health setting.

Figure 8. Interview themes

Summary

National and state policies, mental health legislation and service reviews all underpinned the function of the integrated community mental health teams. Additionally, during fieldwork further reform of community mental health services was commencing. This chapter has provided an ethnographic account of care planning processes that occurred for individuals who were on a CTO at the study site. Details have been provided of the fieldwork that was conducted over 18 months, including a description of all participants involved in care planning for the eight consumer care journeys that were observed over a 12-month period. In the following two chapters, data from these ethnographic observations and interviews will be used to elucidate the main findings of the thesis regarding care planning processes and experiences from the perspectives of consumers, carers and clinicians.

CHAPTER SIX
A CULTURE OF RISK

Introduction

Care planning in community mental health care settings is situated within frameworks that promote recovery-oriented and trauma-informed care approaches. This thesis, however, has found that in practice the dominant framework informing care planning with individuals on CTOs was risk. Risk was the main driver for CTO use and was also found to be the most significant influencing factor informing care approaches and contacts with consumers. Risk was understood and framed differently by consumers, their families and mental health clinicians. The conceptualisation of risk by services, however, was the dominant narrative informing care planning approaches. This narrative positioned the consumer in ways that influenced clinicians' engagement with individuals and families, and resulted in care that focused on mitigating risk that was conceptualised as being "within" the individual, rather than focusing on external risk factors. Although some individuals on CTOs were being supported in their recovery, the sweeping culture of risk made it challenging for clinicians to view the person in their broader context and to create a care planning context that was truly supportive of recovery. Instead, a risk culture often resulted in care planning processes and approaches that were causing further harm for consumers on CTOs. Many clinicians who were working within this culture of risk acknowledged systems-level problems; however, overall the current system structures and culture restricted rather than facilitated ways of working that were aligned with promoting recovery.

Figure 9 below maps the key components that combined, created and informed the culture in which care planning occurred: a culture of risk. In the first section of this chapter, the differing understandings of risk and the related concept of insight are explored. Following this, the positionings of the different participants in the care planning relationship are conceptualised, including an examination of the juxtaposed care focus when the person was situated within their broader context. The chapter then concludes with a preliminary exploration of the impact of service culture on care planning. A note on terminology: Throughout the following two chapters, the term "capacity" is used to refer to clinical interpretations of a person's ability to look after themselves and decide what is best for themselves. Unless clearly stated, the legal definition of capacity is not being used.

Figure 9. A culture of risk

Defining risk

> Risk is not … the same as hazard or danger … The idea of risk is bound up with the aspiration to control and particularly with the idea of controlling the future. The observation is important. The idea of "risk society" might suggest a world which has become more hazardous, but this is not necessarily so. Rather, it is a society increasingly preoccupied with the future (and also with safety), which generates the notion of risk (Giddens, 1999, p. 3).

This sociological definition of risk is relevant to the current interpretation of risk by the mental health services that were studied in this thesis project. In response to possible threats to the individual and community by individuals with a mental health illness, community mental health services have been positioned to manage risk. The following definition of risk assessment is taken from the Clinical business rules (SA Health, 2013), which detailed the processes and governance of clinical care at the study site:

> Risk assessment is a systematic and objective approach to identifying risk behaviours, with the aim of enabling appropriate management of identified risks (SA Health, 2013).

Mental health clinicians were tasked with managing risk in an attempt to forestall unwanted and hazardous events/threats. While risk assessments are conducted on all consumers engaged with mental health services, risk was a core consideration in relation to individuals on CTOs.

> Risk is the key issue. If there isn’t risk, there is no justification for a CTO. You can be as mad as you like, there is no crime in that, you can be quietly mad and do weird things … If there is no risk, there is no CTO.
> [Doctor, Focus group]

The following section details the different understandings of risk and the challenges for clinicians to “objectively” identify and mitigate risk while balancing the need to support a person’s recovery.

Risk: Differing understandings

Risk was discussed and understood differently by consumers, carers and clinicians. Clinicians commonly referred to risks that arose from the medical narrative of illness, namely, harm to self or others, and functional and cognitive decline. Carers were more concerned with broader issues that related to their relative’s lived experience and the impact that having a mental illness had on their relative’s and their own daily lives. They were concerned with issues such as loneliness, lack of purpose and poor physical health. Risk was not a relevant concept to consumers, who were concerned with broader and immediate issues that impacted on their wellbeing and daily life, including unemployment, unsuitable housing, drug use, loneliness and stressful relationships.

In general, risk was broadly defined among consumers and carers, and was focused on external factors and conditions, placing risks as factors external to the person. While some clinicians acknowledged these broader risks, their focus was generally narrower, with risk situated internally, within the person. This significant mismatch in understandings between groups impacted on how individuals were positioned in relation to one another and therefore how they were able to participate in the care planning process and ultimately the care plan that was formulated to direct service contacts.

Mental health clinicians’ understandings of risk

The most common risks clinicians referred to included risk of self-harm (intentional or through misadventure), risk towards others and risk of cognitive and/or functional decline as a result of having an untreated illness or further relapse. These risks were situated within a medical narrative of illness and were the focus of service risk-assessment tools. Some clinicians referred to risks that related to the consumer’s context and lived experience. These risks covered broader domains such as loss of roles (leisure and vocational), unsuitable housing, disrupted life trajectory and ruptured relationships.

The broader risks that related to the individual's lived experience were situated within a recovery narrative. Clinicians also referred to iatrogenic risks that resulted from the CTO (forced medication and contacts) and treatment (side effects). They expressed concerns about the lack of power consumers had within the CTO framework and the possible detrimental consequences of this for the consumer:

> I struggle to remember historical risk. He has self-harmed in the past. I don't think he's at significant risk of self-harming now, or at risk to others now. I don't think he is especially vulnerable. He is able to speak up for himself. He might be in a position where he would be vulnerable to accepting people's suggestions as a result of having been on the CTO and going, "I need to be a good patient, cooperative and just agree". Rather than actually saying, "No, that's not OK, not what I need."
>
> [Junior doctor – Wu, Interview]

Regardless, all clinicians considered the benefits gained from CTOs outweighed the possible disadvantages:

> Nigel is very independent and a very unique and very proud individual, and putting an involuntary treatment order has a big issue for his personhood, so making the decision is worse than easy; however my feeling is that he will become more independent and more productive if we use this for the short term.
>
> [Psychiatrist – Mark, Interview]

The dominance and pervasiveness of the medical narrative around risk among clinicians were reinforced at a systems level (e.g. through the use of service risk-assessment tools and outcomes measures). The focus on concerns with risk of harm to self and others overshadowed the assessment of risks workers made that related to an individual's personhood and recovery. This meant that even when workers were sensitive to the broader risks, they continued to primarily engage with consumers around the former internally situated risks. Some clinicians were aware of this dichotomy, which highlights the lack of power that workers had within the system. Furthermore, the dominant discourse that situated risks within the person served to compound stigma. As a result of this, broader risks such as ruptured relationships and reduced support – "Dad is overseas. Mum is burnt out with him" – were presented more as contextual information, rather than risks that could be further impacting on the person's wellbeing. This view again focused on the person as the "risk object" themselves, rather than being "at risk" due to their illness and other compounding factors external to them.

The systems view of risk, primarily informed by the medical narrative, was reductionist, facilitated to be so by the emphasis on risk at the systems level. Consequently, clinicians were hindered from seeing and working with consumers within a broader conceptualisation of risk that aligned with the person's lived experience and recovery. Care for many consumers on CTOs was focused on risk management rather than personal recovery. This dominant service view was in stark contrast to how carers and consumers spoke about risk.

Carers' understandings of risk

Carers' understandings of risk were broad and included concerns about their relative's physical and mental health, social issues and adversity, impact of caring roles and service contacts, and fears that services would not stay involved. Carers were concerned about quality of life: lack of meaningful purpose, housing insecurity, loneliness and fears regarding the future. These risks were about how the person was living in the present and into the future, rather than about their illness, with the broader contextual risks and needs identified by family aligning with a need for care that addressed broader social issues:

> He, they find it very difficult to get friendships, and the friendships that they do have are usually people also with problems and they don't last. So, it's a very lonely life … God, we've got to live to make sure we're around for another 20 years at least. Cause then he'd be in his 60s … People our age, I'm 72 and [my wife] is 70, start looking at who is going to do the running around that we do. You can't inflict it on your other child because it affects their life.
> [Father – Tom, Interview]

> He's very lonely. And when he does meet someone, it tends to be the wrong sort of person. He's not going to attract the really good girls, or even a nice guy as a friend. Which is sad, and he's lonely. Definitely lonely.
> [Mother – David, Interview]

Although less frequently raised, carers also referred to concerns regarding self-harm, harm to others and severe self-neglect. In the discussion from which the second excerpt was taken, David's mother spoke about her son and the risks that had resulted from the impact that his mental illness had on him, including loss of work and relationships. She also spoke about significant risks that her son posed to the family, in the context of mental illness and illicit drug use, that had resulted in her being left as the sole carer. Regardless of the risks that the family experienced, however, the mother remained concerned for her son's wellbeing and aware of the compounding negative impact that factors such as social isolation and adversity were having on him.

A feature of many carers' experiences was that they had endured and managed risks over prolonged periods of time, both with and without mental health service involvement. For some families, the consequences of managing the broad spectrum of risks were significant. Parents reported relationship strains because of having differing views from one another regarding the support needs for their relative, as well as needing to balance relations with their other children.

Several parents referred to the internal conflict and guilt that they experienced in their caring role, which could include being an advocate for medication while holding the knowledge that this same medication would “take years off my son’s life” [Father – Mark, Interview]. Stability was often very tenuous in the lives of these families and the person themselves. Families were experiencing vicarious trauma as a result of extreme persistent stress over many years. The mother in the excerpt below reported that she had meticulously recorded all the deteriorations in her son’s health and service responses that she had witnessed over many years:

> It was stunning to us to find that he’d gone down so quick. He’d finished his injection in December, and about three or four months later, he must have been going down, and then he stopped talking to us. … And then two months later he has to be yanked off to hospital again … because of how life threatening it was.
> [Mother – Mark, Interview].

> The door has bashed down before. I’ve been there for some, there have been three emergencies. He doesn’t fight very much, though he did the last time they took him in an ambulance. He objected to it and started to struggle.
> [Father – Mark, Interview]

Carers frequently expressed concerns about iatrogenic risks, most frequently side effects from medications but also the negative impact of coercive care contacts:

> We don’t get the information on how this injection is affecting his body for a start, the kidneys, liver, they don’t tell you anything. There’s hardly any communication within the mental health system.
> [Father – Mark, Interview]

The mismatch between the service’s focus on an individual’s risk to self or others and carers’ focus on the broader social determinants meant that care from services was often focused on mitigating the narrow risks, to the detriment of addressing the contextual risk factors that were perpetuating and compounding risks. Subsequently, families were often left to support their relative in areas of living and required to take on caring roles that included day-to-day support with everyday life tasks (e.g. washing, paying bills and grocery shopping). Many families viewed the support provided by mental health services as narrow and not addressing what was of most relevance to their relative. The mismatch, however, between services’ conceptualisation of risk and consumers’ understanding of risk was even wider.

Consumers’ understandings of risk

Risk was a service-driven concept and was not perceived by consumers as a framework that was relevant to them. Consumers did not use the language of risk, although the issues that they raised were typically framed as “risks” by services. Similarly to family members, consumers spoke about the broader issues that they were experiencing prior to an exacerbation in their illness, as well as ongoing stressors. Consumers spoke about their lived experience, the contextual issues that they understood as impacting negatively on their wellbeing and health. Stressors that consumers described included difficult living situations, homelessness, death of a close family member, loneliness, stressful relationships, lack of finances, unemployment and drug use.

> I was just out of hand last year. I was going crazy because the place I was staying in wasn’t really a good environment for me. I was having daily arguments with one of the blokes who was staying there.
> [Sam, Interview]

Many consumers also referred to iatrogenic harms, predominantly the consequences and side effects of medication. This was particularly important as consumers reported a lack of opportunity to make changes to medication while being under a CTO. They also spoke about the struggle and sense of powerlessness that they experienced when the dominant service discourse mismatched their personal narrative, as illustrated below:

> They don’t like any of my ideas to do with what I’ve studied. They say, “Have I heard any voices recently?” It’s a bit uncomfortable talking about it because I know their preconceived idea is to say that it’s a chemical imbalance and they’ll just up my medication. So, I get to the point where I think, “Where are they from with their viewpoint”? Is it science based?” I like to know more about who the people are deciding my situation. I’ve met people through meditation who have no problem with people who have psychic abilities.
> [Tom, Interview]

Differing risk conceptualisations and decision-making

When risk was conceptualised by clinicians narrowly through a biomedical lens, this resulted in engagement that was focused on risk management, with an over-reliance on medication to mitigate risks. The dominant medical narrative was observed during many care contacts with consumers, as well as discussions among clinicians. Consumers responded to the dominant medical focus in various ways, including acquiescing to the approach, minimising symptoms, “avoiding” services or openly challenging clinicians’ views. These responses typically resulted in the positioning of consumers as being either “compliant” or “non-compliant” with services, although all options resulted in further loss for the consumer.

When there was a lack of shared understanding of risk between clinicians and consumers, the opportunity for collaborative discussions to manage identified stressors (or risks) was diminished. Additionally, clinicians’ focus on medication to manage risks often further polarised the chance of collaborative engagement. In the illustration below, taken from a discussion between a doctor and consumer during a medical review, the consumer believed that he was reducing his risk of further psychotic episodes by ceasing drugs and that he therefore did not require anti-psychotic medication. This was contrary to the doctor's recommendation to continue with medication, with the consumer's action of ceasing medication subsequently viewed as "non-compliance" by the team:

> Junior doctor: What diagnoses have you been given that you know of?
>
> John: ADHD, schizophrenia, drug-induced psychosis, depression, anxiety.
>
> Junior doctor: Who gave you the diagnosis of [schizophrenia]?
>
> John: Doctor […] from here. But that's because I was saying I hadn't been using ice because I didn't want it to get back to the parole board. So, I had to bullshit a bit.
>
> Junior doctor: Why did you stop [the medication]?
>
> John: Because I stopped the drugs. I was off ice 2012–2016 and I didn't have any psychotic symptoms then.
> [Medical review]

This dialogue highlights the tension that was evident in interactions when consumers and clinicians held differing views of risk and strategies to mitigate risk. This difference resulted in a discourse that was conflictual, with limited scope for collaboratively developing a risk-management plan.

When consumers' and clinicians' understandings of risk aligned, the formulation of shared plans was more likely, which in turn facilitated a care focus that was more likely to be relevant to consumers. This shared focus tended to occur when there was an agreement regarding the relevance of the broader contextual risk factors that existed for an individual, with the treating team acknowledging and addressing the identified issues such as homelessness or unemployment as a priority. The following excerpt is an interaction between a consumer and their treating doctor during a medical review. This shared understanding of the broader risks that Sam was facing translated into care that was focused on addressing these contextual risk factors:

> Sam: I was doing quite well, but my housemate was saying some stuff like "Go hang yourself". I've cut back on cannabis. I need to get THC free. I want to look into peer work but need to get my housing sorted first.
>
> Doctor: In most scenarios, you would be considered homeless right now. You need to get accommodation sorted and then you could look at courses and work … The pressing issue is your accommodation.
> [Medical review]

In summary, clinicians were required to assess and manage risks that aligned with the biomedical narrative of illness. The concept of insight was closely related to risk, as this was used by clinicians as an indicator of a consumer's understanding (or lack thereof) of their risks and the need for psychiatric treatment.

A preoccupation with insight

Insight, defined as "a person's awareness of their mental disorder" (Dawson & Mullen, 2008, p. 270), was an important concept for clinicians informing engagement, decision-making and care focus. Although capacity to make decisions about care is referenced in CTO legislation, the concept of insight appeared to have a greater impact on care decisions. Data demonstrates clinicians emphasised biomedical understandings of illness, which meant that the consumer's insight was measured against their acceptance of, and compliance with, treatment that was primarily informed by the biomedical model. This included the person's alignment with clinicians' views of mental illness and their assessed risk.

> I don't think he has very good insight, I think he's very convinced that it's more a … unique spiritual aspect to him rather than any sort of schizophrenia, and it's very strong … very concrete … there's no real getting past that.
> [Nurse – Tom, Interview]

Insight was used as a tool of assessment and measure of improvement, with clinicians aligning poor insight with reduced possibility of recovery. This impacted on how consumers were positioned within the care planning relationship, as well as clinicians' focus of care and engagement with the person. The impact of this bias on care planning is briefly discussed here, with a more in-depth exploration in the following findings chapter.

Insight as a label

Insight was frequently used by clinicians as a quick identifier of an individual's understanding of their illness and compliance with treatment. Although insight was not discussed with consumers, it influenced how workers conceptualised and positioned the person. References to insight during clinical discussions were tacit, without detailed discussion or reflection:

> He's got a chronic psychotic illness, he's insightless.

> Nil insight.

Although labels of insight suggested a simplistic binary, rather than a more nuanced variation of understanding, during the research interviews some clinicians spoke about the complexity of the concept, including people's choice not to accept treatment or become unwell:

> As a principle, I suppose, people have the right to be unwell … people have that choice ... He still has no real insight or his awareness of the need to prepare for prevention. That is one area that we have to work on with him.
> [Psychiatrist – Mark, Interview]

In day-to-day clinical practice, insight as a structural concept in mental health was operationalised by clinicians into their assessments and informed decision-making regarding care. This process was structurally reinforced around the broader concept of the dialogue of pathology and risk. However, insight and risk were both concepts that were closed to consumers. Risk assessments were conducted by clinicians in isolation from, rather than in partnership with, the person, with risk issues generally spoken about indirectly. This lack of transparency and dialogue limited the opportunity for consumers and clinicians to develop shared understandings. Family members were more frequently included in dialogues regarding insight and risk. Although the concept of insight was given significant weight by the team, the use of insight as something that was objectively measurable was “unhelpfully inexact” (Dawson & Mullen, 2008, p. 270), as demonstrated in the following excerpts:

> He has some insight into his illness … [he’s] frustrated about the fact that the CTO is about to lapse and we’ll be applying for another one … he doesn’t have any insight into why he’s having treatment at the moment, although that’s variable, sometimes he does, but I think that’s an indicator of his mental state as well.
> [Social worker – Wu, Clinical review]

References to insight highlighted the emphasis on biogenetic understandings of mental illness and clinicians’ aims to align formulations and treatment options with the biomedical model:

> Plenty of people without insight take meds, plenty of people with insight don’t take meds. It doesn’t matter if you’ve got insight into your illness or not, it matters if you take treatment or not.
> [Doctor – Tom, Interview]

> Insight is just flagged around so much, but at the end of the day, if they don’t have it, we have to take some responsibility for that, ’cause it’s our role to educate them and help them to understand their illness’... I’ve worked with people, they’ve been with the service for 10 years and they don’t even know what schizophrenia is.
> [Social worker, Focus group]

When consumers expressed alternative narratives outside the illness model, there was little scope for clinicians to work with them outside the diagnostic model:

> They're not really interested in metaphysical or spiritual matters. They see it as chemical imbalance and they don't have time to ponder questions about if any of my stuff is true.
> [Tom, Interview]

Although some clinicians acknowledged alternate frameworks for understanding and conceptualising a person's experience of mental illness, this often did not translate into the exploration or offer of different treatment options. This was the case even when clinicians expressed an awareness of different understandings of mental illness among different cultural groups. Less acknowledged among clinicians were individuals' personal explanations of their distress (or illness), for example, those who explained their experiences according to a spiritual framework, drug use or persistent stress experienced day after day. These alternate narratives, therefore, became backgrounded at a systems level with no active alternate options outside the biomedical model available to access and explore, for either consumers or clinicians. This was a systems-level gap, with few options available outside medication as treatment and narrow choice of psychosocial supports and interventions.

For many consumers on CTOs, doctors were the professional group with whom they had the most frequent contacts at the centre. This meant that engagement was primarily within a medical framework that was based on diagnosis and treatment with medication. This was another systems-level issue but reinforced a focus on medication as treatment:

> Sometimes it's very difficult to do anything much with medication. Because of the person's lack of insight, you're left with just treating them with depot medication. So, it can be a bit half-arsed. If the person had some insight. They're not necessarily on the best treatment, they're on the fallback position of what we can actually get into them, what we can manage with their presentation and their illness.
> [Doctor – Sally, Interview]

This view that poor insight could result in less effective medication regimes was a consequence of the conundrum of insight as a dominant narrative regarding care for individuals who were on CTOs, with a focus on medication as frontline treatment. Doctors, however, also referred to the limitations of medication and expressed frustration regarding the limited options of alternative therapeutic interventions available for individuals.

Insight linked with capacity

Labels of "no insight" promoted a sense of stasis and encouraged clinicians to conceptualise consumers as lacking capacity. Insight, however, was not static, with many participants across groups acknowledging that an individual's understanding of their illness usually fluctuated over time, often in relation to broader contextual factors. The following excerpts from a consumer and family member highlight this flux:

> When I was first diagnosed, I didn’t accept it and my friends … at the time didn’t help. The mental health services have been more constant here.
> [Sam, Medical review]

> Up until a few years ago, he wouldn’t even admit it. But now I think he knows it. But he knows it some days and other days totally denies it. It’s still not an issue you can really talk to him about. I can’t … I mean, they’ve always said: “Lack of insight! Lack of insight!” And they said it will take a long time for some, and it seems to have taken forever for him.
> [Mother – David, Interview]

Clinicians considered that poor insight negatively impacted on an individual’s recovery. Thus, insight was also used as a measure of improvement:

> Since being at Elpida, Wu has developed insight. As he has gotten better, he is expressing grief and sadness about his losses.
> [Social worker – Wu, Urgent clinical review]

While some family members reported a lack of engagement from clinicians with their relative in this space, some clinicians were attempting to work with consumers in the space between “insight” and “no insight”. This meant acknowledging that insight was not binary and often meant focusing on the person’s broader needs:

> Social worker: I do think it’s a lot about our approach.
>
> Psychiatrist: And you don’t have to have insight, you have to offer the person something that is of value to them, and that’s not necessarily the medical treatment that comes with side effects.
> [Focus group]

When clinicians focused on the person’s capacity rather than deficits, a different scope and possibility around engagement was available. The focus of engagement became less about monitoring and mitigating risk, and more about an individual’s personal goals. Capacity aligned with recovery and was not dependent on either the dichotomy of consumers needing to agree that they had an illness and that they required medication, or that they denied its existence and therefore required engagement through the CTO process. Considering what was relevant to the consumer almost always meant less emphasis on medication as the primary treatment, as articulated by the psychiatrist below:

> The issue with him is more of a psychosocial coaching in terms of intervention, psychological, not necessarily talking, but more behavioural, or some kind of action.
> [Psychiatrist – David, Interview]

In summary, the biomedical model was informing clinicians' conceptualisation of consumers, with concerns regarding the person's insight and risk foregrounded, and capacity and strengths backgrounded. With regards to care planning, although some clinicians were attempting to work with consumers in the space between "insight" and "no insight", these labels served to relieve clinicians of responsibility for delivering care that was supportive of building capacity. Insight and risk became labels that reinforced the dominant cultural discourse of risk and positioned consumers and clinicians in the care planning space. The following section examines how conceptualisations of risk and insight impacted on the positionings of the key stakeholders within the care planning space.

Positionings of the care planning participants

The positioning of all participants involved in care planning was influenced by service culture. The conceptualisation of risk by services, which situated risk as being within the person, encouraged a focus on the person's deficits rather than strengths and positioned the consumer in ways that influenced clinicians' own positioning and engagement with individuals in their care. Consumers on CTOs were often conceptualised with language that was descriptive of deficits and labelled as being "insight(less)", "risky" and "uncooperative". This focus on deficits was unintended, although it hindered clinicians from taking a strength-based approach with consumers:

> He is currently treatment resistant … He sees his dad and has buddied up with [another consumer], so not sure what mischief they get into … He's just trucking along, no issues at the supported residential facility.
> [Social worker, Clinical review]

The various ways in which consumers, carers and clinicians were positioned in the care planning relationship are explored in Figure 10. Each of these positionings interacted with and reinforced relations and decision-making in the care planning space. Furthermore, service systems that excluded consumers from active participation in dialogue about their care, with clinical reviews held without consumers' or their family's presence, compounded these various positionings.

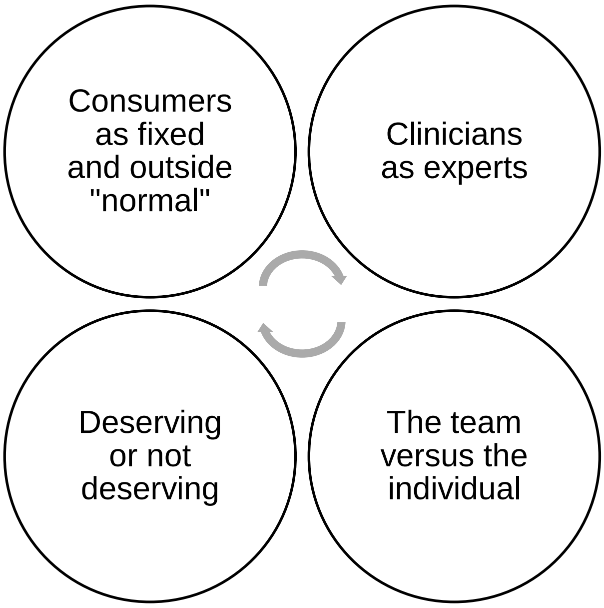


Figure 10. Positionings of the care planning participants

Consumers as fixed and outside “normal”

Risk as a label was pervasive in its impact on how the consumer was positioned, as even when risks were resolved, past risk remained central to the team’s conceptualisation of the person. In the risk-assessment tool used by the service, certain past events were assessed as static risk factors that were unchangeable and permanent. Thus, risk became a permanent and fixed label, and remained with consumers indefinitely or for long periods of time. Potential risks based on past events often had the same weight in decision-making about current and future care as current risk, specifically, the need for a CTO:

> Well, it doesn’t have to be a risk here and now … where it’s certain that a risk will develop in the distant future if treatment ends.
> [Doctor, Focus group]

Being labelled as risky meant that there was a pervasive focus on the potential of harm. Consumers and clinicians agreed that past risks influenced current care contacts and decisions. The following dialogue between a consumer and their treating doctor illustrates this from the consumer’s perspective:

> Junior doctor: Do you remember the last time we caught up?
>
> Wu: Yeah, at my home.
>
> Junior doctor: We were worried about you at that moment.

> Wu: I’m on a CTO, I had no choice.
>
> Junior doctor: Do you know why?
>
> Wu: Well, they put me on one straight away because of my past.
> [Medical review]

Labelling consumers “risky” or “insightless” positioned individuals outside “normal” with a pervasive focus on deficits and the potential to harm themselves or others. Language used in clinical reviews between clinicians further compounded this view, with a moral undertone that consumers made active choices regarding their behaviour. Subsequently, consumers were described as “cooperative” or “uncooperative”, with clinicians having to “catch” or “keep a tab” on the person. All participant groups spoke about the profound impact that being positioned outside “normal” had for individuals, with consumers often articulating their experience of feeling “other”:

> I still think he grapples with the fact that he feels different from his peers and he wonders if he will ever feel completely “normal” [stated with air commas].
> [Social worker – Wu, Interview]

> I’d like to move on from psychiatry and get some other model, like a spiritualist community to help me. I don’t feel like I’m being helped … and that’s been forced on me for 20 years. And my parents now think that I’m just a “schizophrenic”. A disabled person.
> [Tom, Interview]

> Tom feels social workers are checking up on him all the time, and about organising that he’s got to come and get his injection. So, the whole focus is the injection rather than him.
> [Father – Tom, Interview]

This conceptualisation influenced care planning relationships and contributed to clinicians’ low expectations of change, and resulted in a task-based care focus ensuring “compliance” rather than one that was relational in focus. A further consequence of a service focus on the potential for harm was that it reinforced risk-averse practices. Risk resulted in actions from clinicians that were intended to forestall harm. Clinicians expressed their frustration with this, recognising the negative impact that this could have on consumers. In the excerpt below, the worker referred to how risk-averse practices became a barrier to discharging individuals from mental health services or CTOs:

> Sometimes I think when we go through the clinical review process … sometimes things are suggested that are above and beyond what is required to discharge clients because, “What if?” Well, we know from the history that this is what happens.
> [Nurse, Focus Group]

As mentioned, service systems that excluded consumers from clinical reviews and allocated clinicians on brief rotations limited opportunities for clinicians to get to know consumers and challenge or change the team's conceptualisation of risk. This further compounded the fixing of a consumer's positioning:

> There's no time to get to know someone. What you have is the previous doctor's assessment … it's just this sort of cobbled together piece of information about their profile, psychiatric history and admissions … and then you meet them once for 30 to 45 minutes.
> [Junior doctor – Amanda & Tom, Interview]

Clinicians as experts

Positioning consumers as outside "normal" and focusing on deficits positioned clinicians as the experts in the care planning relationship. This positioning was explicit. Consumers were expected to accept recommendations made by the team, with an implicit and backgrounded expectation that they trust clinicians:

> The thing with insight as well is that it's our job to educate the person, we're the experts, the clients aren't psychiatrists.
> [Social worker, Focus group]

Collaborative identification of a person's strengths and needs is a skilled process, although it is considered a core component of the provision of recovery-oriented care. In the following excerpt, the clinician informed John what his primary issue was:

> You've got great insight into your illness; that's fantastic. And you understand why you need to take medication. So, your main issue lately is motivation.
> [Junior doctor – John, Medical review]

Even when attempts were made by clinicians to collaborate with consumers, the power differential remained intact, with clinicians' decision-making regarding CTO use dependent on the person's level of insight and acceptance of medication as treatment. Clinicians, however, reported being sensitive to the need and benefits of including the person in decision-making whenever possible:

> I certainly try and come from a stance of being an adviser to people. That's the position we generally and I certainly feel most comfortable. We can advise them and in the end it's their decision-making and consequences about their own life. In situations where the risk is too high or they lack some decision-making capacity around the potential consequences, I think that's when we use the CTO to take on that responsibility. But then try and work with them still. I think if they still feel they're being worked with and heard, that they are usually more accepting of it … if we can work with them off a CTO, that's even better. But again, that really

> depends on risk and how well they're managed, and what insight they develop around their medication and their illness.
>
> [Psychiatrist – Caleb, Interview]

The team ("we") versus the individual ("you")

Decisions related to CTOs, specifically regarding medication and continuation or discharge from a CTO, were often presented to consumers by clinicians as a team decision, further highlighting the uneven power differential. "As a team we've decided to apply for a new CTO*"*. This positioned consumers as separate, individual and outside the group (the clinical team). Consequently, consumers who disagreed with treatment recommendations found that they were opposed to the dominant group and system, rather than to an individual clinician. This cultural practice occurred frequently; however, it was implicit, with the excerpt below illustrating this dynamic:

> Psychiatrist: And you've got a CTO at the moment? I think we'd like to keep it going because you've done well on treatment and when things go wrong for you, it goes very wrong. How do you feel about that?
>
> Caleb: I prefer not, but I understand why … I don't want an injection at all. Can't you look at tablets?
>
> Psychiatrist: We're too nervous to do it at this stage as we don't know if you'd take it every day.
> [Medical review]

Workers had the "numbers" (other team members) and "knowledge" (expert opinion) on their side. This dynamic had the potential to promote consumer distrust of the system, of which individual clinicians were representatives. This positioning also impacted upon how clinicians talked about consumer engagement among themselves:

> One thing is, he seems to be more cooperative, so more agreeable to listen and take things on board. In the past he was always very independent and dismissive of assistance.
> [Junior doctor – Sam, Interview]

> He's evaded recent blood tests … he's returned to being evasive … the continuous evasiveness is a problem.
> [Junior doctor, Clinical review]

At times, family members were requested by the team to support the CTO. For families, this meant potentially feeling co-opted to be complicit with services. For consumers, this potentially resulted in experiencing family as additional numbers against them regarding care decisions:

> His mother is very on our side about it. Not that there are sides, but his mother has been very supportive of the CTOs. So that was a really good factor in saying “It’s not just us against you, your mother has got concerns about you as well”. So, the decision-making was shared with her.
> [Junior doctor – Tom, Interview]

Family members spoke about the conflict that they experienced around being required to support the CTO process:

> She didn’t like going to get her depot … it was very hard for myself and my son to take her to the [clinic] … because she used to want to run off … Yeah, it was very stressful doing it that way.
> [Mother – Amanda, Interview]

Some families chose to advocate on behalf of their family member against CTO use, which carers described as challenging to navigate, particularly if their family member then experienced a further relapse in their illness:

> Mother: Going back, yes, I encouraged [mental health services] to consider him coming off the injections. And I was pleased for the first two months or so. He was good. Then he stopped his carer and he stopped an appointment or two. Then he rang me up and said, “Don’t bother ringing me again”.
>
> Researcher: So, tell me a little more about your support for him to stop the depot.
>
> Mother: Because he was so well and he was saying he didn’t want to be on it, and it was awful and terrible, and he felt tired …
>
> Researcher: So, it sounds like your views of the role of the medication and CTO has changed?
>
> Mother: Yes, because how life threatening it was [the last relapse] …
>
> Researcher: How has that been?
>
> Mother: Oh, it’s awful. Awful. I think somehow [my husband] can hold his own for the moment, and I try and hold it altogether. You just think, this is your son, and what have I done. It’s a dreadful experience.
> [Mother – Mark, Interview]

“Deserving” or “Not deserving”

At times consumers were positioned by the team as being “deserving” or “not deserving” of their support. This appeared to be a consequence of an implicit belief among clinicians that consumers were responsible for their actions. This dichotomy reinforced the moral concept of individuals as a “good” or “bad” patient, which subsequently influenced how the team engaged with them. In the excerpt below, the consumer was viewed as not having any responsibility for his illness and therefore “deserving” of support. Conversely, consumer drug use and poor engagement often resulted in clinicians allocating increased personal responsibility to individuals for their illness. In these scenarios, clinicians were less likely to advocate for resources.

> This is not a person who has ever deliberately missed medication … he had no hand in it … Issues like no housing and really having to fight tooth and nail for super-limited resources … in this instance, I feel this is a person who is genuinely deserving. He has need that he has no control over, plus he’s demonstrated that he should be considered for good things. [Social worker – Wu, Interview]

The positioning of consumers as “deserving” or “non-deserving” could potentially be communicated to the person themselves. The dialogue below between a consumer and two workers provides an example of how this could occur. In this example, the consumer was effectively being told that he was being rewarded for his efforts “over the years”, with one worker referring to him in the third person although he was part of the discussion. While this was well intentioned, it perpetuated the power differential, as well as the notion that care was conditional on “good” behaviour:

> Caleb: I had some wine about two weeks ago. I’ve lost the taste for alcohol. It’s not like I’m drinking every dollar I have.
>
> NGO support worker: I’m really impressed with Caleb.
>
> Social worker: That’s why I’ve been willing to invest in you over the years, because you really do try.
>
> [Medical review]

Being positioned by the team as “deserving” or “not deserving” of care could impact on care options offered to the person and the extent to which clinicians were prepared to advocate for individuals around their broader needs, including independent housing and access to rehabilitation services. The related concepts of responsibility and blame are explored below.

Risk, responsibility and blame

Allocation of responsibility was a direct consequence of a risk culture. The aim of the CTO and care contacts was to avoid or minimise risk. The responsibilities for enacting the CTO were allocated to all participants in the care planning relationship. Consumers had responsibilities to engage with services and accept treatment. Carers' responsibilities included ensuring their relative attended medical appointments and complied with treatment. Clinicians' responsibilities included regular assessment and management of a person's risk and addressing broader needs through care planning. Allocating blame was a backgrounded cultural theme. Increased risk and adverse events were viewed by clinicians as something that should be avoided. Although these events were considered by services as a learning opportunity to inform practice, allocation of blame often occurred simultaneously. The risk of blame impeded development of trust among all participants at both personal and systems levels, whereby clinicians expressed fear of personal blame by services as well as the broader systems (the coroner or the media) if an adverse event were to occur.

Responsibility and blame influenced communication and decisions by promoting paternalistic and risk-averse practices. The following excerpt, taken from a medical appointment, illustrates the tension of allocated responsibilities related to the CTO. Within this exchange, responsibility was explicitly linked to trust or lack thereof. Blaming the consumer was implicit. This example illustrates the relationship between responsibility, blame and trust at the relational level, with consumers and family members often viewed as sabotaging treatment when they did not follow the team's recommendations:

> Junior doctor: So, you're on a CTO and part of the responsibility therefore falls on the community team that you take your medication. So, we've had a discussion with the team, like I said I would, and we suggest changing to orals rather than the jab … I've done this in good faith and trusted you that you would take the medication … [now] together with the team we've decided to go to orals …
>
> Father: You're the doctor, you tell him what's best to do …
>
> Junior doctor: I do need you to take medication and attend medical appointments. As you're on a treatment order, the minimum is that you do this.
>
> Jim: And if I wanted to see a doctor on my own?
>
> Junior doctor: You mean a private psychiatrist? ... We don't have a choice in terms of us following this up. I know we've had issues in the past, but the benefit for you, is I've taken you off the injection. But it's up to you, if you don't attend appointments.
>
> Jim: Yeah, yeah, I know that's the deal. You don't have to say that.
> [Medical review]

Clinicians referred to responsibilities and the possibility for blame that related to high-risk concerns, including having to answer to “the coroner” in the case of an adverse event, as well as lower level concerns including risk to reputation:

> Well, I’m feeling quite vulnerable. I can’t assess him. I feel I’m at risk and the service is at risk. If something happens, they’ll say “why haven’t you done something?” I’m really quite concerned about my inability to assess his mental state.
> [Nurse, Clinical review]

> I tried to [revoke a CTO] once and it was rejected by SACAT because it didn’t quite meet the criteria well enough. For revocation you have to show they no longer meet the criteria for having a CTO. And then it got sent to the Office of the Chief Psychiatrist and I was like, “Oh no, so embarrassing.”
>
> [Junior doctor, Interview]

Fear of blame influenced decisions in care planning by promoting risk-averse practice and at times limited support options available to consumers. Clinicians saw it as their responsibility (or duty) to take on increased responsibility for decisions for consumers who were perceived to lack capacity or insight. Clinicians, for example, were typically cautious to discharge consumers from CTOs and administration orders. Conversely, at other times services reduced or withdrew support and care because of the implicit belief that consumers were responsible for their lack of engagement in the recommended treatment plan or because it was deemed not possible to enforce the CTO:

> We can’t keep him in the service if he’s not taking medication due to risk … The alternative is to enforce the depot and attend with SAPOL and SAAS, but his current risk does not require this level of coercion.
> [Junior doctor – Jim, Interview]

> One NGO was pulling away and saying it’s “his choice, his behaviour”, they saw him less and less and less. I was arguing that he needed more … so then we all set him up for that failure, and a spectacular relapse where he assaulted the doctor, he assaulted a man [in public].
> [Social worker – Caleb, Interview]

Clinicians found themselves situated between responsibilities to the system and to individual consumers. This included responsibility to compensate for the impacts of the CTO on an individual’s choices and options:

> Doctor: It’s often quite a weight on your mind … People think we are rushing to put people on CTOs, but we’re not, we’re trying really hard to avoid that. That’s the last resort.
>
> Researcher: And when you say it’s not easy, what are you referring to?
>
> Doctor: Well, one is the responsibility of it, in that you’ve taken liberties away from this person. So then how are you going to compensate for that? So, you’re going to try and bend over backwards to make everything as comfortable as possible for them. You want things to be going right for them … just generally being treated for their illness and hoping that the trajectory of their illness can be improved.
> [Doctor – Sally, Interview]

In summary, all participants in the care planning relationship were constrained by the potential and actual blame that could be allocated because of the responsibilities that came with the use of CTOs and the intention of avoiding harm. Clinicians were aware of risk-averse practices, with some reporting being required to follow team decisions rather than their own preferred decision which was aligned with greater risk taking. Additionally, families often blamed themselves when their family member became unwell, especially if they had supported their family member in advocating against the CTO.

Many of the themes described above were concurrently interacting and impacting on the positioning of the consumer, and therefore the care planning relationship and engagement process in this space. The following section explores how care planning differed when risk or capacity were foregrounded. Although the person’s wider context was often neglected during care planning, it was evident that some clinicians were working with the person within their broader context.

Context dismissed

Care planning for consumers on CTOs was occurring within a culture that was dominated by risk which often dismissed the person’s broader context. This was inclusive of settings that both included and excluded consumers and their family members. In a risk culture, consumers were expected to trust clinicians, positioned as the experts and representatives of the system, and at the same time prove that they could be trusted (be morally worthy). Conversely, when consumers were seen holistically and in their broader context, the care planning relationship facilitated a focus on a person’s capacity and increased the opportunity for the development of mutual trust. Although some clinicians were engaging with consumers with a focus on capacity, the dominant culture of engagement within the services was informed by a view of the consumer that focused on deficits.

The following excerpts, taken over three months of observations of care contacts with the same consumer, further demonstrate how consumers and clinicians were positioned when care was driven by risk. For context, Wu was a young man who during the study period was admitted to an acute unit, then a community rehabilitation centre, where he was actively engaged in the program. In each excerpt, the team were positioned as an expert group separate to the consumer. The consumer needed to prove that he was trustworthy, with all participants understanding that this meant following service recommendations. Conversations were deficit-focused.

May 2018
Wu: The experience with [the mental health team] is pretty good, as long as you follow what you have to do. Researcher: What does that mean? Wu: I accept the services.
June 2018
His insight is really good now and it's a combination of his very settled mental state … of the input of some of the staff and the peer worker … This is the kind of person you trust to not be on a CTO eventually. Because if he can maintain the routines … if he can sustain his wellness … he's going to be a candidate for no CTO. [Social worker]
August 2018
Doctor: What are your thoughts [about the CTO expiring]? Wu: I'm hoping to make it voluntary. Doctor: I agree. You've done really well. I'm going to let it lapse and it's up to you to show us it's the right decision. I think everyone would be in agreement. [Registrar]

A person in context

Situating a person in their broader context appeared to counteract some of the morally informed dynamics detailed in the various positionings described above. Taking a holistic approach meant seeing the person's capacity as well as their needs. Additionally, focusing on the person's psychosocial issues, for example employment or education, highlighted areas important to the consumer that lay outside the area of clinical expertise, thus repositioning the workers away from being the experts in the care planning space:

> David's insight is impaired. David probably also has a degree of mild frontal lobe impairment or executive dysfunction or intellectual disability. So, with that background, David was always being a challenge [and] being managed by a treatment order ever since I saw him. However, David was able to work part-time as a kitchenhand before. And although he was disengaged … at least tried to become an apprentice as a mechanic. So, there was evidence of his motivation and willingness to engage in the workforce and in the mainstream.
> [Psychiatrist – David, Interview]

In the example above, although the doctor referred to various deficits, this was situated alongside the consumer's strengths and hopes. Situating a person in their psychosocial context influenced care planning, as it promoted a sense of hope among clinicians and consumers, and influenced which services were engaged with to support the person. In the example below, the care coordinator linked with youth services that supported the consumer to re-engage with education:

> Researcher: So, what's important to Amanda?
>
> Nurse: … I think it's the usual things of a young person. She wants to have friendships with people her age, wants to get out with people her age, wants to mingle with them. She wants to get an education … [college] or some other study. She wants to do some form of work in the future. And I think down the track she'd be wanting to move out of home.
> [Nurse – Amanda, Interview]

The excerpt below gives an example of care that was driven by capacity, whereby the discussion was future focused, hopeful and relevant to the individual's life goals. Focusing on broader issues that lay outside the area of clinical expertise repositioned clinicians away from being the experts:

> Nurse: If things could get better, where would it be now? Because things are going really well.
>
> Amanda: Probably being more independent.
>
> Nurse: So, what is that?
>
> Amanda: Going to the gym, getting to TAFE.
>
> Nurse: And in the next year?
>
> Amanda: Getting my drivers licence.
> [Medical review]

Table 10 summarises the consequences of positioning the consumer in these different ways.

Table 10. Consequences of care that is informed by risk or capacity

CARE INFORMED BY RISK	CARE INFORMED BY CAPACITY
Fixed	Possibility of change
Labels of “risky” & “insight(less)”	Focus on strengths
Focus on deficits	Right to choose and to “fail”
Untrustworthiness	Trust
Powerlessness	Choice

The power differential that was evident in the morally informed positionings that were a consequence of the risk culture will be explored in greater detail in the next chapter, which focuses on engagement in care planning.

Summary

This chapter has explored the culture of care planning for consumers on CTOs at a CMHC. Risk and the forestalling of risk were found to be central to the day-to-day work and communication among mental health clinicians. This focus was despite mental health policy and services promoting care that is recovery-oriented. The impact of a risk culture was significant for all participants in the care planning relationship. The dominant narrative, which situated risk as internal to the person, influenced the positioning of all participants in the care planning relationship. Although clinicians identified problems in care planning approaches and processes, and some viewed the person in their broader psychosocial context, current system culture and structures restricted rather than facilitated ways of working that were more aligned with promoting recovery. The next chapter will explore in further detail how clinicians, consumers and carers were engaging with one another in the care planning process within a culture of risk.

CHAPTER SEVEN
CARE PLANNING WITH CONSUMERS ON CTOS

Introduction

As previously defined, care planning was considered broadly to include communication about treatment and care among clinicians, and between clinicians, consumers and their family. These discussions were documented in the case notes and informed the person's care plan. Key components in the care planning process included engagement and decision-making about a person's support needs and care options. This chapter explores how these key components were enacted during service care contacts. To reflect the focus on care planning discussions, illustrations used in this chapter are drawn mainly from ethnographic observations of such discussions. The culture of risk, as detailed in the previous chapter, influenced how consumers on CTOs and clinicians were positioned in the care planning relationship. These positionings influenced engagement and decision-making processes, and care opportunities for consumers. This chapter explores the impact of these positionings within the care planning space, the impact of the CTO on engagement and decision-making processes within the care planning process and service systems that further impacted upon and constrained care planning processes. The tension that was evident between the risk and recovery discourses is threaded throughout the themes.

CTOs as a tool for engagement

Consumers on CTOs were viewed by clinicians through a lens that focused on risks that were situated within the person. This focus on internalised risk shaped workers' views and impacted on current and future care planning. Assessment and management of risk were central to many service care contacts and impacted directly on engagement and decision-making processes. Furthermore, when consumers were conceptualised as "risky" this had implications for clinicians who were attempting to engage and develop an alliance. Before exploring this in more detail, this section explores how the CTO itself was used as a tool for engagement.

The presence of a CTO meant that the consumer and the mental health team were both legally bound to maintain contact for the purpose of treatment and care. This dual binding was acknowledged by both groups; however, it was viewed as a forced relationship with responsibilities, rather than a reciprocal relationship with choices. Clinicians spoke about CTOs being used to engage individuals in care when other approaches of engagement by the team had failed:

> He's someone who will abide to a legal order but not to a doctor-to-patient relationship. [Psychiatrist, Community ward round]

Although clinicians acknowledged CTOs were not the “best care”, the use of CTOs was often a default option taken by teams to ensure that a basic level of engagement was maintained with the consumer:

> There’s been a failure to a certain degree if you have to go to a CTO … and sometimes that’s not always the best medical care. But it’s better to have people engaged than not.
> [Psychiatrist, Focus group]

CTOs were also used by the mental health system more broadly to ensure that a community mental health team remained involved in a person’s care. Thus, CTOs were also a tool for engaging the team: “The CTO is an order on us. We are required to stay involved” [Doctor, Focus group]. The binding of a team to a consumer for provision of care often spanned different treating teams, with one team (typically inpatient services) initiating a CTO to ensure another team (community services) remained involved in the person’s care.

The following excerpt provides an example of an individual’s care being transferred between two different treating teams. The CTO had been initiated by the inpatient team; however, following discharge the community team was required to support the application. During a discussion after the medical review (excerpt below), the doctor informed the researcher that he thought the CTO was not required and that he had felt uncomfortable having to present a case for the order at the South Australian Civil and Administrative Tribunal (SACAT) hearing. The CTO had facilitated discharge from the inpatient setting; however, this decision was not made by, nor necessarily supported by, the community team:

> Psychiatric registrar: How are you feeling about the CTO?
>
> John: Doesn’t bother me.
>
> Psychiatric registrar: What’s your understanding of it?
>
> John: Because my schizophrenia can come on so quick, it’s best I’m on a treatment order so I stay well and stable. It’s for my own safety. I’ve been told people want to get off them. I want to get on one.
>
> Psychiatric registrar: Well, some, like yourself, have got insight and realise what treatment benefits them … you’ve had firsthand experience how impaired you can become when you’re ill … The CTO sits in the background only to be used if your engagement dwindles, or you’re not accepting of medication.
> [Medical review – John]

Consumers were aware that the CTO meant ongoing oversight from the mental health team, which was experienced variably. Some consumers considered the CTO benign, as above, while others felt strongly that being on a CTO was a negative experience and not about care, but rather about being monitored or under surveillance by the team: “I can’t get rid of it. It’s a heinous thing, it’s more for you guys” [Medical review – David].

Although clinicians acknowledged the dual responsibilities that existed for the mental health team and consumer to engage in the care process, there was an overemphasis on the consumer’s responsibility to engage within this transaction, which seemed contradictory to the rationale for CTO use: “It’s up to him; if he can’t engage, we can’t get a medication change” [Nurse, Clinical review]. The team’s expectation that consumers engage in the CTO process impacted negatively on the care planning process and care relationships. Clinicians who held this view often expressed frustration with the consumer, which negatively influenced the chance of the development of a positive alliance and influenced their course of action:

> Junior doctor: It sounds like he’s not engaging with the CTO …
>
> Psychiatrist 1: You said he’s usually OK to go there to give the depot … would he consider coming in here to see a doctor? ...
>
> Psychiatrist 2: Yes … So why not take a doctor out? It’s about bringing him in. At the moment we are bending over backwards. So, let’s get him to start taking responsibility. It’s a stepwise thing.
> [Urgent clinical review]

The teams’ belief that consumers had a responsibility to engage in care was implicit and backgrounded. For some consumers, the presence of a CTO appeared to influence the team’s view of what level and type of engagement was appropriate. At times, a CTO meant that expectations of worker engagement were set up as minimal contact from the outset. This narrow engagement, however, made it impossible for the clinician to get to know the person. The following dialogue between clinicians during a clinical review involved a discussion about the initial care plan and provides an example of an accepted minimal level of oversight. It also demonstrates the lack of input of consumers and carers at this early stage, with the decision-making situated solely among the team*:*

> Psychiatrist 1: So, he’s not going to come in for depot?
>
> Nurse: Well, I think he will with mum.
>
> Psychiatrist 2: Set up behaviour of him coming here to start with. It will be interesting to see if his behaviour changes when he drops off licence.
>
> Nurse: He’s on a CTO.

> Psychiatrist 3: So really, we’re not going to be able to discharge him in the next 6 months.
>
> Nurse: I need to pull everything together in a comprehensive assessment, So at this stage …
>
> Psychiatrist 1: It’s follow-up.
>
> Nurse: So fortnightly?
>
> Doctor: Suppose so.
>
> Nurse: I’m comfortable with fortnightly for the depot, then stepping it up if need to.
> [Urgent clinical review]

The focus of this initial clinical review was entirely on management of risk and medication. There was no exploration of the person’s strengths, needs or views regarding contacts with mental health services. Although the care coordinator referred to the need to present “a comprehensive assessment”, this initial presentation set up an agreed minimal contact from the services. Additionally, the acknowledgement that the team were “not going to be able to discharge him in the next 6 months” referenced the system’s focus on ‘flow’, highlighting the pressure on clinicians to consider discharge from the point of service entry. The care plan for the consumer was to maintain minimal contacts for the period of the CTO and discharge as soon as possible. Evident in these contacts was the dichotomy of setting up minimal contacts based on medication as treatment, which the person often did not want.

Focus of engagement: Monitoring versus supporting recovery

The meaning and purpose of care contacts often differed for each participant in the care planning relationship. Care contacts for individuals varied in time (frequently or infrequently), space (on the phone or in person) and place (the mental health centre, home or other setting). Contacts that were narrow in focus were effectively concerned with monitoring the individual. These contacts were clinician-led and focused on tasks that were deemed to be priorities by the service, typically assessment of the individual’s mental state, management of risk and ensuring compliance. Contacts that were broader in focus were more aligned with the individual’s broader contextual needs. Although the service model of care, business rules and policy promoted care approaches that were person-centred and recovery-oriented, clinicians were often observed to prioritise service-driven tasks that were related to managing risk. These service priorities were neither driven by the consumer nor recovery in focus. This narrow care focus was a direct consequence of the culture of risk and dominant biomedical model which influenced and limited clinicians’ understandings of individuals’ needs.

The following dialogue, taken from a medical review, provides an illustration of these two disparate foci of engagement occurring within the one setting. This included monitoring (by the doctor) and an exploration of the individual's broader contextual issues (by the care coordinator). For further context, the doctor was an intern and was not pursuing psychiatry. Many consumers, however, were regularly allocated junior doctors on rotation.

> Junior doctor: And you've been taking medication?,...
>
> Amanda: Yeah.
>
> Junior doctor: So, it's not actually working because it's not in the therapeutic range.
>
> Mum: But she's doing a lot better in her mood, her sleep.
>
> Junior doctor: So, let's start at the beginning. Do you know why you are seeing us?
>
> Amanda: Yeah, so I don't relapse.
>
> Junior doctor: Yeah, and do you know your diagnosis?
>
> Amanda: Yeah, bipolar disorder.
>
> Junior doctor: Yeah, it's more schizoaffective disorder … The thing is, you've been in hospital numerous times.
>
> Mum: Yeah, we know that, you don't need to tell us that. [frustrated]
>
> Junior doctor: So, the reason you've been in hospital is non-compliance.
>
> Amanda: Yeah, we're taking it.
>
> Junior doctor: So, would you take two [tablets]?
>
> Mum: Yeah, as long as she feels good in her body.
>
> [Amanda and her mum reiterated that she was feeling well and doing much more than previously.]
>
> Junior doctor: Yeah, but this is to prevent things deteriorating in the future. As well as feeling good now.

Amanda's emotional presentation changed during this conversation from being open to shutting down. There was a rupture in her relationship with the doctor, who was presenting himself as the expert and focused on diagnosis and medication, missing what Amanda and her mum were communicating. There was a complete absence of SDM and no focus on strengths. The care coordinator appeared uncomfortable with the above transaction and took over the conversation and changed the focus:

> Nurse: If things could get better, where would it be now? Because things are going really well.
>
> Amanda: Probably being more independent.
>
> Nurse: So, what is that?
>
> Amanda: Going to the gym, getting to college.
>
> Nurse: And in the next year?
>
> Amanda: Getting my drivers licence.
> [Medical review]

The care coordinator asked Amanda about her current life, future goals and feelings about attending the mental health centre. Their approach was strengths-focused, respectful and inclusive. The following sections explore in more detail service care contacts that were narrow as well as broader in focus. The variations in purpose, meaning and frequency of care contacts observed at the study site are explored from the perspectives of consumers, their carers and clinicians. Additionally, systems-level structures that influenced these contacts are presented.

A narrow focus of engagement

Contributing factors to a narrow care focus included service system structures, the dominant biomedical framework that reinforced diagnosis and medication as treatment and, consequently, workers' low expectations of consumers. The following two excerpts, from two medical appointments with the same participants several months apart, illustrate the narrow care focus that many consumers were regularly experiencing. Wu was a young man in his twenties who at the time of these medical appointments was residing in a CRC and was actively engaged in a rehabilitation program:

> Junior doctor: It sounds like you're doing great. Tell me about the voices.
>
> Wu: They come at night. They talk about God …
>
> Junior doctor: Do they tell you to harm yourself or others?
>
> Wu: No. [slightly frustrated] Do you know, though, I'm back in society … It's an optimistic world in [the rehab unit].
>
> Junior doctor: Do you think the olanzapine has helped with the voices?

> Wu: The voices are not as frequent … I feel normal … [the voices] tell me what's happening spiritually … So just now a voice said "[Jane]".
>
> Junior doctor: Who is [Jane]?
>
> Wu: Someone I know. She annoys the shit out of me.
>
> Junior doctor: Do you get thoughts of harming her?
>
> Wu: No. [slightly frustrated]
> [Medical review – Wu, November 2017]

This form of engagement was monitoring, with the care contact a missed opportunity for the doctor to engage therapeutically with the consumer. This was despite Wu talking about his experience of his voices and recovery. Wu clearly expressed his frustration with the questions which were led by the doctor and focused on the task of assessing his risk. Explorations of risk in medical appointments were often formulaic. Consequently, consumers were observed to anticipate the direction of the conversation within this context. As illustrated below, several months later Wu voluntarily, and unprompted, clarified issues specific to the clinician's concerns about "his" risk. The contact was effectively a repeated experience for Wu; however, he was adapting to the risk framework. Wu was aware of what the doctor wanted to know and did not express any frustration with the questions. Implicit, however, in the process of continual risk assessment was the implication that consumers were inherently "risky":

> Junior doctor: So, it's been a couple of months since I saw you, how have things been?
>
> Wu: The voices were playing up last night … They were telling me to wake up … but not telling me to harm myself, just annoying me, saying, "He's listening".
>
> Junior doctor: Do they tell you to harm others?
>
> Wu: No.
> [Medical review – Wu, January 2018]

The generic consumer

Service structures and cultural assumptions of consumers among clinicians became barriers to workers getting to know the person, which then impacted on care planning. Frequent changes in allocated clinicians and service endorsement of care contacts that were narrow in focus made it challenging for meaningful relationships to be developed between consumers and clinicians. Additionally, the positioning of consumers that focused on deficits biased clinicians' views and resulted in the tendency to minimise a person's capacity. This meant there was often a mismatch in what was relevant to and needed by the consumer, and what was deemed a priority regarding support by mental health services. Missed opportunities for clinicians to gain an understanding of a person's strengths and needs were occurring at various transition points, including handovers between clinicians and between teams. This included transitions that occurred from acute inpatient to community teams, as highlighted in the following example, where a consumer unknown to the community team was presented to clinicians attending a clinical review. This person had been living independently for many years without any supports from services, but was introduced through a lens that focused on his deficits:

> Henry was put on a CTO level 2 as there were concerns he could not engage, very poor insight … would not manage independent living … Henry has longstanding schizophrenia and was previously managed by his GP. At the home visit the house was immaculate. Henry could rationalise the need to do housework, gardening [said in a patronising tone]. He hadn't complied with orals. Henry kinda got lost to post discharge and by the time we saw him it was 6 weeks post discharge. He is only seeing us because of the CTO. Engagement is superficial. At this stage poor [worker's name] is trying to catch him on the phone and when he comes in for depot and OPD. Henry is fine if we keep it superficial ... There is constant contact to build rapport, trust and information about early warning signs so we can nab him sooner. He doesn't understand the concept of care coordination … we phone every 2 weeks just around rapport building and touching base … and in the rambling you get information … It appears he is managing better than the discharge summary indicated.
> [Social worker, Urgent clinical review]

The lack of personalisation resulted in individuals being conceptualised as a generic consumer rather than a person with individual needs, strengths and preferences. A focus on symptoms and risk influenced the objectification of consumers by clinicians and impacted on the care options offered. The excerpt below provides a further example of clinicians not seeing individuals within their broader context. This consumer lived with his fiancée, actively pursued several interests (cars and music) and worked part-time for a family member. However, in the dialogue led by the doctor, rather than exploring and aligning support needs with what was relevant to John, standard service referral options were offered. The resultant care plan was generic and not relevant to John's specific context and needs. As a result, John withdrew from the care planning discussion and reverted to one-word answers. This experience also negatively influenced future care contacts.

> Junior doctor: So, most of the time you're home?
>
> John: Yeah.
>
> [The doctor suggested attending a mental health day program.]

> Junior doctor: It’s a way for clients to be able to do things outside your home.
>
> John: No.
>
> Junior doctor: It’s something we’ll continue offering once we get on top of those symptoms.
>
> John: I already do things out of the home.
> [Medical review – John]

Knowing the person required a level of connection. While some clinicians appeared to readily connect with what was relevant and important to the person, often time was needed for both parties to develop such a connection, highlighting a benefit of continuity of care. The following excerpts show a change over time in a clinician’s perception of the consumer (including their capacity) as their relationship developed. This resulted in a change in the clinician’s approach to care contacts from passive holder of care to that of an active advocate. Care became person-centred with different care and service options available to the person.

September 2017
He has Hebephrenic schizophrenia, really pronounced negative symptoms ... The family tolerate him like a slightly inconvenient occupant of the house. I inherited him about a year ago. [Clinical review – Wu]
February 2018
I would like to offer this young man the best opportunity. He is a candidate for IPS, meta cognitive therapy. [Urgent clinical review – Wu]

When clinicians changed their care focus, this could lead to different conceptualisations of the person. The following clinician described taking over the care of a woman who had experienced a long history of adversarial contacts with services. On changing the approach and acknowledging the trauma and damage of such contacts with the consumer, the clinician commented:

> She’s a different person now to back then.
> [Social worker, Informal discussion]

Clinicians’ low expectations of, and for, consumers

Clinicians’ low expectations of consumers impacted on their engagement with individuals in addition to the services the person was offered:

> No benefit from extensive input. He just needs to be chased up every month. Probably nothing else really.
> [Psychiatrist, Clinical review]

At times tension was evident between different workers, with some more open to the possibility of recovery and actively supporting this, and others more aligned with a narrower focus of care:

> Social worker 1: The CTO was started after a short admission. I met him last week and we spoke briefly … He engaged superficially. Our role is to kinda keep tabs on him; see how he settles into [the hostel] ... We were initially sceptical about him staying … but he's familiar with the area from his childhood, so he's enjoying reconnecting with the area and organising to go fishing ...
>
> Occupational therapist: So, he's motivated towards activity and interests.
>
> Social worker 1: Yes …
>
> Social worker 2: He might benefit from the routine/structure from the SRF.
>
> Social worker 1: He has had multiple accommodations ...
>
> Doctor: If he plays up, we might need to be aggressive with the CTO, it's too early to judge.
> [Clinical review]

In the above excerpt of dialogue taken from a discussion during a clinical review, although there were positive comments made by some clinicians relating to the consumer being self-directed and re-engaging in personal interests, the overall discussion was diminishing of the person. The focus of care – to "keep tabs on him" – was narrow and set up an adversarial dynamic: "if he plays up, we might need to be aggressive with the CTO".

Clinicians' low expectations of consumers were informed and restricted by their attempts to understand the person's behaviour and choices within the biomedical framework of diagnosis and medication as treatment:

> Social worker: Normally he just bumbles along and he seems fairly content … He was very unmotivated … and he had these very pronounced negative features of his illness … Whereas at the moment he's got a bit more energy because he's acute …
>
> Researcher: So, what you might do with him might change as a result?
>
> Social worker: Yeah, for a while. But what I want to do first before I implement anything is get the mental state settled and then say, "Look, what do you want?" 'Cause he might be like "Nothing". I haven't seen him for ages because he's mainly depot, so nurses go out to

> do it, and he's been travelling smoothly for like over a year … He's a very chronic young man … he won't be going anywhere. He'll be needing medication for life.
> [Discussion with care coordinator after clinical review – Wu]

Clinicians from all disciplines were influenced by the dominant biomedical model. The clinician above, a social worker, was assessing consumer readiness and ability to engage and make changes as being dependent on the medication being effective. Clinicians' low expectations of consumers links with the next theme, whereby consumers were placed in a "holding pattern" by the system.

Consumers placed in a "holding pattern"

Many consumers identified by the services as requiring a care focus that was labelled maintenance were placed in a "holding pattern". This meant that the care plan was static rather than an active changing process. In one team, consumers in this group were not always allocated a care coordinator and therefore were not necessarily known by an individual worker (as described below). At a systems level, there was little oversight of clinicians to be accountable for engaging with consumers to determine if this level of care was appropriate. Subsequently, consumers could be left languishing in a holding pattern for indefinite periods:

> Well, I inherited him from another worker … so I didn't know him ... So, he knew the service, but he didn't really have a specific person attached to him. And for a long time initially it was more the depot clinic nurse who was going out to the family home to give him his injection ... he was cooperative, but largely uncommunicative as well. So, his acute relapse at the end of last year was actually where a lot of the rapport building happened between him and me because we worked so closely … It was a lengthy admission.
> [Social worker – Wu, Interview]

Wu was someone for whom the clinician's expectations for change were initially low and who had subsequently been left in a holding pattern for several years. Wu, however, made significant progress soon after the above conversation. He was admitted to an acute ward, established a relationship with his care coordinator and was referred to the community rehabilitation centre, which provided him with the opportunity to actively participate in his recovery. The dominant care approach that had been about holding changed to care that was active and recovery-oriented in focus.

Clinicians were restrained by care approaches and systems that were already in place, with many continuing a care pattern that had been established by previous workers. Some clinicians, however, expressed concern about the limited opportunities available to consumers on CTOs within current service systems and actively implemented a different care approach:

> Obviously on CTOs you have the more enduring and chronic client … [who] you might see once a month … or once every 3 months these days … in the depot clinic, for medication. But what happens in between all that … Where's the recovery in that? What's in between? ... What opportunity do the clients get to improve when they are seen once a month by a care coordinator or one of the doctors?
> [Nurse, Focus group]

A broader focus of engagement

Engaging with broader issues resulted in provision of care that was personalised and inclusive of psychosocial goals. Care coordinators linked with family or other services to assist individuals to expand social, recreational and work opportunities or assist with day-to-day living. These clinicians acknowledged that the quality of the therapeutic relationship with the consumer was enhanced by providing support that was relevant to them:

> I've just had two clients who have been taken off the CTO, not worked well with the system for years, and just a different approach … I found that with those two people, it was working on their other stuff … getting them linked with good job network providers … they've both got work, and got more well … We were able to develop a better relationship. So, there is a lot of stuff that we can do.
> [Social worker, Focus group]

Addressing consumers' broader needs facilitated the development of trusting relationships. This trust appeared to extend to different workers and the system:

> It's my social life at the moment … It's a ridiculous thing to say, but clinicians and so on, breaks up the day, or the week or whatever … I'll see a worker at least once every day. The only day I don't is a day on the weekend … I miss it actually. I look forward to it.
> [Caleb, Interview]

> Like [my care coordinator] said, there's a family, the Community Health, she goes, it's a family, basically, of networking to get to know you … Yeah, it does feel like a family.
> [Wu, Interview]

There was evidence of clinicians attempting to focus on broader issues that were relevant to the person, although finding themselves constrained by system pressures, priorities and cultural assumptions. Clinicians who were interested in incorporating broader approaches into their clinical practice described a lack of support from the system, including limited involvement from care coordinators and alternate care options:

> You have to rely a lot on other people, and some people have a lot of input and you open up your notes to do your next appointment for them and there's been so much contact from various people, or from the case coordinator, you go "Phew, stuff's happening, I don't have to spearhead anything". Other people … the last note was your last medical review, so nothing's been documented that's been done for the last four weeks or whatever, and it feels a bit more like "I'm on my own, if there's anything that needs to happen for this patient, I have to be the one pushing for it". It's also really limited in terms of the non-pharmacological things we can do.
> [Junior doctor, Interview]

In the excerpt below, the psychiatrist below spoke about the complexity of determining the "right [or] realistic goal" for consumers, acknowledging that the possibility of further harm needed to be balanced with promoting hope. This highlights the tension between risk and recovery by demonstrating the constraining influence of risk on clinicians who were attempting to provide care that was person-centred and recovery-focused:

> I wanted him to go back to work … but somehow, without knowing, set this high expectation from me and from family that had a negative impact and in another year he became very very avoidant … In this setting, the team focusing on occupation, we have a service that is aimed to help these people … whenever you see patients, you probably 80% … talk about work and sometimes this is taken by the patient that you are very critical, or "They are judging me" ... "I'm a failure" … How do we handle this or make it more neutral?
> [Psychiatrist – David, Interview]

Finally, when clinicians took a broader approach to care contacts, this did not always enhance engagement, as described by the carer of the same consumer:

> The services have tried. When he got out of hospital, they put in an amazing amount of support … They came and saw him every afternoon for at least two weeks, just to make sure he was taking his medication, and keeping an eye on him. Then they sent someone to offer to take him out, and I think he went out with him once and then rejected it. Then [they] took someone from the drug and alcohol … David refused to have anything to do with that … So, they did really swing in an enormous amount of support, but he rejected it. So, what can you do?
> [Mother – David, Interview]

The remainder of the chapter examines the impact of the different positionings of the participants on care planning.

Positioning and power

The various consumer and clinician positionings in the care planning relationship were explored in the previous chapter. These positionings resulted in consumers on CTOs commonly viewed through a lens of risk and deficits, with care contacts informed by this. Conversely, although less frequently, some consumers on CTOs were viewed through a lens of strengths and capacity. However, the dominant cultural positioning of consumers as “other” and outside the dominant group (the mental health team) and communication structures such as clinical reviews that excluded consumers and their families resulted in significant disparity in power between consumers, carers and clinicians. The impact of the disparity in power and participants’ positioning in care planning on engagement and decision-making processes (see Table 11) is now discussed.

Table 11. The impact of power and positioning on care planning

Positioning and Power	**The silence of risk**
	A mismatch of issues and goals
	Minimising consumers’ concerns
	Clinicians leading decision-making
	Persuasion, leverage and threats
	Trust or lack thereof
	The impact of place and space

The various positionings set up adversarial dynamics between consumers and clinicians, and impacted negatively on the potential for the development of mutual trust:

> You’ve got these people on never-ending CTOs, so how do you agree to disagree with them and still support them? You have to become adversarial as these people will not engage.
> [Psychiatrist, Clinical review]

Although clinicians were aware of the power differential, this awareness did not result in discussions or actions to directly redress this imbalance with consumers:

> He just agreed to everything. But he is very agreeable, which is concerning … Whether he's just saying stuff for us to leave him alone, and that's not what we want. We want him to engage and we want him to feel like he's owning this recovery process.
> [Nurse – Mark, Interview]

The remainder of this chapter explores the impact of consumer positionings, the subsequent power relations and how these impacted on the care planning process.

The silence of risk

Explicit discussions with consumers about how their assessed risk impacted upon clinicians' decision-making when applying for, enforcing or renewing a CTO were lacking. Although risk was explored with consumers and their carers during face-to-face contacts, this exploration was mostly implicit. This silence and resulting power imbalance between consumers and clinicians negatively impacted on the establishment of rapport and trust, and meant that consumers were left with the polarised options of either acquiescing or avoiding contacts with services.

In the dialogue below, although communication appeared respectful, engagement was superficial. The consumer was positioned as separate to the team and their opinion immediately excluded from the decision-making process by the doctor. The lack of transparent dialogue limited opportunities for consumers to understand what they could do to get off a CTO. The issue of managing risk was reduced to compliance. Hence, consumers learnt to comply with the clinicians' views regarding necessary action to mitigate risk, which was usually acquiescing to medication:

> Junior doctor: What are your thoughts about a new CTO?
>
> Phillip: I'm going to take medication anyway. I don't need a CTO.
>
> Junior doctor: So, would you support a CTO?
>
> Phillip: No.
>
> Junior doctor: As a team, we've decided to apply for a new CTO.
> [Medical review]

Paternalistic views were evident, with some clinicians explicitly stating that they did not directly address the issue of risk with consumers, believing that it would be unhelpful for the person. While the intention of clinicians was to prevent further harm, this view reinforced paternalistic practice and was a missed opportunity for greater transparency and inclusive decision-making:

> It's not the kind of conversation I'd have with him and say "Hey, Wu, do you understand what your risks are?" But I think along the way he's made comments about some of the stuff he's done when he hasn't been well … So, he can talk about those things … I would talk about it in terms of "What are the things that are keeping you well and moving towards

> what you want for yourself?” versus talking about the destructive things.
> [Social worker – Wu, Interview]

A few in-depth discussions related to risk were observed. These discussions were typically held between experienced doctors and consumers who openly discussed behaviours that they experienced as distressing or out of character. Some consumers spoke about previous self-harming incidents, suicide attempts, drug use or aggressive behaviour towards family or friends as signs that they were not coping. There were, however, many missed opportunities for engagement in discussions and in-depth exploration of risks between clinicians and consumers.

A mismatch of issues and goals

As explored previously, consumers were predominantly concerned with issues related to broader life domains, and clinicians with issues related to illness and treatment. This resulted in the frequent mismatching of goals between consumers, families and clinicians. Although clinicians often elicited individuals’ primary concerns and hopes through discussion, this did not always translate into support towards consumer-identified goals. A lack of in-depth exploration of what was relevant to consumers was frequently observed during medical reviews. This was a systems-level issue that impacted on consumer’s experiences of care and, potentially, their engagement with services.

To provide further context for the disparity in goals between consumers and clinicians, the following list details the future hopes and goals that were provided by consumer participants:

> My hobbies are drawing and sometimes, if I feel up to it, painting. I did kids’ books and illustrations,…,I’ve been trying to get work.
> [Tom]

> To get a well-paid job. A career or something.
> [Amanda]

> To be a little more active,…,Hopefully a job,…,Probably stacking shelves at a supermarket.
> [Mark]

> To be a big rock n’ roll star. [laughter] Not to be a big rock n’ roll star, but just to play in a band, a regular band.
> [Caleb]

Those clinicians attempting to address the broader social inequities that consumers faced described systems-level barriers to the provision of such support. The following worker spoke about the risk-averse culture that impeded incorporating different approaches e.g. the Maastricht approach:

> You tend to put your focus in where the rest of the team is, like: “You come in; You depot” and that’s the model that you’re following. I think if the environment and the culture here was more exploring those things, you’d be more encouraged to spend time doing those things … and be aware that there’s probably going to be errors and mistakes and things could go wrong.
> [Nurse – Tom, Interview]

Typically, clinicians who were involving consumers in their care planning focused on issues that were within the scope of the biopsychosocial model: symptoms and interventions to address these (medication, psychology and behavioural activation). Less emphasis, however, was given to the broader issues impacting on an individual’s daily life. The following extended excerpt demonstrates the discrepancy in priorities which impacted upon goal identification and service supports offered. While the doctor made significant efforts to empower the consumer with choice around medication, the consumer’s primary concern, lack of finances, remained unaddressed:

> Junior doctor: You said you usually hear voices in the context of drugs … So, we will review the need for medication … You said that psychology wasn’t that helpful.
>
> John: Yeah, I probably didn’t participate much ...
>
> Junior doctor: It’s important for your mood that you have activities every day that are fun, that you enjoy.
>
> Partner: Yeah, I try to get him to come out to the shop and to friends.
>
> Junior doctor: I guess you’ve tried different medication and didn’t get much benefit.
>
> John: Yeah.
>
> Junior doctor: How are you finding the current medication?
>
> John: OK.
>
> Junior doctor: This one can help with mood, anxiety and sleep, and in larger doses psychotic symptoms … What do you think? ... [The doctor presents 2 options and pros and cons of each] Your call really.
>
> John: The second option.
>
> Junior doctor: OK … It’s a bit of a trial … Anything else you’re worried about?
>
> John: Money.

> Junior doctor: Do you have any debts?
>
> John: No, just bills.
> [Medical review]

The discussion was focused was on exploring symptoms (anxiety and depression) and suggested interventions (behavioural activation and medication), missing the issue that John identified as his primary problem. The plan of action (or goals) documented from this session were determined by the doctor's priorities.

The disparity between the consumer's goals and service goals, and the complexity around this, were acknowledged by some clinicians. Compounding factors in this disparity included differing personal values and a service focus on treating mental illness. Clinicians found it challenging when consumers' values, and therefore goals, did not align with their wellbeing or were not future-focused. This was particularly evident when people were pre-contemplative regarding drug use. The following two excerpts are taken from discussions among clinicians where references were made to the challenges faced in determining mutually relevant goals:

> Bradley is not too happy with me trying to discuss future plans … he's very focused on immediate needs and wants.
> [Occupational therapist, Clinical review]
>
> Social worker: He's insightless around his illness and history … I tell him these are a sleeping man's goals but I'm here if you want to do more, such as go to the gym or find a job. He's only 31.
>
> Occupational therapist: How does he occupy himself?
>
> Social worker: Gambling, drug taking, hanging out with friends … I realise I'm making a value judgement about how I think money should be spent, but he could spend it on life goals like going travelling. He will state "I want to be left alone".
> [Clinical review]

During an interview, one of the doctors explicitly acknowledged the benefits to the system when a consumer's goals aligned with the medical model:

> He seems to be really driving his own recovery and … doing it in a way that's really acceptable to the medical model. He's not going "I'm not going to take any medications" and making us worry.
> [Junior doctor – Wu, Interview]

At times family members expressed wishes for their relative which did not align with what the person wanted themselves, with clinicians required to balance these differing views. The following excerpt provides an example whereby the consumer's issues were raised during a medical review, although not addressed in any meaningful way, with the doctor's and family members' priorities taking precedence:

> Junior doctor: How's college?
>
> Jim: It's hard. It takes more brain power than I'd expected. But at least I know the study load now.
>
> [Jim talked about the IT course he was doing]
>
> Junior doctor: How are you going with it? Assignments?
>
> Jim: It's hard, I don't have a computer at home.
>
> [The doctor acknowledges that it would be impossible to study, particularly an IT course, without a computer at home and asks Jim about the possibility of getting one. Jim's dad, however, changes the topic and asked about screen distance and the association with headaches.]
>
> Junior doctor: Well, I hold my iPad about here [demonstrates the distance], which is probably too close, and I get headaches.
>
> [There is laughter from most in the room. The doctor then asks some questions about sleep and there is no return to Jim's issues regarding the challenges he was having with study]. [Medical review – Jim]

The potential impact of a mismatch in the identification of a person's needs and goals could include discharge from the CTO and mental health services altogether. Jim was one of the care journey consumer participants with whom it was not possible to meet again after this medical review, as following this meeting the team explored discharging Jim from the services due to perceived lack of engagement. Thus, a further dichotomy that presented for clinicians working in a risk culture and associated with differing participant perceptions of needs and goals were the options to discharge someone due to their perceived lack of engagement or to enforce medication. Enforcing medication could require a high level of coercion and force (including attending the person's home with police); thus, the level of assessed risk typically determined the team's actions. Clinical reasoning that was foregrounded in these instances included preserving the relationship with the consumer and their family, and adhering to the principle of providing the least restrictive care. Backgrounded assumptions that influenced clinical reasoning and decision-making included the positioning of consumers and their families as "not deserving", as in this example they were "not playing ball" and "preventing the depot". Additionally, limited resources were prioritised for those consumers who were "deserving" (as explored in the previous chapter). Minimising Jim's concerns (and goals) potentially impacted on his engagement with services, a theme that is further explored below.

Minimising consumers' concerns

Consumers' concerns regarding their care experiences, as well as experience of being on a CTO itself, were often minimised by clinicians. When consumers communicated their preferences regarding medications, this typically did not result in changes, with clinicians' approaches to such discussions often paternalistic and disempowering. Again, this reinforced the power differential between clinicians and consumers, and impacted negatively on the therapeutic relationship and specifically the development of trust. Below are several dialogues that illustrate this dynamic within the context of medical reviews. In the first example, although the consumer clearly raised her concerns regarding side effects from medications, the doctor neither empathised with nor explored her concerns regarding treatment. The dialogue would likely have resulted in polarisation and an adversarial dynamic, rather than connection and collaboration:

> Amanda: Could I change to Abilify as I'm putting on lots of weight and I don't like it?
>
> Junior doctor: In terms of management, it also involves careful diet and exercise.
>
> Amanda: Yeah, but I prefer …
>
> Junior doctor: I have read your documents. You've been in hospital 9 times and they did try Abilify.
>
> Amanda: But only for 2 weeks.
>
> Junior doctor: I think it's not an appropriate option. So, I think it's important you stay on the current medication. You're looking so well and doing so much.
> [Medical review]

Care approaches that were task-driven often overrode care that emphasised connection during medical appointments. Below, the treating doctor missed the opportunity to connect with the consumer's sadness and concerns, and remained focused on the task of ensuring medication compliance:

> Jim: The fact that I have to take medication is a bit saddening too, to be honest. I just hope I don't get any side effects.
>
> Junior doctor: I'm putting a lot of faith in you, putting you on orals.

> Jim: The sodium valproate is a bit high.
>
> Junior doctor: I need you to get a blood test.
>
> Jim: There won't be any trace in my blood as I haven't taken it for some time.
>
> Junior doctor: You need to restart it.
> [Medical review]

The impact that being on a CTO itself had on consumers was also often minimised by clinicians, who viewed the CTO as being in the background of an individual's experience. All consumers interviewed in this research project, however, spoke about how they felt disempowered (to differing degrees) because of being on a CTO:

> I've yet to talk to a consumer who is really ok with being on a CTO!
> [Excerpt from fieldwork journal, May 2018]
>
> I think [the CTO] reassures them … It's just like a hands-on, lets them know where I'm at, what I'm doing. There's no spy, but it gets close. You know what I mean?
> [Caleb, Interview]

In addition to minimising the impact of a CTO, the presence of a CTO was laden with the expectation and responsibility that consumers were cooperative with services. This expectation was at times implicit and at other times explicit (as below), whereby the comment made by the doctor could be viewed as a veiled (although unintended) threat:

> Sam: I found out today I was on a CTO. I thought it had expired last year.
>
> Doctor: Yeah, till July. We're not actually making you do anything. If you're being cooperative and assuming you continue, a CTO will not make any difference.
>
> Sam: Yeah. [somewhat resigned]
> [Medical review]

Clinicians leading decision-making

CTOs gave jurisdiction to mental health clinicians and services around treatment for the person's mental illness. Within this domain, decisions regarding CTO use and medication were almost always made by clinicians, with this acknowledged by workers, consumers and families. This power differential was a foregrounded cultural norm. While doctors discussed medication with consumers, often in detail, the final decision was almost always made by clinicians. Although consumers regularly raised concerns regarding medication (particularly side effects), they typically did not get the changes they sought. This contributed to adversarial relationships, with consumers labelled and positioned as non-compliant with treatment if they chose to stop or self-reduce medication. This is another example of consumers being presented with no choice other than to comply. Consumers rarely initiated any discussion directly about the CTO itself.

The excerpts below illustrate the lack of involvement consumers had in decision-making and lack of options available to them to redress this within current system structures. In the first dialogue, conducted between a psychiatrist with many years' experience and a consumer, the consumer had little influence over any decisions regarding their medication, with the psychiatrist deferring the decision to an unknown time in the future and making it dependent on discussions with other clinicians. The consumer was positioned as outside the team, with the team responsible for making the decision:

> Caleb: Speaking of medications, I've got an opinion on this. I've been putting on a lot of weight. Before I was on a depot and they substituted it with a tablet, and I lost weight … I don't want an injection at all. Can't you look at tablets?
>
> Psychiatrist: We're too nervous to do it at this stage as we don't know if you'd take it every day.
>
> Caleb: Well, they know I take it every day as they come around every morning and watch me take it.
>
> Psychiatrist: At some later point we could look at changing to tablets.
>
> Caleb: [sighs] Oh, OK then.
>
> Psychiatrist: Look, I'll talk to [care coordinator] about switching. We don't want you to get unwell, as when you get unwell you seem to get in trouble with the police.
>
> Caleb: Yeah. [sighs]
> [Medical review]

Systems processes that excluded consumers from discussions where decisions were made about their care further compounded their solitary position and made it challenging, rather than facilitatory, for clinicians and consumers to engage collaboratively. Clinical reviews were attended by mental health clinicians only; thus, decisions made within this context excluded the consumer and family. In the next excerpt, the same consumer, Caleb, was being discussed in a clinical review that occurred after the discussion between Caleb and the doctor (as detailed above). It was clear that Caleb had no advocate in the decision-making space, from which he was excluded. The clinician's comment that Caleb was "fixated" with his weight minimised his experience of side effects and invalidated this concern as "normal". This view, as well as the clinician's needs (workload and stress), appeared to inform the decision-making process, rather than Caleb's preferences:

> Psychiatrist: I saw him last week. He was complaining about the medication and weight gain. We discussed switching medication …
>
> Social worker: He's also mentioned the weight gain to me and he's quite fixated on it … [The] GP [is] looking at a physical health assessment. Having another complex client switch meds? I'm worried about this … I'm wondering if it might be better to change medications after court, as he may forget about it.
> [Clinical review – Caleb]

Consumers on CTOs often had very complex needs. Consequently, at times significant and recent perceived risks made it challenging for clinicians to engage in genuine SDM around medication. The three following excerpts involve the same consumer (Mark), family member (his mother), psychiatrist and care coordinator grouping on two occasions almost 12 months apart and highlights the challenges for all participants. In the first appointment, the psychiatrist was supportive of and responsive to Mark's wish to reduce medication:

> Mark: Are we getting the medication reduced today?
>
> Psychiatrist: Yes, how do you feel? How is the medication helping you?
>
> Mark: Well, I don't know if it's helping. But I feel fine.
>
> Psychiatrist: Have you had the depot yet today?
>
> Mark: No, after this.
>
> Psychiatrist: Definitely we can reduce it. Let me try to review the situation.
> [Medical review]

In the second appointment, although the psychiatrist explored Mark's capacity to make decisions about his treatment, the discussion terminated abruptly, with the doctor making the final decision. For further context, this was the first medical review scheduled following a long admission where Mark had relapsed and been found in an extremely physically compromised state:

> Psychiatrist: Good to see you. How are you?
>
> [There are pauses for each question with Mark giving brief answers.]

> The issue for me is, after being through the trauma, we need to continue the treatment until you're well. We need to look at the pros and cons. This time I will be a bit firmer. What is your view?
>
> Mark: I'm not too keen on it.
>
> Psychiatrist: Do you think you need treatment?
>
> Mark: No.
>
> Psychiatrist: What might happen if you stop?
>
> Mark: I don't know. I probably need to be monitored a little bit, to see I don't keep to myself too much.
>
> Psychiatrist: Who will monitor?
>
> Mark: Well, I go to my parents on the weekend, so they see I'm active, which leaves me the rest of the week.
>
> Psychiatrist: So, you think by being active people will see you are ok? You don't need medication?
>
> Mark: No, I don't think so.
>
> Psychiatrist: So, our plan is organising for fortnightly depot ... We can change it to three-monthly in the future.
> [Medical review]

In this instance, the psychiatrist was making a "reasonable prediction of an unwelcome event" (Szmukler & Appelbaum, 2009, p. 238) based on a significant history of relapses that had been life threatening to the consumer. In this instance, Szmukler and Appelbaum (2009) would not consider this action to be coercive. The negative consequences, however, for consumers of this power imbalance in decision-making, even when necessary, are evident. Mark described the loss of active involvement in decisions regarding his care as "disorientating":

> Mark: Taking some of the decision-making away from me is a bit disorientating. I don't like it that much …
>
> Researcher: What kind of decisions do you feel involved in?
>
> Mark: I can't think of any at the moment … [laughs] … In some cases, yes. But they go their merry old way in some ways …

> Researcher: So, do you think you have much choice in relation to your care?
>
> Mark: Not with the medication, you don't. I'd like to have less medication, but they don't seem to like that idea.
> [Mark, Interview]

The challenge for clinicians engaging with consumers when there were disparate views, particularly around medication, is explored further below.

Persuasion, leverage and threats

> I've certainly had that conversation that the medication continues and if you fail to come in for the medication, I'm going to get orders again.
> [Doctor, Focus group].

Within the context of CTOs, use of persuasion, leverage and threats was apparent in discussions among clinicians and between clinicians and consumers. Paternalistic views, an emphasis on risk mitigation and the positioning of consumers as "other" likely informed this approach. Clinicians were generally explicit in their use of persuasion or leverage, with offers of food vouchers or other supports used for leverage to promote engagement in care. The use of threats, however, was both explicit and implicit, with clinicians not consistently aware that they were resorting to this means of coercion. Use of threats typically appeared to be a result of worker frustration and a shortcut to achieve compliance from consumers. The following excerpts provide examples of discussions among clinicians where the use of threats was explicit, with the stated intentions being to enforce treatment and minimise risk of harm. At times clinicians referred to the need for reduced capacity as a justification for coercive approaches:

> Junior doctor: I'm quite conflicted. My opinion is drugs are driving it ... If there weren't the kids in the picture, we'd back off … So, you could threaten him with that every single time …
>
> Psychiatrist: So that might be the leverage. I suspect we need to go through the more coercive path in the first instance. There are children at risk.
> [Urgent clinical review]
>
> Occupational therapist: So, he doesn't identify with schizophrenia, but is compliant. I'd be interested to know what his values are ... Is he taking it because of legal ramifications?
>
> Doctor: In an SRF [supported residential facility] they get the message they don't have a choice. They are told the staff can get the police and they can go back to hospital. If people absolutely refuse, we can't do anything, but we can put a lot of pressure on them in a SRF.

> Occupational therapist: So, it’s an enforced decision.
> [Clinical review]

The next two dialogues provide illustrations of the use of threats which appeared unintended. On both occasions, the threats were made following in-depth conversations between the doctor and consumer about medications. Prior to using threats, both doctors had provided significant information and choice, but in the end resorted to low-level threats to imply the need for compliance. Use of threats de-emphasised the value of the therapeutic relationship and was a shortcut to the skilled negotiations that would be required if the person were not on an order. The introduction of a threat was driven by each doctor’s frustration at not reaching an agreement after an extended discussion with the consumer. Effectively, there was no choice for the consumers to not take medication:

> Registrar: OK, I think we’ll give the current medication about a month.
>
> John: I’ve always found I’m best on no medications.
>
> Registrar: Well, I guess we’ll try this first. I guess you’re on an order.
> [Medical review]

When clinicians were unaware that they were introducing a threat, the threat was implied and without a clearly stated consequence. Consumers, however, were often aware of implied threats:

> Junior doctor: We don’t have a choice in terms of us following this up. I know we’ve had issues in the past, but the benefit for you is I’ve taken you off the injection. But it’s up to you, if you don’t attend appointments …
>
> Jim: Yeah, yeah, I know that’s the deal. You don’t have to say that.
> [Medical review]

Occasionally clinicians and families did not correct an individual’s misunderstanding of their CTO status. Szmukler and Appelbaum (2009) labelled this a form of deception:

> His parents are propagating that he is still on a CTO though he hasn’t been on one for years.
> [Clinical review]

Finally, the threat of the option to apply for a CTO was used by some clinicians to maintain an individual’s engagement and compliance:

> The introduction of the CTO level 1 as a possibility has increased compliance. If you say, “If you don’t take your medication, I will apply for a level 1 CTO”. This is mainly for people who

> have previously been on a CTO 2. People are no longer on rollover CTOs because of this.
> [Doctor, Focus group]

Trust or lack thereof

Consumers' positioning, their subsequent lack of power and care that was focused on the service priorities of treatment compliance all made developing trusting relationships between clinicians and consumers challenging. When consumers were positioned as "risky" and "untrustworthy", this negatively biased clinicians who were attempting to develop alliances with individuals. As highlighted in the excerpts below, this issue was conceived and reinforced by the systems, with individual workers constrained by the dominant risk culture. The focus of care was on the task, which was often medication compliance, rather than relational:

> There's a trust issue. How can they get to trust this person? ... The system in these cases doesn't seem to allow for the very thing that is the problem: the paranoia; and the need for consistency and relationship building … the whole focus is the injection rather than him … the system needs to establish a relationship with Tom other than just administering the needle.
> [Father – Tom, Interview]

Although clinicians were aware of the impact that coercion had on their relationship with the person, the potential pervasiveness of the damage that was being done more broadly remained culturally backgrounded. To illustrate this cultural assumption, in the excerpt below the doctor believed that the consumer would trust "others" in the service who were not directly involved in implementing the CTO:

> Doctor: So, she has good engagement with [the nurses] and very poor engagement with me. That's something that I'll often construct.
>
> Nurse: Good cop, bad cop.
>
> Doctor: I'll say, "This is my decision, not the nurses', they just follow my orders."
> [Focus group]

Care that was truly person-centred and recovery in orientation went against the tide of the service preoccupation with risk. It was also dependent on and emphasised the value of relationships and trust. Trusting relationships enabled consumers to take risks and express their dissatisfaction with care:

> Caleb: Well, when a decision comes up that has to be made, they put it to me and I give them my response.
>
> Researcher: And do you feel heard or listened to?

> Caleb: Yeah, I think so … they're helpful. I don't think they are interfering, because that's when I get a bit irritable … and I've let them know, I've said, "Listen, I just don't like this."
>
> Researcher: In what way have people interfered?
>
> Caleb: When a person touches a bit too much on personal, you know what I mean?

Mutual trust also facilitated positive risk taking by clinicians working within the system and appeared to enable clinicians to have more transparent discussions in the care planning space:

> A woman with a 20-year history of … Police … that was really the only engagement. It changed just because she was in hospital … I was able to go in there … and really build rapport … So now she actually has trust and faith in the system after 20 years of just seeing us as someone who just brings round the SWAT team when she's not had her depot.
> [Social worker, Focus group]

> Psychiatrist: So, I'm thinking to increase your medication a little.
>
> David: OK, whatever, I trust you.
>
> Psychiatrist: Mary, what do you think?
>
> Mary (mother): I think David is not really seeing that towards the end of the medication, it runs out.
>
> David: Yeah, I agree with that.
>
> Mary: And we get strange behaviour.
>
> David: Yeah, I agree with that.
> [Medical review]

The impact of place and space

Although most of the ethnographic observations were conducted at the mental health centre, many consumers, carers and clinicians highlighted the impact of place and space within the context of forced care. Consumers, their families and clinicians often reported a sense of intrusion when care contacts, in the context of a CTO, occurred within the person's home. Some clinicians, sensitive to this intrusion, offered consumers choice regarding location for care contacts:

> Maybe stop asking other people to come to my house and try to talk to me, because I like my own space.
> [Amanda, Interview]

> How do you think I feel about that letter [CTO application] arriving in my letterbox with all that stuff written about me?
> [Tom, Interview]

> That's intense fear, and also it's in his home. We bought him that home so that he would be independent ... So, when he locks his door, he thinks he's safe. But in fact he discovered he's not, because they [MHS and police] can smash it in.
> [Father – Tom, Interview]

> It's the worst intrusion to do it at home … I really don't like holding people down in their own homes. I think it's the biggest human rights violation.
> [Social worker, Clinical review]

Although there was variation in consumers' experiences and preferences regarding preferred place to meet with clinicians, this was an area that could have quite a profound impact on the person's sense of safety and wellbeing within their own home.

Summary

This chapter has explored how consumer positionings influenced all core components of the care planning process, including engagement, decision-making processes and care options. While risk was the dominant service narrative, recovery-focused care was still occurring at the site. Although CTOs often resulted in biased assumptions among clinicians regarding a consumer's capacity, and a focus on deficits rather than strengths, some clinicians were providing person-centred care that focused on the person's capacity. Overall, however, the recovery narrative was stifled, with mental health clinicians' focus aligned less with the person's broader goals and more with the service's goal of ensuring compliance. Service systems that impacted upon and further constrained care planning processes have been touched upon in this chapter. The following chapter will extend the analysis and examine the structural elements that were constraining care practice.

CHAPTER EIGHT
A SYSTEM CONSTRAINED BY THE BIOMEDICAL MODEL

Introduction

This thesis seeks to gain an in-depth understanding of interpersonal and structural issues impacting upon the care planning process for individuals on a CTO. The service focus on risk, and the impact of this on the positioning of individuals in the care planning relationship, care approaches taken by clinicians, and care options available for individuals on CTOs, have been elucidated in the previous two chapters. Stage four of Carspecken's (1996) methodology involves the identification of possible origins to the cultural themes present at the study site. This chapter broadens the analysis and links the cultural themes established from the reconstructive analyses, presented in the previous findings chapters, to the broader cultural context (Carspecken, 1996).

Various theories have dominated psychiatry since its inception (Geekie & Read, 2009; Lebowitz & Appelbaum, 2019), although the biomedical and biopsychosocial models are most relevant to this thesis due to their currency internationally and locally. This chapter situates and critiques the key findings at a systems level, drawing on theoretical explanations and understandings of mental illness and specifically the phenomenon of the ongoing dominance of the biomedical model in mental health practice. The biomedical model underpinned, reinforced and constrained service culture and practice at the study site. Models affect practical care issues, including "the nature of care, roles in treatment, responsibility for care, and venues of interventions" (Corrigan & Penn, 1997, p. 356). These are core features of interest in this ethnographic exploration of the phenomenon of care planning. Although this thesis focuses specifically on care planning with individuals on CTOs, the author acknowledges that many care experiences that have been conceptualised in the findings chapters would be relevant to many individuals attending a range of mental health services seeking support and care.

Understandings of madness

Models of illness are culturally informed understandings of disease and illness. The prominent models that inform how mental illness (or "madness") is currently understood include the biomedical, biopsychosocial and psychosocial models. The bio-bio-bio model (Read, Bentall & Fosse, 2009; Sharfstein, 2005), is a critique of the application of the dominant biomedical model and thus important to present as it pertains to current care provision in psychiatric settings. Models are important as they govern understandings of mental illness and interventions offered, and therefore have practical implications for individuals who attend mental health services for care (Corrigan & Penn, 1997; Geekie & Read, 2009; Lebowitz & Appelbaum, 2019; Read et al., 2009). Models also inform clinicians' attitudes about people diagnosed with mental disorders and assumptions around prognoses and outcomes (Lebowitz & Appelbaum, 2019). In the first section of this chapter, the current key models are briefly explored theoretically. The impact of the structural components of these different models are then positioned against some of the key findings of this thesis in the latter section of this chapter.

The biomedical model

Biomedicine has informed the dominant understanding and conceptualisation of mental illness within mental health systems for decades (Moncrieff, 1999; Vanheule, 2017). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (American Psychiatric Association, 2013a) is the system used by clinicians to diagnose and classify mental disorders and inform treatment planning. The DSM-5 informs an approach to diagnosis and treatment that centralises the concept of "building on symptoms as the foundation for care" (American Psychiatric Association, 2013b, p. 1). Symptom-based diagnoses, however, are rare in other areas of medicine and the reliability of the DSM classification of mental disorders has long been contested (Vanheule, 2017). Biomedicine focuses on exploring what is wrong with the person (diagnosis of a disorder) and what the person needs to do to change (acceptance of interventions to eradicate or reduce symptoms and related impairments). The processes (genetic or neurobiological abnormalities) that result in a mental disorder arise from within the person and are not context dependent (Bracken et al., 2012). The biomedical framework is thus primarily concerned with clinical recovery: symptom reduction and behavioural management, and the individual's interpersonal and environmental context, and personal meanings are of lesser importance (Bracken et al., 2012; Vanheule, 2017). The following excerpt from the thesis data illustrates this biomedical framework. The junior doctor drew on medical training which foregrounds the importance of biogenetics and emphasises the importance of diagnosis and medication as treatment:

> Junior doctor: So, let's start at the beginning. Do you know why you are seeing us?
>
> Amanda: Yeah, so I don't relapse.
>
> Junior doctor: Yeah, and do you know your diagnosis?
>
> Amanda: Yeah, bipolar disorder.
>
> Junior doctor: Yeah, it's more schizoaffective disorder … The thing is, you've been in hospital numerous times.
>
> Mum: Yeah, we know that, you don't need to tell us that. [somewhat frustrated]
>
> Junior doctor: So, the reason you've been in hospital is non-compliance.
> [Medical review]

The cumulative impact of these interactions on the person receiving care could be profound, although any potential negative impact was backgrounded and implicit at the worker and service levels. Rather than promoting the biomedical model, with its accepted limited scope, mental health service policies worldwide identify the biopsychosocial model as the primary model informing current care provision (Patel et al., 2018).

The biopsychosocial model

The biopsychosocial model, developed by the psychiatrist Engel in 1977, was a critique of biomedical reductionism and an attempt to reform the medical model (Engel, 1977; Pilgrim, 2014). Engel argued that biological, psychological and social processes all contribute to the development of a disease (Engel, 1977). While the biopsychosocial model is broader than the biomedical model, it continues to place biological malfunction as primary, and relational and social factors as secondary, causal factors in the development of mental illness (Read, Fink, Rudegeair, Filetti & Whitfield, 2008). Read (2005) argued that the biopsychosocial model has not been "an integration of models" but rather a "colonisation of the psychological and social by the biological" (p. 597). Specifically, a core concept of the biopsychosocial framework, "stress-vulnerability", has been interpreted as an acknowledgement that life events or stressors can trigger development of an illness, but only for those already genetically vulnerable (Read, 2005; Read et al., 2008). Interestingly, this interpretation has occurred despite the original developers of the model assuming vulnerability to stress could be acquired (Read et al., 2009; Read et al., 2008)

In this thesis, clinicians at the study site perceived that they were applying a biopsychosocial lens to clinical care, although this was frequently observed to be backgrounded to the biomedical model. The dominance of the biomedical model was an implicit cultural norm. The clinician quoted below, although describing various factors which could impact on a team's decision-making regarding enforcing care, emphasised risks related to relapse and chronic illness. Risk was foregrounded and problematised through a lens reflecting the disease paradigm:

> There's lots of things to balance – civil liberties, risk, risk aversion, relapse, worker frustration. And there is the view that if someone has repeated relapses, they're on course for a chronic illness, and then what do you do then?
> [Social worker, discussion after urgent clinical review]

Psychosocial models

There continues to be a significant and growing evidence base demonstrating that psychosocial and environmental factors are causal factors of psychosis and other mental disorders, rather than secondary consequences (Bentall et al., 2014; Kessler et al., 2010; Read et al., 2008). Causal events include childhood abuse and maltreatment, social adversity and other trauma that may occur throughout a person's life (Kessler et al., 2010; Read et al., 2008). There is also emerging evidence that specific types of adversity are linked to specific symptoms; for example, childhood sexual abuse has been linked to auditory hallucinations, and disruptive attachment to paranoia (Bentall et al., 2014). More broadly, political and economic factors have been found to impact on the prevalence and course of schizophrenia, with times of increased unemployment associated with increased prevalence and worse outcomes (Warner, 2005). These research findings align with studies whereby individuals who have lived experience of a mental illness and also the general public endorse psychosocial factors as the main cause of mental illness (Carter, Read, Pyle & Morrison, 2018; Read, 2020).

The bio-bio-bio model

While mental health policies worldwide have promoted the biopsychosocial model, the biogenetic perspective in psychiatry has also been strengthening following developments occurring in pharmacology and brain imaging (Double, 2004, 2007). During this time, researchers, survivors of psychiatric services, consumers and clinicians have expressed increased concern that psychiatry has moved towards an "over-medicalisation of mental disorders and the overuse of medications" (Sharfstein, 2005, p. 3). The dominance of biological psychiatry has thus been directly linked to the pharmaceutical industry (Moncrieff, 1999; Read, 2005; Sharfstein, 2005). On this basis, the former president of the American Psychiatric Association warned his colleagues that they must collectively "examine the fact that as a profession, we have allowed the biopsychosocial model to become the bio-bio-bio model" (Sharfstein, 2005, p. 3).

Although warnings of a shift towards the bio-bio-bio model have come from within the psychiatric profession itself, the ongoing emphasis on the importance of biology and genetics in psychiatry, although contested, has meant that the biomedical model continues to dominate in the provision of mental health care. The context and consequences of this dominance are discussed below.

The differing paradigms of mental illness

A paradigm refers to a set of ideas. The paradigms of disease and discrimination, as described in a paper authored by Corrigan and Penn (1997) over 20 years ago, provide a means to conceptualise the two prominent differing perspectives for understanding mental illness and situate the models presented above. The paradigm of disease is underpinned by the biomedical model and is based on the concept that mental illness arises from genetic or neurobiological abnormalities (Corrigan & Penn, 1997; Lebowitz & Appelbaum, 2019). The paradigm of discrimination acknowledges the stigma and discrimination that individuals living with a mental illness experience, and privileges the need for social action. This paradigm is underpinned by psychosocial understandings which locate an individual's experience of mental illness (or distress) within the person's life experience (Corrigan & Penn, 1997; Geekie & Read, 2009; Read et al., 2009). The paradigm of discrimination emphasises the person's social, psychological and environmental contexts, and is informed by values of social justice (Bentall et al., 2014; Corrigan & Penn, 1997; Longden & Read, 2017).

Advocates of this paradigm highlight the need to broaden the conceptualisation of mental illness and redress the limited opportunities, resources and supports available to individuals with a mental illness (Central Potential – Te Rito Māia, 2008; Corrigan, 2016; Slade et al., 2014). There is, however, overlap in the paradigms, with the biopsychosocial model informed by both the paradigms of disease and discrimination (see Figure 11).

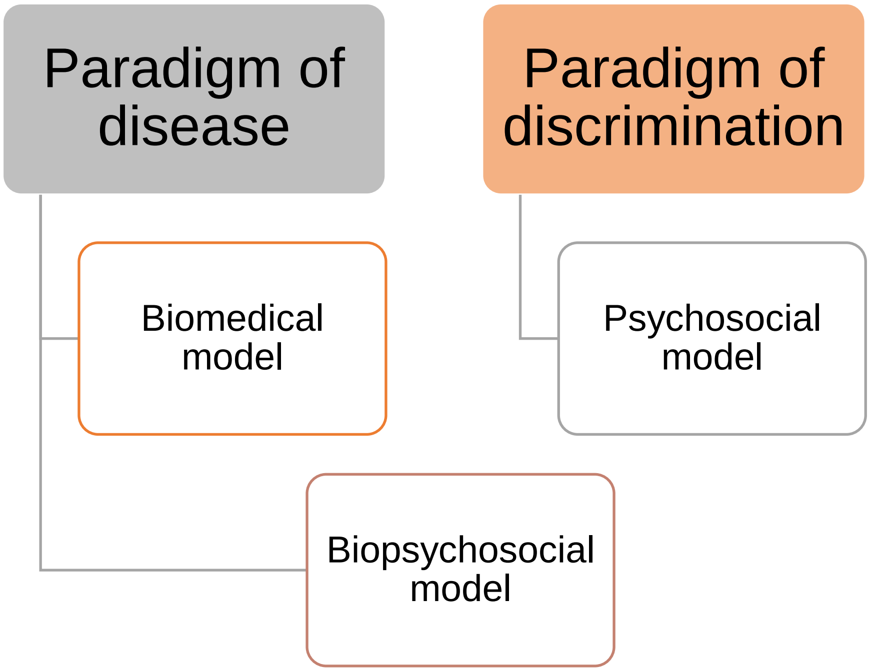


Figure 11. The differing paradigms of mental illness

Corrigan and Penn (1997) explored the fundamental assumptions and epistemology underpinning the conceptualisation of severe mental illness according to each paradigm, as well as the practical impacts that these differing assumptions have for individuals receiving care. Table 12 provides a summary of the key structural components and consequences of the paradigm of disease and the paradigm of discrimination in mental health care settings. The table has been adapted from a theoretical presentation of "local versus global knowledge in mental health" (Thomas et al., 2005, p. 31). The authors' theoretical tenets have been applied to the analysis in this thesis to delineate differences between the paradigms of disease and discrimination. The impact of the structural components of each paradigm are presented and later explored in relation to the findings of this thesis. This includes the political domain, which informs and reinforces the dominance of the biomedical model in mental health care settings.

Table 12. Knowledge informed by the paradigm of disease versus the paradigm of discrimination (adapted from Thomas et al., 2005 p. 31)

	Paradigm of disease	Paradigm of discrimination
Epistemology	Universal: knowledge is defined, bound and protected by language, terminology, jargon and notions of expertise	Heterogeneous: knowledge is held in personal and community experience and stories
Values	Oligarchy Un- or pseudo-democratic Global capitalism Exploitation of human relationships	Participatory Democratic Social justice Negotiated Sustainable human relationships Diversity
Interests served	Centralised bureaucracies Governments Professional groups – psychiatry, clinical psychology	Users of services Families Communities
Interpretive systems	Science and biomedicine Psychiatry and psychology	Social and political struggles Alternative lay belief systems Households and families Personal narratives, lived experience
Understandings of madness	Mental illness, risk Exclusion Cure Moral understandings Blame Personal deficiency Poor prognosis	Normal Journey Spiritual Crisis, risk Inclusion Recovery, hope Trauma – cultural, economic, personal, environmental Stigma
Accountability	Oligarchs	Individuals Individual groups Local communities
Solutions	Imposed, forced, assertive, alienating, mass, standardised, frightening, short-term projects, eradication of symptoms or inappropriate behaviour	Local, small scale, evolutionary, relevant, individual, involving, meaningful, owned, long term, informed by and operated by people with lived experience, trauma informed

The relevance of the paradigm of disease continuing to dominate mental health care is contested, with significant research and discourse exploring the limitations and damage that results from the dominance of the biomedical model in psychiatric settings (Lebowitz & Appelbaum, 2019; Longden, Read & Dillon, 2016; O'Hagan, 1993; Thomas et al., 2005). This dominance remains despite psychosocial factors (financial concerns, loneliness and social isolation) consistently reported as causing greater concern for individuals than symptoms associated with psychosis (Morgan et al., 2012). The following section provides further context to the ongoing dominance of the paradigm of disease in mental health care.

Psychiatric hegemony

The psychiatric profession’s primacy in mental health care is well established. Psychiatry, a speciality within the medical profession, is the most remunerated of the professions in mental health care. Critical to the profession’s power base is the DSM, the primary classification system of mental disorders (Newnes, 2014). In addition to guiding the management and treatment of people diagnosed with a mental disorder (National Institute for Health and Care Excellence, 2014), the DSM is inherently linked to the economics of mental health care, informing financial investment in services and staff (Vanheule, 2017). Public mental health care services remain dependent on the biomedical model for their justification, orientation and funding.

Over the decades, researchers, clinicians and users of psychiatric services have critiqued and condemned what they view as the abuse of power in psychiatry. Psychiatry has been described as overmedicalising normal human distress and being reductionistic in its approach (Moncrieff, 2003; O'Hagan, 2017). Many critics highlight that the biomedical model is insufficient for understanding mental health problems (Bracken et al., 2012). The use of medication, the main intervention of the biomedical model, has been increasingly found to have limited impact and benefits for individuals with a severe mental illness (Bracken et al., 2012; Danborg & Gøtzsche, 2019). Additionally, following decades of research there remains no robust evidence of a genetic predisposition for schizophrenia (Read et al., 2009). The interests of psychiatry have not always aligned with those of the individuals to whom they are providing care, with the profession’s links with the pharmaceutical industry repeatedly emphasised (Moncrieff, 1999, 2003). Furthermore, treatment should be acceptable to “patients”, with people receiving diagnoses able to report the process as helpful, although this is often not the case (Pilgrim, 2014). In summary, criticism of the psychiatric profession’s use of power has occurred over many decades, including from within the medical profession (Bracken et al., 2012; Gøtzsche & Sørensen, 2020; Szasz, 2012).

However, regardless of this extensive critique, as Pilgrim (2014) highlighted: “Although psychiatric knowledge is weak, psychiatric authority is powerful” (p. 60).

Although the importance of biogenetics in understanding mental illness has been spearheaded by psychiatry, other professional groups have increasingly aligned themselves with the paradigm of disease. Psychology, for example, often conceptualises mental health problems as arising from within the person via abnormal psychological events (Bracken et al., 2012). Critics claim that nursing professionals vicariously exercise power that belongs to psychiatry, as informed by the biomedical model (Barker, 2000; Cutcliffe & Happell, 2009). However, interactions of power are often enacted at the micro-level, for example, clinicians deciding what issues are discussed and addressed during care contacts (Cutcliffe & Happell, 2009), with the individual clinician accountable for their actions.

In many countries, the increased role of other professional groups in mental health care occurred with the move to community-based services, which increased the role of nursing and allied health staff in “managing” and supporting individuals living with a mental illness outside the hospital setting (Barker, 2000; Killaspy, 2006). Alongside this process, there was an expansion in partnerships between health and the NGO sector to meet people’s needs in the community (Killaspy, 2006). In the Australian context, further complexity results from care that is provided by services from different levels of government, resulting in fragmentation of care (Henderson & Battams, 2011). This partnership model increases segregation of responsibilities and the creation of silos (Henderson & Battams, 2011) that has the potential to separate the professions as “clinical experts” from the NGO sector. A consequence of this structural spilt, that was encountered in this study, is that it appears to have resulted in clinicians abdicating responsibility for people’s psychosocial issues, with this seen as the area of responsibility of the NGO sector.

Consumer advocates and researchers continue to emphasise the need for a rebalancing of the power differential between clinicians and individuals diagnosed with a mental illness seeking care (Cutcliffe & Happell, 2009; O'Hagan, 2009). This is inclusive of face-to-face care contacts, but also more broadly through advocacy and consumer-led programs (Central Potential – Te Rito Māia, 2008; Corrigan & Penn, 1997; Grey & O’Hagan, 2015; O'Hagan, 2009). For this to go beyond rhetoric, however, high-level systems support is required. From the data collected for this thesis, it is evident that this was not occurring within the South Australian public mental health service context, where the biomedical model was foregrounded at a systems level. A current example of this foregrounding is evidenced in the community mental health services redesign process, where the lived-experience workforce was explicitly excluded from the workforce profile. This decision was contradictory to emerging evidence of the value of the lived-experience workforce (Davidson et al., 2018) and reinforced the dominance of the biomedical model. Service documents were found to be structurally aligned with the dominant biomedical model.

Dominance of the medical narrative

At the study site, consumers and carers were expected to adopt the dominant medical narrative of diagnosis and medication as treatment, as highlighted in the following excerpt of an interview with a carer. For individuals on CTOs, this extended to being monitored by services, which was a form of surveillance:

> Carer: He also said at the hearing that he thinks he should just be monitored and I'm thinking "Wow, that's a change of tack". Because previously he'd say, "I'm fine, there's nothing wrong with me".
>
> Researcher: What do you think his understanding of the reason he's on a CTO is?
>
> Carer: I think he's confused about it all. He doesn't accept much of it. He's only now coming to think, "Oh maybe there is something here," even though he must have seen dozens of doctors at least, and they've all said the same thing: "Schizophrenia!" But he's still appearing [as] … "I'm the ok one". He's ok. However, he doesn't ever say, "I'll go out and get a job". I think he realises that's a bit out of his reach.
> [Mother – Mark, Interview]

Some consumers were accepting of the dominant mode of engagement, oversight of compliance, although they did not accept the medical narrative. In the excerpt below, Mark attempted to negotiate his needs and preferences during a medical review:

> Psychiatrist: Do you think you need treatment?
>
> Mark: No.
>
> Psychiatrist: What might happen if you stop?
>
> Mark: I don't know. I probably need to be monitored a little bit, to see I don't keep to myself too much.
>
> Psychiatrist: Who will monitor?
>
> Mark: Well, I go to my parents on the weekend, so they see I'm active, which leaves me the rest of the week.

> Psychiatrist: So, you think by being active people will see you are ok? You don’t need medication?
>
> Mark: No, I don’t think so.
> [Medical review]

The dominant medical narrative had significant consequences for care planning relationships. It was challenging for all participants in the care planning relationship to explore illness narratives that differed from the dominant medical narrative, which aligns with other research (Hamilton & Roper, 2006; Ringer & Holen, 2016):

> [At] the SACAT hearing he, actually, I found that his argument was reasonably good in that he used, there’s a model of care for people with schizophrenia … where they don’t use medication and I think they’re big on things such as the Maastricht approach … And I think it’s quite an accepted form of therapy. I believe he was really keen for us to consider something more like that. But that model of care is not really generally accepted here. They don’t have the services set up, I think, to really, to, I don’t know if it’s the right word, to experiment with that kind of therapy.
> [Nurse – Tom, Interview]

Services perpetuating harm

Overall, there is significant evidence that the paradigm of disease should not be the only (or primary) framework for understanding mental illness, nor is it the most useful framework for providing care that is deemed relevant and needed by those who use mental health services (Lebowitz & Appelbaum, 2019; O'Hagan, 2017; Read et al., 2009). In the community mental health setting examined in this thesis, the dominant paradigm informing care practices and approaches was the disease paradigm, primarily informed by the biomedical model. As discussed, models for understanding mental illness have practical implications for care planning. In a recently published paper, Lebowitz and Appelbaum (2019), drawing on a broad range of research, discussed the significant negative impacts of the biomedical model on clinicians (with regards to therapeutic alliance, treatment selection, clinical attitudes, beliefs and expectations), individuals with a mental illness (with regards to self-stigma, self-blame and personal agency) and the general public (with regards to dangerousness, immutability, blame and social distance). Many of these issues were evident in observations of care planning discussions and approaches at the study site examined in this thesis. Figure 12 provides a summary of the key issues of the impact of the biomedical model on care planning for individuals on a CTO from the study findings and endorsed in the literature.

The core consequence of the dominance of the biomedical model appeared to be the enhancement of stigma. Stigma informed the positioning of mental health clinicians and people diagnosed with a mental disorder, care approaches and care options. Stigmatising attitudes towards individuals with a mental illness have been found to be held by the general population, as well as mental health clinicians (Henderson et al., 2014; Read, Haslam, Sayce & Davies, 2006). Consequences of stigma include social distancing from others, underemployment and challenges accessing suitable housing (Angermeyer, Holzinger, Carta & Schomerus, 2011).The impact of stigma for individuals on CTOs on the care planning process is discussed next in relation to some of the key findings of this study and the literature.

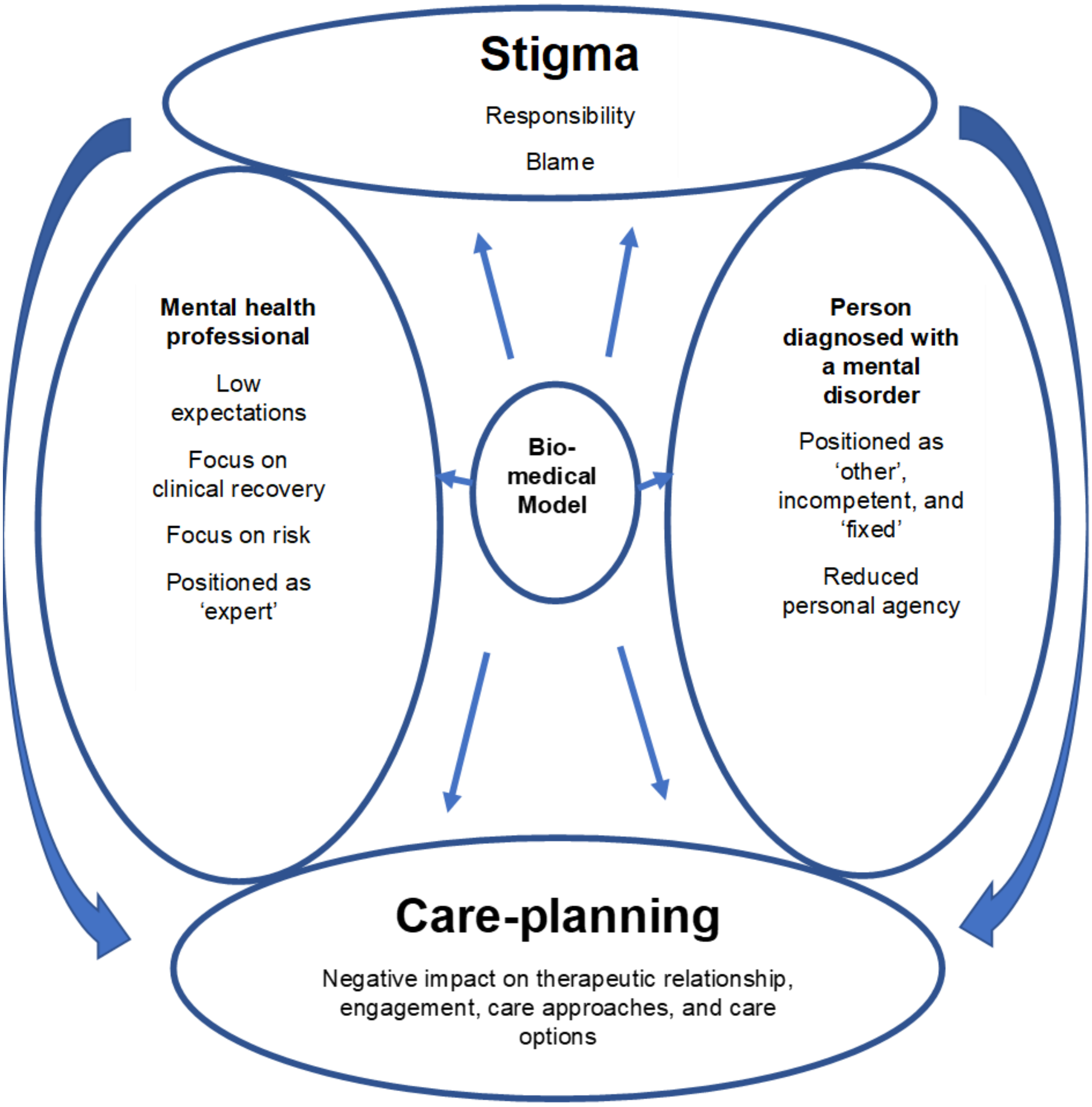


Figure 12. Perpetuating stigma

Stigma: The impact on the therapeutic relationship

Diagnostic labelling positioned the different participants in the care planning relationship. The findings from this study align with Goffman's (1963) early theory on stigma and social identity. Goffman (1963) described stigma as a social process whereby people who are different to the group are "reduced … from a whole and usual person to a tainted, discounted one" (p. 3). In this study, the person diagnosed with the mental disorder was positioned as "other" and outside the group. Mental health clinicians presented themselves as belonging to a larger collective offering "expertise" and directing care:

> You've got great insight into your illness, that's fantastic. And you understand why you need to take medication. So, your main issue lately is motivation.
> [Junior doctor – John, Medical review].

Biogenetic understandings of mental illness enhance the stigma associated with severe mental illness, predominantly psychosis (Angermeyer et al., 2011; Lebowitz & Appelbaum, 2019; Longden & Read, 2017), and have been linked with psychological essentialism, which implies that there is an "immutable essence – located in the brain or DNA – that produces the symptoms and behaviour of patients" (Lebowitz & Ahn, 2014, p. 17786). Individuals with psychosis are perceived as being dangerous, incompetent, unpredictable and lacking recovery potential (Haslam & Kvaale, 2015; Longden & Read, 2017). The impact of stigmatising attitudes from those providing care is significant. Research continues to demonstrate that a good relationship between the person being helped and the people offering help is associated with the best outcomes (Davidson & Chan, 2014). Mental health clinicians, however, have been found to have pessimistic views regarding prognosis and the person's potential for change (Haslam & Kvaale, 2015). Additionally, when mental disorders are understood using biological models, clinicians have been shown to have less empathy towards the person with a mental disorder, a key component in the development of a positive therapeutic relationship (Lebowitz & Ahn, 2014). The person who is stigmatised has been found to be sensitive to others' negative emotions such as frustration, anger and fear (Link & Phelan, 2013), which would likely impact on the relationship. At the study site, low expectations of change were implicitly underpinned by stigmatising attitudes that arose from an emphasis on biogenetic explanations that labelled and fixed individuals as "other" and "incompetent":

> So, he is currently treatment resistant … He sees his dad and has buddied up with [another consumer], so not sure what mischief they get into … He's just trucking along, no issues at the SRF.
> [Social worker, Clinical review]

The medical review was the most frequent care contact for many individuals on CTOs at the study site. The clinical interview focused on continual assessment of the person's symptomatology and effectiveness of treatment, typically medication. As Pilgrim (2015) highlighted, "because of subjectivity, and particularly rationality, being important in the understanding of psychological abnormality, the patient's experience and conduct have to be constantly reviewed and scrutinised" (p. 6). Doctors directed care discussions to meet requirements of the clinical interview based on the DSM and service priorities: assessing and managing risk, and facilitating flow. These formulaic meetings constructed the person as ill, in need of professional intervention and often irresponsible and unpredictable (Stevenson, 2000). Pilgrim (2015) described the "clinical gaze" as inwardly directed and missing the individual's personal meanings of their experience and social context. Consumers were narrowly defined by their diagnosis (or disease), which limited the discussions as well as care options presented to them:

> You go in and get asked the same questions by the next doctor … it's just a waste of an appointment … if I was with the same doctor, then every appointment would be concentrating on my treatment, not so much on getting to know my conditions.
> [John, Interview]

Both clinicians and consumers were constrained by the structure of the clinical interview. Although general principles of the psychiatric interview place an emphasis on the importance of being empathic and connected with the person being interviewed, and an exploration of the person's broader context (past history and present circumstances), the purpose of the clinical interview was effectively to develop a therapeutic alliance to help maintain medication compliance and assist the person to identify signs of relapse (American Psychiatric Association, 2006). The clinical interview was often more of an interaction that served clinicians' need for information gathering rather than an ongoing therapeutic relationship (Barker, 2000). In the case of individuals on CTOs, the purpose of the medical review was often even further narrowed:

> Going into it, I knew they were on CTOs and … that assessment for continuing CTOs was part of, if not the only reason for assessment. And … [it] makes it a different assessment, I think, because you're thinking about all the criteria: … "This person has a mental illness – Do they have insight? Are they compliant?" So … you're assessing them like that, rather than, like, in a holistic way.
> [Junior doctor – Tom & Amanda, Interview]

Stigma: Risk, responsibility and blame, and the impact on care options

Stigmatising attitudes, preoccupation with risk and allocation of personal responsibility undermine and limit opportunities for many individuals who have a severe mental illness (Corrigan et al., 2009; Rose, 1998). Although biogenetic explanations may result in reductions of blame for individuals diagnosed with a mental illness (Kvaale, Gottdiener & Haslam, 2013), it also results in pessimistic staff attitudes and beliefs about prognosis (Lebowitz & Appelbaum, 2019). Stigma also results in the perception that the person has reduced capacity. In this research, individuals' actions and choices were defined according to the dominant conceptualisation of illness. In the excerpt below, the person's choice to disengage with supports was viewed as incongruent with service expectations regarding the person's responsibility to engage with supports. Stigmatising attitudes, a perception that people had reduced capacity and allocation of personal responsibility and blame all influenced care options available to individuals on CTOs. Care options, including pathways to accommodation, were defined by services, rather than being evidence-based (e.g. the current model of provision of accommodation, then support) (Slade et al., 2014). This was a culturally implicit norm:

> Social worker: Robert is frustrated with the SRF as they take all his money. He doesn't want to do anything. He disengaged with [the NGO supports] and doesn't want to explore re-engaging …
>
> Occupational therapist: There is an incongruence between what he is saying he wants, and what he is doing.
> [Clinical review]

There was an overemphasis on the role of medication in the treatment of mental illness, even though this emphasis is challenged and iatrogenic harms are significant (Moncrieff, 2003). In the following excerpt, the carer highlighted the plight of his son, who was receiving care in this context:

> The fact that he is just administered medicine without anyone looking to understand his problem from a humanitarian point of view and do something other about it besides the medicine. The medicine might be more acceptable if there were other more positive things going on in his life.
> [Father – Tom, Interview]

Although the focus of this discussion has been on the person receiving care, it is acknowledged that viewing individuals within their broader context often includes family. In this study, families reported mixed experiences regarding the support and contact that they received from the services. Several carers reported not wanting to make demands on the services, although linking with carers has long been supported by professional groups and policy (Mind Australia and Helping Minds, 2016; Royal Australian and New Zealand College of Psychiatrists, 2012):

> I could ring [the care coordinator] virtually at any time, I suppose. I tend to try to ring her through the switch because that's more ethical ... I try to respect that because I think she doesn't need me, I don't know, harassing her.
> [Mother – David, Interview]

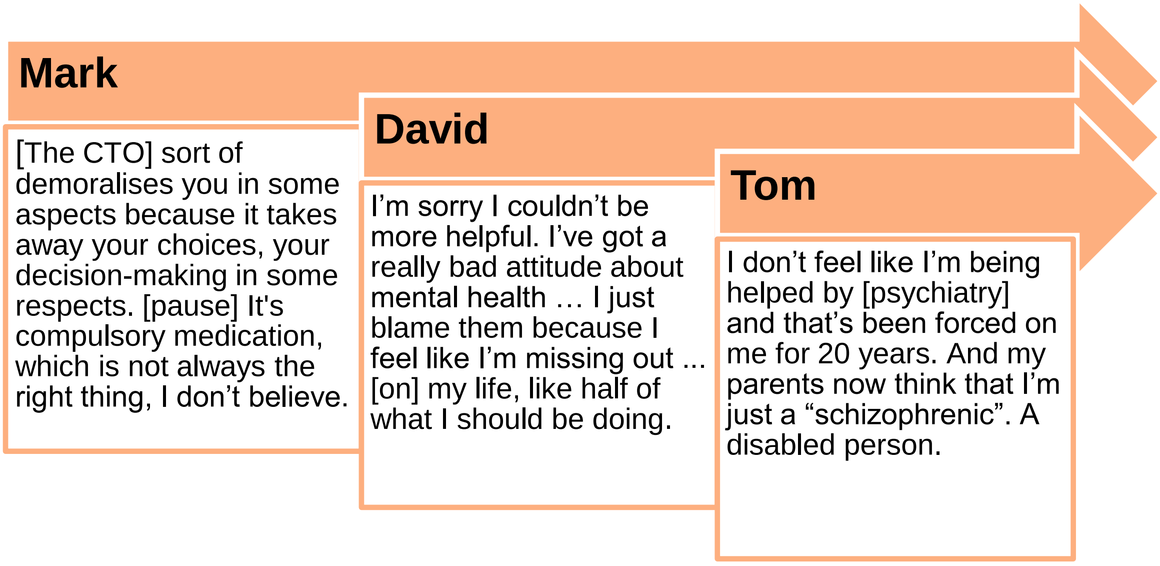
All carers in this study reported experiencing high levels of responsibility towards their relative's welfare, with some also blaming themselves when crises arose. Families could experience vicarious trauma as an indirect consequence of the impact of the dominant biomedical model that prioritises medication as treatment (Morrison & Stomski, 2019). Families in this study were concerned less with symptoms and more with everyday issues that related to living, now and into the future, which aligns with the literature (Askey, Holmshaw, Gamble & Gray, 2009; Morrison & Stomski, 2019):

> I suppose we are the support system … we've got a brother-in-law that will take him out for a coffee just for a half hour, and that's really good for him, but he doesn't see enough people ... We've got to live to make sure we're around for another 20 years at least.
> [Father – Tom, Interview]

Stigma: Multiple compounding impacts on the person

The many and accumulative stigmatising interactions that individuals with a mental illness face, including care contacts with clinicians, are likely to profoundly impact on a person's sense of self and morale (Lebowitz & Appelbaum, 2019). Thus, the impact of labelling is pervasive and goes beyond the clinical encounter. All consumer participants spoke about losses that they experienced because of their connection with mental health services that related to stigma. These included impacts on the person's sense of autonomy, self-determination and self-identity (see Figure 13 for examples).

figure



Mark

[The CTO] sort of demoralises you in some aspects because it takes away your choices, your decision-making in some respects. [pause] It's compulsory medication, which is not always the right thing, I don't believe.

David

I'm sorry I couldn't be more helpful. I've got a really bad attitude about mental health … I just blame them because I feel like I'm missing out ... [on] my life, like half of what I should be doing.

Tom

I don't feel like I'm being helped by [psychiatry] and that's been forced on me for 20 years. And my parents now think that I'm just a "schizophrenic". A disabled person.

Figure 13. Impact of stigma explained

Sociological theories on personal illness narratives point to the damage that is likely occurring for many individuals faced with biogenetic explanations that engender moral judgement from others of being "abnormal" (Goffman, 1963) and differ from personal beliefs of the illness experience. Moral narratives, the person's account for changes in themselves, the illness and social identity, likely negatively impact on the person's sense of worth and social place in this context (Bury, 2001). The demoralisation that comes from self-stigma negatively impacts on individuals' self-esteem and self-efficacy (Corrigan et al., 2009).

Workers enculturated into the disease paradigm

Mental health clinicians are enculturated into health systems, with systems and culture producing behaviours that are dependent on context. This process was clearly articulated by Goffman, who described the features of "total institutions" including psychiatric hospitals (Goffman, 1957, 1961). Several decades later, following deinstitutionalisation, Barrett (1996) emphasised the role the psychiatric team had in defining the person with a mental illness and cautioned that, "Compared to Goffman's institution, teams are more modern and less oppressive, yet … also more efficient in their capacity to produce total knowledge of the patient" (p. 102). At its worst, the mental health services were perpetuating further harm, rather than addressing the distress and broader needs of people attending services and seeking help. In the excerpt below, the clinician had recently graduated and was new to the team. The young woman being discussed had requested a female doctor in the context of a previous sexual assault. This punishing viewpoint arose from the biomedical model that enhances stigma and blame. This demonstrates the risk of individual workers' behaviour aligning with service culture rather than professional and personal values:

> Nurse: So, with the doctor, is it a male for the last one?
>
> Consultant: Yes, she will be allocated to [a male RMO].
>
> Allied health professional: That's probably appropriate so that she doesn't get the expectation that she will get what she wants.
> [Clinical review – Amanda]

There were also, however, many clinicians who were acutely aware of the damage that was being inflicted on individuals by services and they strove to provide care that was respectful and aligned with the person's wishes as much as was possible:

> I remember … he came in … and I have no choice, and that sets this response that he will feel … that he will never get out of the system. So, this is a dilemma and [the] sad thing as well, is that, "If I don't go there, I will be detained, so I go there and explain to the doctor, I'm still detained. What's the point?"… So, in his case overall … we did our best according to the best guideline, and also the good intention of … our team … which is wellbeing for him … But the issue with him is that [the] traumatic experience with the health care workers continue[s]. The family lost trust and faith in our mental health before because he was discharged from [the] CTO, and then became unwell … but to get help, it took a long time to intervene with a detention order.
> [Psychiatrist – David]

The cultural themes identified in these findings were a result of systems that were perpetuating stigma that constrained workers and impacted on individuals attending mental health services. Conversely, in another study conducted at the same site during the same period of data collection for this thesis, clinicians spoke about this dilemma, highlighting the scope for positive cultural change. The teams were the first in metropolitan Adelaide to implement Individual Placement and Support (IPS), an evidence-based employment program which supports people to find and maintain work (Dawson, Muller, Renigers, Varona & Kernot, 2020). Most clinicians had embraced this program, which addresses individuals' broader needs and wishes:

> So [IPS] helped change the perspective of my clients, of employers, but also of me, of the actual case coordinator working with people. It's actually given – yeah,

> changed my perspective of … and given me … a powerful change of hope (Dawson et al., 2020).

Emphasising the paradigm of discrimination

Most individuals were able to express their hopes for the future. In the excerpt below, the young woman clearly articulated her recovery goals. In this instance, the care coordinator's approach to care planning was informed by the biopsychosocial model and there was clear evidence of personal recovery during the research period:

> Researcher: And what are your hopes for the future?
>
> Amanda: To get a well-paid job. A career or something … You need a purpose in life … just to get you up every morning, and doing something, it helps … Medication gives you opportunities to do things more if you're well. It makes you feel really run down as well … It's not always the best cure for you. I mean, it's not a cure, but it's got to do with it though …
>
> Researcher: So, what do you think and feel about being on a CTO?
>
> Amanda: I think it's helping me to do things and get on with my life … I don't know if I'd be doing … [college]. I wanted a job. I wasn't focused though. I wasn't really thinking properly.
> [Amanda, Interview]

Referring to the inadequacies of community-based mental health care, Longden, Read and Dillon (2017) posed two dialogues which problematise the issue. The first dialogue referred to governance and procedures regarding service commissioning, organisation and delivery, and the second referred to "the ideological basis on which community care operates" (p. 23). The authors argue that a conceptual change in the provision of mental health services at the ideological level is both necessary and feasible, and these authors are among many who are calling for a paradigm shift in the provision of mental health care (Longden & Read, 2017; O'Hagan, 2017; Read et al., 2009; Thomas et al., 2005). The young woman presented above had experienced multiple admissions prior to current care contacts. There was a long history of conflict between the family and mental health teams as they had differing views regarding the cause and therefore treatment of mental illness. It is likely that the young woman would have experienced a different journey had she encountered a service that emphasised psychosocial models for understanding mental illness.

Summary

The continued dominance of the biomedical model in mental health care has a long history of being contested; however, the paradigm of disease continues to dominate locally and internationally. This chapter has examined the structural components maintaining and reinforcing care interactions, approaches and options at the study site. The impact of the biomedical model was significant, causing further stigmatising attitudes and severely limiting care options for individuals on CTOs. The paradigm of disease constrained workers and obstructed care approaches and options that were recovery-focused. Carspecken (2006) highlighted the importance of using knowledge for emancipatory purposes; thus the final chapter includes an exploration of how a paradigm shift could occur. As Read et al. (2009) highlighted, to achieve a change in paradigm, work must be done “across disciplinary boundaries, to build on these beginnings of a truly integrated bio-psycho-social model” (p. 307). Fortunately, there is significant evidence regarding approaches, strategies and interventions that could be drawn upon to support a change in orientation. The final chapter shows the potentially profound impact for individuals on CTOs receiving care if mental health services were to align care approaches and options with the paradigm of discrimination, rather than the paradigm of disease.

CHAPTER NINE
DISCUSSION

> Discrimination is the biggest single barrier to recovery, and it pervades the justifications, criteria and processes involved in legal coercion in mental health.
>
> (Mary O'Hagan, 2012)

Introduction

In community mental health services, care planning occurs between individuals with the aim of developing a set of plans to guide recovery-based mental health care; the process, however, is situated within broader systems and structures. The findings presented in this thesis reveal how care planning, care practices, and service and cultural structures were perpetuating stigma and discrimination for individuals on CTOs in a community mental health setting. Despite mental health legislation and policy assigning priority to recovery-informed care values, mental health services' emphasis on risk and risk management made it challenging for mental health clinicians to work with individuals in ways that aligned with recovery. Structurally, the biomedical model remains the dominant framework informing care contacts (at the relational level), service structures (at the organisational level) and service options, policy and allocation of funds (at the systems level). This chapter builds on the analyses detailed in the previous chapters that identified the care planning processes, cultural themes and structural components maintaining and reinforcing these themes (Carspecken, 1996). Overall, service culture, systems and structures were not supportive of clinicians working within a recovery orientation, with an emphasis on risk resulting in the backgrounding of recovery. Subsequently, care planning was not being used as intended. Clinicians were found to foreground service needs over those of the person on the CTO in the care planning process, although many expressed frustration with this position. Costs of this service focus on risk included a devaluing of the therapeutic relationship, silencing of consumers' and carers' voices in the care planning process, and reinforcing and compounding of a service culture that perpetuated the disempowerment and discrimination of consumers.

To provide an explanatory framework for the findings, the final stage of Carspecken's (1996) analysis involves linking the cultural themes to the relevant social theories, which, in this thesis, are the related theories of risk and trust (Beck, 1992; Giddens, 1990, 1991, 1994, 1999; Luhmann, 1979, 1990, 2000). Additionally, possible means for cultural change are threaded throughout the discussion. As highlighted in the previous chapter, this requires a de-emphasis of the paradigm of disease and an emphasis of the paradigm of discrimination through implementation of strategies, approaches and interventions that are supportive of individuals' recovering citizenship. Although some clinicians were working within a recovery-informed approach, coercive practices were occurring at the site which were consequences of the system. Subsequently, while there was scope for change at the clinical interface (in care planning), to ensure a service culture that prioritised and facilitated clinical practice which was recovery-focused change was required at the systems level. The first section of the chapter focuses on the constraints of care planning in the context of risk.

Care planning constrained: Not as intended

Care planning in mental health settings guides the development of care plans that aim to meet individuals' personalised needs and includes linking with the person's natural and other service supports (Rapp & Goscha, 2012; Ross et al., 2011). To be effective, the care planning process should be collaborative, personalised and recovery-focused (Coffey, Hannigan, et al., 2017). Recent research, however, acknowledges the various challenges and shortfalls in the provision of care planning that adheres to these principles in mental health care (Brooks et al., 2018; Brophy et al., 2014; Hannigan et al., 2018; Jones et al., 2018). In mental health care, risk assessment is an important function of care planning, with care coordinators also responsible for the management of CTO requirements (Coffey, Cohen, et al., 2017; Dawson et al., 2016). The findings from this thesis focus specifically on individuals who are on a CTO, where compulsory care poses additional challenges for clinicians to engage in personalised care planning in ways that promote empowerment and self-determination.

The taken-for-granted prioritising of risk was displayed in everyday talk between clinicians and in their consultations with consumers. Although many clinicians were aware of the conflicting service and care mandates of risk and recovery, in clinical practice observations of care planning highlighted the prioritisation of risk. Conflicting and unclear goals are common features of organisations, with workers often required to navigate and manage this ambiguity (Dobransky, 2014). In this thesis, care planning with consumers on CTOs was not occurring as intended, with the process constrained by culture, service systems and broader structures. Carspecken (1996) highlighted that communicative actions are both intended and unintended, which is an important delineation that has been applied to the findings in this thesis. Although this theoretical distinction does not excuse poor practice, it alludes to the power that dominant cultural themes, in this case risk, had on clinicians' attitudes and actions. The positioning of consumers as “risky” and “insight(less)” went against recovery principles. Although this was not intended by clinicians, it has been shown that people are perceptive of stigmatising actions from others (Link & Phelan, 2013). Subtle communicative actions (verbal and behavioural) that send disparaging messages to individuals of marginalised groups, including individuals with a mental illness, are referred to in the literature as micro-aggressions (Gonzales, Davidoff, Nadal & Yanos, 2015). While often occurring unconsciously, consequences of micro-aggressions in the care planning context include disrupted therapeutic alliances, reinforcement of stigma and marginalisation (Gonzales et al., 2015). The ways in which risk and risk-management practices impacted on care planning with individuals on CTOs are first examined by situating the thesis findings alongside theories of risk and the literature pertaining to risk in mental health care.

Risk and risk management: Concepts that are unhelpfully inexact

> Reflexive modernity is primarily defined by an increase in the awareness of risk, uncertainty, contingency and insecurity and by an increase in attempts to colonize and control the near and distant future (Ekberg, 2007, p. 345).

The above tenets of sociological risk theories are those that are most relevant to the findings in this thesis. Modern society, also referred to as the “risk society”, has developed increasingly complex social systems and structures (Beck, 1992; Luhmann, 2000). Consequently, there is increased diversity of what is both familiar and unfamiliar, and the concept of danger has been replaced with risk (Luhmann, 2000). Risk is a concern about the future (Giddens, 1991), although it is not the same as hazard or danger (Giddens, 1999). Beck’s and Giddens’s articulations of society’s understandings of and attitudes to risk, which include an increased sensitivity to social and political consequences of risk, inform the following critique of the thesis findings related to risk (Ekberg, 2007). Risk, and society’s preoccupation with this, are elusive and flawed concepts (Ekberg, 2007). Risk is misinterpreted as actual danger, with risk assessment an attempt to predict potential harm and management an attempt to control the present and future in order to minimise uncertainty. On this basis, risk assessment is also flawed.

> Risk assessment has a significance that is more symbolic than instrumental; it answers not to the reality of dangers but to the politics of insecurity (Rose, 2005, p. 17).

Mental health clinicians have been tasked with the responsibility to manage individuals who are perceived as “risky”, with risk assessment and management integral components of mental health care work (Rose, 1998). Sociologically, risk is conceptualised as value-laden and political, with public opinion that is culturally contingent influencing identification of and responses to risk “objects” and “events” (Ekberg, 2007; Giddens, 1999; Szmukler & Rose, 2013). Consequently, not all risks are dealt with in the same way (Pilgrim, 2018), with individuals with a mental illness often inaccurately assessed as being dangerous and incompetent (Szmukler & Rose, 2013). The risk-assessment process has been found to wrongly identify many individuals as being at risk of various harms and may then result in coercive care (Large et al., 2011; Szmukler & Rose, 2013). Adding to the complexity of the issue, however, are the high costs for all involved if a serious incident occurs, such as suicide or other forms of violence or neglect. In these instances, media reports increase public anxiety and fear, which negatively influences public opinion of individuals with a mental illness and use of restrictive care practices (Hallam, 2002).

In this thesis, risk was given significant weight by clinicians in assessment and decision-making regarding care, including justification for CTO use. During discussions with consumers, however, clinicians lacked transparency regarding the use of information collected from the person, and collateral sources, to inform decision-making regarding risk. Risk was a closed and irrelevant concept to consumers, who did not approach their care needs from a risk perspective. Instead, consumers and carers referred to broader psychosocial needs and stressors, while service conceptualisations predominantly related to potential harm. As previously discussed, the former conceptualisation situated risk within the person, and the latter more broadly with the community and society. In mental health care settings, focusing on risk may result in loss of trust, a narrow care focus and actuarial approaches; the surveillance of individuals considered high risk (Szmukler & Rose, 2013). These impacts were regularly observed at the study site. The moral costs of risk and risk assessment thereby extends to workers, with resultant “negative effects on professional practice” (Szmukler & Rose, 2013, p. 125). In terms of care planning, therapeutic relationships were often negatively impacted, resulting in reduced care options. Furthermore, aligning with another study’s findings, CTOs were used by some clinicians to engage consumers in treatment, rather than spending the time required to develop trusting relationships (McMillan et al., 2019). An example of this was a nurse’s reflection that he had aligned his practice to the team’s primary focus on brief contacts to ensure medication compliance (refer to section – A mismatch of issues and goals). At a systems level, a risk focus influences monitoring and reporting procedures, with compliance to risk assessment and management overriding other outcomes relevant to consumers (Szmukler & Rose, 2013), such as reported jobs or social contacts. These service requirements were impacting on and guiding clinical practice (Hannigan et al., 2018).

Although risk and risk management practices are “unhelpfully inexact” concepts with regards to usefulness in accurately predicting risk events (Szmukler & Rose, 2013) or relevance for consumers (Light, Robertson et al., 2015), risk remained a significant factor influencing current care practices at the study site. Coffey et al. (2016) found that clinicians adapted to the culturally informed “accepted fictions” of risk-management practices to enable them to work within systems that emphasised the importance of risk. In this study, although clinicians referred to limitations arising from the prioritisation of risk, including risk-averse practices such as delays in discharging, the profound impact that this had on consumers, namely perpetuating stigma, remained culturally backgrounded. Mental illness stigma emphasises difference (Goffman, 1963), which provides justification for mental health policies and legislation that facilitate enforced treatment (Pilgrim & Tomasini, 2012). Reinforced by family and the public, and ultimately enforced by mental health clinicians, this highlights the paradox of mental health legislation being inherently discriminatory while purportedly promoting care (Pilgrim & Tomasini, 2012; Szmukler & Rose, 2013). How discrimination manifested in care planning is discussed below.

Foregrounding risk: Missing what is relevant

While care planning that was supportive of people’s recovery was occurring at the study site, service structures that prioritised a focus on risk influenced clinicians’ attitudes and approaches to care planning. In clinical practice, foregrounding risk encouraged an emphasis on consumers’ deficits (reduced capacity), rather than their needs and strengths. As a result, care planning discussions often missed addressing what was most relevant to the person. Key concepts from the findings that relate to this theme include the influence of service risk-assessment tools, care planning processes and available care options (at the systems level) and clinicians’ emphasis on insight over capacity evident during discussions (at the relational level).

Service risk assessment: A hindrance to meaningful care planning

Risk-assessment tools inform how clinicians make sense of and report risk (Waring, 2009). More specifically, assessment processes have been found to influence clinicians’ reporting of complex issues that do not easily fit the predetermined domains of service assessment tools, resulting in reduced reporting, standardised meanings and interpretations of risk, and a devaluing of clinicians’ knowledge (Waring, 2009). In this study, additional consequences of the assessment process included missed identification of issues and concerns that were most relevant to consumers. As reported, care planning discussions were often clinician-led and focused on tasks related to ongoing assessment and compliance with treatment, with consumers’ needs neither prioritised nor addressed during these discussions. This was occurring despite consumers consistently referring to broader stressors that they were experiencing, including distressing symptoms (Wu, section – A narrow focus of engagement), iatrogenic issues (Caleb, section – Clinicians leading decision-making), financial strain (John, section – A mismatch of issues and goals) and inability to engage in meaningful activity such as study (Jim, section – A mismatch of issues and goals). These issues aligned with those identified by carers in this study, as well as a recent survey of carers in Australia who prioritised functional recovery over concerns with safety (Morrison & Stomski, 2019). While some clinicians referred to high caseloads, competing work demands or service expectations as factors preventing them from focusing on psychosocial needs, others managed to retain a broader care focus and address consumers' psychosocial needs, (see section – Differing risk conceptualisations and decision-making, where the doctor's focus was on a person's housing needs). The emphasis on risk, and the assessment process itself, was effectively disempowering to clinicians, encouraging a narrow conceptualisation of risk and care focus, but also facilitating poor practice at a systems level.

Recent research on risk in mental health care settings has highlighted the need to broaden conceptualisations of risk and include consumers in discussions about formulations (Coffey, Cohen et al., 2017; Deering, Pawson, Summers & Williams, 2019; Light, Robertson et al., 2015). This is despite clinical knowledge that risk formulations should incorporate the complex and dynamic factors that may be impacting on any individual's risk, including housing, employment and substance misuse (Rose, 1998, 2005). Light et al. (2015) explored risk from the perspectives of consumers, their caregivers, clinicians and mental health review tribunal members, and developed a framework that is inclusive of broader conceptualisations. While this includes risks that relate to harm to self or others, it extends to other issues the person faces including social adversity, interpersonal and illness-related distress, and iatrogenic harms. Light et al. (2015) postulated that an integrated risk model that incorporates the perspectives of all care planning participant groups could potentially provide a framework to facilitate meaningful discussions about risk (including within care planning contexts), as well as reducing the stigma and discrimination that result from narrow conceptualisations. While inclusion of consumers could be viewed as co-opting them to the services' preoccupation with risk, the purpose would be to enhance clinician understandings of the discrimination individuals face and assist clinicians to conjointly identify consumer needs to be addressed in care planning. Coffey et al. (2016) highlighted that denying consumers opportunities to gain self-knowledge is effectively "a form of epistemic injustice", with clinicians justifying lack of consumer engagement in risk assessments via moral work that aligned with paternalistic principles (p. 480). Given mental health services' focus and emphasis on risk, lack of inclusion of consumers in this dialogue perpetuates power imbalances and reinforces the positioning of the consumer in care planning as outside the dominant group. Insight is a closely related issue to risk that further impacted on care planning and is explored below.

Insight: A hindrance to meaningful care planning

In this thesis, clinicians frequently referred to a person's level of insight with brief descriptors that limited their views of and attitudes regarding a person's capacity. The use of insight in clinical practice, "without nuance or descriptive detail", has also been described in other studies (Guidry-Grimes, 2019, p. 178). In psychiatric literature, however, insight is conceptualised as a multidimensional concept that involves a person's ability to recognise that they have a mental illness, relabel psychotic experiences as abnormal and accept treatment (David, 1990). Individuals on CTOs therefore are likely to not meet at least one of these three descriptors of insight and thereby to always be identified as lacking in this area. A recent ethnographic study found that perceived level of insight was a key factor informing decision-making regarding CTO use by members of mental health tribunals (Jobling, 2019), thus emphasising its influence. Like risk, insight is another concept in mental health that produces significant debate regarding its relevance and usefulness (Dawson & Mullen, 2008; Gong, 2017; Guidry-Grimes, 2019). Insight is dependent on consumers' views of their mental illness and need for treatment aligning with those of clinicians (Hamilton & Roper, 2006; Ringer & Holen, 2016). This is widely challenged based on differing cultural and psychosocial models for understanding illness (Read, 2020; Taitimu, Read & McIntosh, 2018) and acknowledgment of the power differential between consumers and clinicians (Hamilton & Roper, 2006; Johnstone et al., 2018). There remains, however, a lack of alternative illness discourses available outside the biomedical model for consumers (and I would argue, also for clinicians) (Ringer & Holen, 2016). In this study, labelling a person "insight(less)" promoted a sense of stasis and reduced possibility of recovery, with some consumers in this category observed to be kept in holding patterns by the services for many years. Similarly, Ringer and Holen (2016) linked insight to recovery and described consumers needing to "take moral responsibility" and acknowledge their "pathology" to be able to recover (p. 171). Thus, this labelling was effectively a form of discrimination that negatively impacted on clinicians' perception of the person, their capacity and the care planning relationship. Interestingly, some clinicians who challenged the usefulness of the concept during interviews were observed referring to consumers' level of insight during care planning discussions among other workers, highlighting the dichotomy of the strength of this cultural practice but also the acknowledged limitations regarding its usefulness.

Although the concept of insight is not referred to in mental health legislation, some researchers have claimed that empirical evidence links insight to decision-making capacity in relation to the need for treatment (David, 1990; David & Ariyo, 2020; Jobling, 2019). Gong's (2017) investigation and critique of the concept of "impaired insight" extended this claim by suggesting that insight was used to expand the use of CTOs. Gong (2017) considered that the concept of insight was used by the systems to govern compliance and thereby mitigate risk. The critique presented here, however, is not concerned with either of these positions (clinical versus political) but, instead, with highlighting the significant implications of the concept for consumers, whereby levels of insight are used by clinicians to inform the extent to which consumers are "trusted as a knower" (Guidry-Grimes, 2019; Hamilton & Roper, 2006). Guidry-Grimes' (2019) theoretical analysis of insight aligns with the findings of this thesis, including her assertion that a clinicians' assessment of level of insight influences how much a consumers' account can be trusted. That analysis included the identification of two significant consequences of the emphasis on insight that have been observed to impact on care planning in this thesis: alienating consumers with unattainable expectations of self-knowledge, and minimising consumers' experiences and perspectives (Guidry-Grimes, 2019).

In this thesis, being untrusted as a knower was observed to have a negative impact on clinicians' views of and engagement with consumers, encouraging a paternalistic or conflictual dynamic. From the clinicians' perspective, McMillan et al. (2019) found that clinicians did not fully trust consumers to understand their predicament and need for treatment, and thus pathologised any resistance that they expressed about the CTO and treatment. From the perspective of a consumer academic, Cath Roper highlighted that in the context of forced care, a person is "judged incompetent, owing to a lack of insight" and subsequently dismissed as a person without equal status to clinicians (Hamilton & Roper, 2006, p. 420). These experiences align with this thesis, where many consumers' care experiences were minimised, including the experience of coercion resulting from being on a CTO and the side effects of medication, issues which have been previously identified as barriers to consumer trust of clinicians (Mechanic & Meyer, 2000). Furthermore, in clinical practice, although some clinicians were attempting to work with consumers in the space between "insight" and "no insight", these labels served to abrogate the responsibility of clinicians for delivering care that would support the building of capacity or focus on what the consumer was identifying as their priority needs.

The impact of clinicians' judgements of a consumer's level of insight, and therefore their trustworthiness, explores epistemic trust from the clinicians' perspective. Epistemic trust, or an individual's willingness to consider knowledge provided by another as trustworthy and relevant (McCraw, 2015), requires further examination in the context of care planning relationships, which are promoted as active partnerships within recovery frameworks (Coffey, Hannigan et al., 2017; De Silva, 2011). The potential impact of the obscuring of trust in the care planning context is significant for all participants in the care planning relationship. The exploration of epistemic trust below, therefore, focuses on clinicians and services as being worthy of trust from the perspectives of consumers and their families.

Care planning relationships undermined by the system

Common to a range of sociological theories are two forms of trust, interpersonal and institutional (or systems) (Meyer, Ward, Coveney & Rogers, 2008; Mollering, 2001). This thesis predominantly draws upon the theories of Giddens and Luhmann because of their major contributions to the literature on trust (Meyer et al., 2008). While there is significant overlap between theories, differing emphases are placed on the roles of personal relationships and social systems in the formation of trust, with Giddens (1990, 1991) emphasising the importance of interpersonal relationships and Luhmann (1979, 1990) emphasising the role of systems (Meyer et al., 2008). While these distinctions are theoretically important, both theories are relevant to the care planning context for consumers on CTOs. CTOs can create “distrust in a health care system and the actors within this system” (McMillan et al., 2019, p. 8), who are then required to come together in the context of care planning. Care planning relationships have been found to be central to consumers’ experiences of services (Foot et al., 2014), with trust considered an essential component of effective therapeutic relationships (Brown, Calnan, Scrivener & Szmukler, 2009; Leach, 2005). The heightened importance and necessity of trust are especially emphasised in mental health care due to the vulnerability and uncertainty faced by individuals seeking care from services (Brown et al., 2009). This is important, as trust has been elucidated as a process that involves the construction of knowledge to overcome and address vulnerability in the context of uncertainty (Mollering, 2001). As discussed in the previous chapter, the empathy of the clinician, an essential component of trusting therapeutic relationships, is reduced when biogenetic understandings of mental illness are emphasised (Lebowitz & Ahn, 2014). Thus, various factors combined undermined the development of trust and therefore the usefulness of care planning relationships at the study site.

Trust and mistrust

Trust is a communicative action between “actors” that is context-specific (Brown et al., 2009; Vassilev & Pilgrim, 2007) and fundamental to effective community living and health care (Brown et al., 2009; Mechanic & Meyer, 2000; Ward & Meyer, 2009). Trust can be conceptualised as an alliance based on the belief that the trustee’s best interests will be maintained by the trusted (Laugharne, Priebe, McCabe, Garland & Clifford, 2012).

Conversely, mistrust is related to a perceived lack of control and agendas that do not align (Brown et al., 2009). In the context of mental health care generally, and legislated treatment (including CTOs) specifically, there are significant challenges that exist for consumers with regards to the development of trust. Vassilev and Pilgrim (2007) extended this concern, stating that legislated treatment “renders both patients and professionals untrustworthy” (p. 354). The issue of forced care is consistently raised by ex-service users as a primary barrier to the provision of care that is supportive of positive relationships and recovery (Central Potential – Te Rito Māia, 2008; Chamberlin, 1995). Consumers who are already vulnerable experience a further loss of control and power in decision-making about their own care (Chamberlin, 1995), including lack of choice of workers (McMillan et al., 2019). Thus, the concept of trust is closely linked to risk and power, further increasing both its relevance and necessity. Mental illness stigma (Longden & Read, 2017), the iatrogenic effects of treatment (side effects and coercion) (Mechanic & Meyer, 2000), which are common features that people with a serious mental illness (such as paranoia, anxiety and impaired cognition) experience (Brown et al., 2009), and ongoing discrimination experienced from care contacts (described in the previous chapter) are significant and valid justifications for consumers to have reduced trust at the interpersonal level (with clinicians) and systems level (with mental health services). Simply put, in the context of forced treatment consumers may not believe that clinicians or services are prioritising their best interests. Additionally, many individuals with a mental illness have experienced significant trauma prior to contact with services (Longden & Read, 2017) and from their actual contact with mental health services (O'Hagan, 1996) and other social systems (Luhmann, 1990), which will further influence their willingness to trust clinicians and the systems they represent.

Theories of trust can inform understandings of the processes that are in operation at the interpersonal and systems levels, and thereby illuminate barriers and facilitators to the development of trust in care planning contexts (Carspecken, 1996; Vassilev & Pilgrim, 2007). In this thesis, trust was indirectly referenced by participants during care discussions. The power differential between clinicians and consumers was a clear barrier to the development of mutual trust. Clinicians’ agendas, which related to treatment compliance and risk assessment, often overrode consumers’ agendas during care discussions. Some clinicians resorted to threats to increase compliance or withheld opportunities, such as advocating for independent housing, which further reduced the development of trust. Coercive practices in mental health care are well acknowledged in the literature (Szmukler & Appelbaum, 2008). In this study, clinicians’ attempts to minimise risk by maximising consumers’ compliance with treatment through the use of leverage or threats was a form of coercion. Consequences of these coercive actions included the forestalling of therapeutic alliances and the subsequent undermining of care planning relationships. Although clinicians acknowledged the impact of coercive practices on the therapeutic alliance, the broader impacts on the person and care planning were unarticulated. Significantly, for consumers coercive actions served to further compound their discrimination.

Trust is considered an enabling factor for social inclusion and personal agency (Ward & Meyer, 2009); thus actions (even unintended) that precluded, rather than promoted, trust during clinical interactions had potentially profoundly negative impacts for consumers beyond the clinical encounter. In a recent study, it was found that consumers' experiences of repeated minor coercive events during care contacts, such as the minimising of their experiences of medications, resulted in the person mistrusting their own experience and capabilities (Nyttingnes et al., 2016). Major coercive events, such as forced medication, were experienced by consumers as "violation and abuse" (p.150). Although the consequences of coercive practices that were compounding discrimination were unintended, for care planning to be meaningful, promote recovery and avoid causing further harm, the profundity of these consequences needs to be acknowledged and addressed by clinicians and services.

Interpersonal trust

Coercive practices reinforced a culture of mistrust from the perspectives of clinicians and consumers. There were, however, positive examples where consumers indicated that they were trusting of workers and able to express dissatisfaction with aspects of their care (section – Trust of lack thereof). Consumers who spoke about having trust typically referenced individual workers, rather than trust in the services more broadly. Overall, the findings favour theories of trust that emphasise the importance of interpersonal relationships (Meyer et al., 2008). This is important as although adversarial dynamics were occurring that were overlooked by the system, these dynamics could be changed at the interpersonal level. This is demonstrated by a social worker's description of working with a consumer to replace a long history of task-focused, adversarial contacts that had involved the police with a relational and strengths-focused approach that involved supporting the person with their self-identified goals (in this case returning to study and active involvement in decisions about their medication) (section – A broader focus of engagement). The focus of care contacts in this instance emphasised the person's psychosocial needs, alongside promotion of active involvement in decision-making regarding their treatment (medication and CTO use). Care approaches that focused on the person's psychosocial needs were observed to result in various gains. In addition to personal gains for the consumer (as described above), gains were evident for clinicians, whereby care practices and approaches were aligned with professional and personal values, and for services, whereby a change in care approach had the potential to reduce coercive contacts (including CTO use and dependence on police support to facilitate forced care contacts) and facilitate discharge.

Systems-level trust

Theoretical frameworks that emphasise the importance of services and systems as the gateway to developing trust in clinicians (Meyer et al., 2008) highlight the importance of recognising potential harms that the person may have experienced prior to their contact with services and acknowledging further harms that current service contacts may be causing. As Vassilev and Pilgrim (2007) cautioned, consumers may be “re-experiencing betrayed trust” through service contacts (p. 355). Service systems that offered minimal contacts which were task-focused, such as phone calls to review the person or home visits to administer depot medication, limited the opportunity for developing trusting relationships between consumers and clinicians. These approaches also impacted on carers. Although several carers expressed a lack of trust in the system, they simultaneously strove to trust individual clinicians. When families perceived care as being inadequate, they appeared to excuse individual clinicians and instead allocated responsibility (and blame) to the system. Many carers expressed frustration regarding the systems-level barriers that they experienced to meaningful engagement of services with their relatives. This included clinicians’ perceived need to narrow their care focus to determine CTO need or ensure compliance, and frequent changes in clinical staff resulting in a lack of opportunity to get to know the person and thereby provide meaningful assessments and support beyond assessment. Although these identified barriers were often related to trust, this was not a concept that was referenced or articulated during care discussions among clinicians. Trust was a backgrounded barrier to engagement.

The thesis findings highlight the interconnectedness between interpersonal and systems trust, with care planning relationships embedded in the service system (Vassilev & Pilgrim, 2007). An illustration of the interconnectedness is the observation that clinicians tended to identify as being a member of a group when discussing issues with consumers that were likely to cause conflict, such as medication changes or CTO renewals. The result of this was an undermining of trust at both the interpersonal and systems levels. A previous study that examined the role of trust among clinicians and consumers on CTOs found that while positive experiences for consumers related to CTOs could enhance their trust in clinicians and the system, negative experiences could result in a permanent “exhaustion of trust” at both levels (McMillan et al., 2019). In this thesis, clinicians’ expectations that consumers and their families would trust them based on their position as experts were based on the premise that trust was via the institution, as well as other social systems (Luhmann, 1979; Meyer et al., 2008). Trust is considered an essential input component for systems that proffer support to individuals (Luhmann, 2000). Given many consumers' previous negative experiences with care and broader systems, clinicians will often have to work hard to develop trust and demonstrate that they are trustworthy. This does not mean avoiding discussions about concerns of harm, but requires finding transparent ways of exploring risks with consumers and their families, including broadening conceptualisations, as previously discussed (Light, Robertson et al., 2015), or reframing risk as needs or issues related to the person's safety (Perkins & Repper, 2016). Evidence-based tools and approaches can be drawn upon to support such change. Possible strategies include use of decision-making tools (Deegan, 2010; Slade, 2017), techniques to link the individual's personal goals to medication use (Deegan et al., 2017) and approaches to repair ruptures in the therapeutic relationship (McCabe & Healey, 2018). Development of trust at the relational level may facilitate the development of trust in the systems among consumers (Luhmann, 2000), which is important in public mental health care, where there is often a lack of continuity in care relationships.

Risk and trust

Risk is an aspect of trust, with the interpretation (what or how much risk) influencing individuals' decision-making to trust others or services (Meyer et al., 2008). Trust is a solution to problems of risk and therefore the basis for risk taking and cooperation (Luhmann, 2000; Mollering, 2001), both of which are essential components of effective care planning relationships. The balancing of risk in decision-making was evident in care planning interactions, although the power imbalance meant that the clinicians' determination of cost versus benefits regarding risk usually dominated. In clinical practice, low-level threats were introduced by clinicians to ensure that they could trust consumers, with the purpose of mitigating risk (section – Persuasion, leverage and threats). The importance of reciprocity in trust is very relevant in this context (Laugharne et al., 2012). The use of threats immediately created a dynamic of mistrust as well as emphasising the power differential between participants. Related to this was an additional component of trust described as a "leap of faith" (Mollering, 2001). Mollering's (2001) synthesis of the work of Simmel included a description of a process whereby individuals "bracket the unknowable" and make a mental leap to trust. Several care discussions between clinicians and consumers demonstrated where this function was occurring, as well as lacking, with experienced clinicians more able or willing to apply this concept, which aligned with a form of risk taking. Trust, or lack thereof, influenced the positioning of consumers and their families in care planning, and is explored in more detail below.

Consumers’ and carers’ absence in care planning

Lack of trust may impact on consumers’ and carers’ participation in care planning in various ways. Clinicians’ low assumptions regarding consumers’ self-knowledge may reduce the value that is given to a consumer’s self-identified goals, for example, to find work or live independently. Although these goals may be recorded in the person’s care plan, support and resources to achieve these may not be prioritised (or even available). Another contributing factor to consumers’ and carers’ absence in care planning was their exclusion from various settings where these discussions occurred. This lack of inclusion further reinforced the power differential, with consumers and families positioned as outside the group and clinicians positioned as the experts in care planning. Ex-service users have highlighted for decades that to work in partnership, it is necessary that they are included in these service meetings (Chamberlin, 1995). Additionally, policy states the need, and benefits, of including consumers and carers in decision-making (Foot et al., 2014). Active inclusion, however, remained limited to certain settings and was thereby dependent on the allocated clinicians, rather than supported at a systems level. In the thesis study, some clinicians were actively engaging with consumers and their families, for example co-developing safety plans, although other families reported an absence of knowledge and input into their family member’s care. Being excluded from care discussions and carer perceptions of poor care have been found to be major sources of stress, guilt and anxiety for carers (Askey et al., 2009). Changing clinical review formats to include consumers and carers as the norm would immediately begin to address their absence in care planning.

Responsibility and blame: Contributing to the reproduction of a risk culture that perpetuated discrimination

> Risks only exist when there are decisions to be taken … What brings into play the notion of responsibility is that someone takes a decision having discernible consequences (Giddens, 1999, p. 8).

The concepts of risk, responsibility and blame were all interlinked and informed decision-making regarding clinical care and resource allocation. This aligns with findings in a recent study that explored allied health leaders’ constructions and influences of risk on these domains (Grant, White, Martin & Haines, 2019). In situ observations of care planning discussions highlighted how risk-averse practices were arising and being maintained, with subsequent allocations of responsibility and blame to all participants further compounding such practices (including justification of CTOs). Consumers on CTOs were assessed as lacking decision-making capacity, while they were simultaneously blamed for not adhering to the CTO. Another ethnographic study found that CTOs were constructed by clinicians and tribunal members as being supportive of facilitating “normality and responsibility”, with medication compliance a key indicator of this (Jobling, 2019, p. 99). However, as Klassen (2017) highlighted, CTO use, and the conceptualisation of individuals who require them as being risky, “eliminate opportunities for rationally informed types of non-compliance” (p. 361). Responsibly complying with a CTO does not allow for personal choice that differs from recommendations made by the treatment team (Klassen, 2017). Factors impacting on this allocation of responsibility, and subsequent blame, include neoliberal views that assign health status as an individual responsibility (Klassen, 2017; Ward & Meyer, 2009) and biogenetic understandings of mental illness that assign individuals as personally responsible for their illness (Read et al., 2006).

As explored in the previous chapter, the consequences for consumers of a service emphasis on biogenetic understandings of mental illness included increased self-stigma and self-blame (Lebowitz & Appelbaum, 2019). Internalised stigma has been found to undermine individuals’ sense of personal agency, meaning that people are less likely to engage in opportunities that would support them to attain their personal goals (Corrigan et al., 2009). Furthermore, in this thesis consumers were deemed to be “deserving” or “not deserving” of resources, which influenced clinicians’ willingness to advocate for scarce resources (such as independent housing). This positioning aligns with other ethnographic studies that found that consumers who were conceptualised by clinicians as being “really ill”, “authentically ill” and “severely mentally ill” were those who were recognised as needing and deserving help (Dobransky, 2014; Ringer & Holen, 2016). Furthermore, Dobransky (2009) found that these consumers were exempt from moral judgements by clinicians, as opposed to those who were perceived as being “not mentally ill” or a “problem”. As with the labelling that is identified in this thesis, those labels were formed through discussions among clinicians within the specific cultural settings. In summary, care planning interactions where consumers were blamed for their lack of participation in treatment were a further form of discrimination.

As highlighted in the findings, all participants in the care planning context were allocated responsibilities and subsequently exposed to blame. This dynamic served to strengthen the culture of risk. Mary Douglas (1992) linked risk with blame many decades ago and named the process a “blaming system” where individuals are held culpable for risks that are considered preventable, thus also tying in personal responsibility. In mental health care contexts, however, high-risk consequences, although they occur infrequently, have profound impacts for all involved. This coupled with a “blaming system” provides a further context for risk-averse practices. Critical political and media responses to adverse incidents have even resulted in changes to mental health policy following some high-profile incidents (Hallam, 2002), further contributing to the risk culture. Clinicians in the study were concerned about risks that could potentially result in negative media and coroner reports, with evidence showing that previous failures at a systems level resulted in blame being devolved to individual clinicians (Hallam, 2002). Additional constraints clinicians faced included differing views within the multidisciplinary team and pressures to avoid hospital admissions and facilitate discharge from services. Many of these systems-levels issues are reported in the literature pertaining to the use of CTOs (Rugkåsa & Burns, 2017). Most consumers on CTOs at the site had very complex needs and previous experiences of treatment orders (both as inpatients and in the community). Consumer complexity, including past (and current) assessed risks, coupled with service and societal culture that is preoccupied with risk, structurally promoted and reinforced clinicians' conceptualisations of individuals as being "risky", thus contributing to the reproduction of a risk culture and the perpetuation of discrimination.

Care planning from the personal to the social

Research and discourse in the area of mental health care highlight the need for a shift in the conceptualisation of risk and recovery from the personal to the social (Beresford, 2002; Light, Robertson et al., 2015; Perkins & Repper, 2016; Tew et al., 2012).This means understanding that a person's experience of distress, as well as recovery, occurs within a social context. Understandings of recovery have broadened over the years from a focus on clinical recovery (reduction of symptoms and impairments) and personal recovery (individual journeys) towards recovering citizenship, emphasising the person's experience, connection with and roles in their community and broader society (Mezzina, 2014; Ponce, Clayton, Gambino & Rowe, 2016; Rowe & Davidson, 2016; Rowe & Pelletier, 2012; Slade, 2009) . The broader context (economic, cultural and political) impacts on people's opportunity to recover, with risk, stigma and discrimination further impeding recovery (Rowe & Davidson, 2016; Warner, 2005). Aligning with the literature, care planning at the study site that was recovery-focused incorporated the person's natural support networks and emphasised linking with their community. Emphasising what an individual wanted to develop in their social context was capacity-focused, repositioned the clinician away from being the expert, avoided clienthood and provided care that was relevant and likely to increase consumer trust, engagement and motivation. The following sections explore possible means for cultural change that aims to reduce the focus on risk and promote the focus on recovery and citizenship.

Reframing risk and recovery in mental health care

> There is a need to step back and re-evaluate risk-centred health care (Grant et al., 2019, p. 14).

While the above statement presents an ideal, the findings from this thesis support the need for a reconceptualisation of risk in mental health care, aligning with recommendations from another Australian study (Light, Robertson et al., 2015). Pragmatically, societal and mental health services' preoccupation with risk and mitigation of this means that the concept of risk will remain part of mental health care for the foreseeable future. This thesis has explored how the emphasis on risk contributes to the discrimination against individuals who are diagnosed with having a mental illness and assessed as requiring care and treatment from services. To start to redress this discrimination, risk formulations need to broaden to incorporate the many social determinants and broader psychosocial stressors that individuals face, as reported in this thesis by consumers and their carers. An alternative option is reframing risk as issues relating to a person's safety and needs (Perkins & Repper, 2016). Both approaches, however, involve an active dialogue about care needs with the consumer themselves.

Given the impact that assessment tools and measures have on clinicians' conceptualisations of the person (Waring, 2009), the inclusion of measures that support clinicians to identify and thereby increase their awareness and knowledge of the broader risks impacting on the person is important (Nugent, Hancock & Honey, 2017). This includes tools that measure recovery and social inclusion from consumers' perspectives, of which there has been significant developments both internationally (O'Connell, Clayton & Rowe, 2017; Shanks et al., 2013) and within the Australian context (Burgess, Pirkis, Coombs & Rosen, 2011; Hancock, Scanlan, Honey, Bundy & O'shea, 2015; Scanlan, Hancock & Honey, 2018). Additionally, consistent with the bidirectional mandate of recovery-oriented services, measures should include those that assess effectiveness of services from the consumer's perspective, specifically the nature of the support they receive from clinicians (Corrigan, 2016; Williams et al., 2012). In the Australian context, a consumer-rated measure of social inclusion (Living in the Community Questionnaire – LCQ) has been recently developed (Coombs, Reed & Rosen, 2016). The LQC focuses on the person's life in the community, specifically their participation in social activities, work, housing situation and physical health. The tool assists in the identification of needs that are relevant to the person and can thereby inform care planning. Interestingly, although the tool has been endorsed for use by public mental health services at a national level, there has not yet been broad uptake by services (Coombs et al., 2016).

Acknowledging the impact of social determinants on people's health (Campion, Bhugra, Bailey & Marmot, 2013; World Health Organization and the Calouste Gulbenkian Foundation, 2014) should further reframe clinicians' conceptualisations of the concepts of risk and recovery. The concept of personal recovery has recently been extended to recovering citizenship, which emphasises an external focus and is informed by human rights (Ponce & Rowe, 2018; Rowe & Davidson, 2016). Citizenship is defined as a person's connections to the "rights, responsibilities, roles, resources, and relationships that society offers to its members … and a sense of belonging in society that is validated by one's fellow citizens" (Ponce & Rowe, 2018, p. 23). As a framework, citizenship supports social inclusion and participation in community life, and directly addresses the various contextual barriers that are limiting people (Ponce & Rowe, 2018). Citizenship interventions include support with housing, employment, community building and financial health (Ponce & Rowe, 2018; Slade et al., 2014). Each of these areas were within the domains of care planning at the study site, with some clinicians supporting consumers on CTOs with housing and finances, although rarely employment. There were, however, also additional restrictive practices in these domains, with the use of administration orders to oversee a person's finances and limited access to independent housing for some individuals. Housing availability was limited; however, as previously explored, clinicians' low expectations of change served to further limit individuals' opportunities. This went against contemporary evidence-based housing models, which recommend placing people in housing first and then providing the required supports (Slade et al., 2014), which goes against typical practice of service recommendations for housing type. The recent rollout of the NDIS may help address this gap in Australia. However, while the scheme aims to offer more choice and control to consumers, early critiques have highlighted concerns regarding its compatibility with the psychosocial needs of individuals living with an mental illness, provision of recovery-oriented services and workforce needs (Brophy et al., 2015; Daya, 2015; Rosenberg, Redmond, Gleeson & Russell, 2019).

Taking a citizenship approach at a systems level could potentially challenge clinicians' views and attitudes, and thereby positively influence care options for consumers. Advocacy for resources (such as housing) is considered an essential component of the strengths-based approach (Rapp & Goscha, 2012). This level of advocacy is not typically viewed as within scope of clinical practice; however, the findings from this thesis suggest that clinicians' perspectives on consumers' capacity may contribute to this stasis. Another study exploring the concept of advocacy found that clinicians reported concerns regarding their ability to influence broader issues, such as discrimination and poverty, as well as concerns that people needed to be well enough to be able to participate as citizens (Ponce et al., 2016).

Ponce et al. (2016) were sensitive to creating additional pressures on clinicians already burdened by service demands and suggested careful planning was needed to broaden the scope of clinical care. This recommendation segues to the next section, which highlights the need for services to focus on resource development, which is core to strengths-based and recovery frameworks (Bird et al., 2014; Rapp & Goscha, 2012).

Uncoupling from the biomedical and emphasising the psychosocial

Many mental health services do not offer contemporary evidence-based interventions beyond those advocated by the biomedical model (Slade et al., 2014). Furthermore, individuals with high levels of psychosocial disability are often not accessing relevant supports (Harvey et al., 2016). For positive change to occur in the care planning context, change needs to occur at the systems level. For this to occur, mental health services require models of care that properly align with the espoused recovery- and trauma-informed values and clinical governance structures that support ongoing implementation. This means supporting approaches, interventions and programs that align with recovery values. Such interventions include SDM (Drake et al., 2010), advance directives (Zelle, Kemp & Bonnie, 2015), illness management and recovery (Mueser et al., 2002), strengths models (Rapp & Goscha, 2012), recovery colleges (Perkins, Meddings, Williams & Repper, 2018), individual placement and support (Bond, Drake & Becker, 2020) and supported housing (Slade et al., 2014). Peer workers are well positioned to enhance strengths-based approaches (Chisholm & Petrakis, 2020; Tse et al., 2016) and foster recovery and social inclusion, with a recent review of evidence of peer-support staff demonstrating various positive outcomes including instilling hope and promoting the pursuit of a meaningful life (Davidson et al., 2018). Advocates with lived experience of mental illness and psychiatric services clearly articulate philosophies and models of care that promote personal power and recovery, with an emphasis on peer supports, within both mainstream as well as peer-run services (Central Potential – Te Rito Māia, 2008; Chamberlin, 1995). Additionally, emerging practices that are congruent with the values of recovery should be made available to enhance individual engagement and outcomes. Examples of such practices and approaches include peer support (Davidson et al., 2018), open dialogue (Seikkula, Alakare & Aaltonen, 2011), recovery narratives (Rennick-Egglestone et al., 2019), the Maastricht approach (Romme & Escher, 2000) and the power–threat–meaning framework (Johnstone et al., 2018). This requires services to remain committed to changing practice and restructure service models and workforces to align with contemporary and best practice.

Unfortunately, the recently proposed community mental health service plan, developed after the fieldwork was completed, although inclusive of recovery- and trauma-informed values, continues to align with the biomedical model, with a list of evidence-based psychological therapies offered according to diagnostic groups exclusion of lived-experience workers in the workforce profile and no consumer-rated measures of recovery or social inclusion (SA Health, 2020). Positively, the plan includes the articulation of social workers' role in advocacy, and service and community development, and an ongoing commitment to the provision of an evidence-based, supported employment program (Dawson et al., 2020). At the study site, community linkages and developments were not prioritised at the systems level, although such linkages had previously successfully occurred at the local level. This highlights the need for systems to allow and prioritise time for clinicians to work beyond the narrow clinical scope to improve services and ultimately consumer outcomes.

A citizenship approach acknowledges that individuals with a mental illness are often marginalised and therefore have fewer opportunities in life (Ponce & Rowe, 2018). People, however, need access to opportunities, environments and relationships that enable rather than hinder recovery (Rapp & Goscha, 2012). Ex-service users have highlighted the need for advocacy and system change for decades (Chamberlin, 1995, O'Hagan, 1991). Currently in the context of public mental health services, allied health professional leaders have responsibilities to advocate for and implement interventions and approaches that align with their profession's values and emphasise psychosocial frameworks. Change at a systems level would require allied health and nursing leaders to uncouple from the dominant biomedical approach and re-evaluate how current care practices are emphasising risk, rather than promoting recovery and citizenship. This requires knowledge of current evidence-based approaches and interventions, the associated outcomes (including reduced hospitalisations and increased employment) and the feasibility of implementation into clinical settings (Tse et al., 2016). A preoccupation with risk at a systems level can result in poor care and further harm; however, service culture can also be used to produce positive change (Cohen, 2017, Grant et al., 2019). A recent study found that increased psychosocial interventions for individuals with mental illness resulted in "increased self-agency and motivation" and improved therapeutic relationships (Oedegaard et al., 2020, p. 8). Additionally, a study conducted concurrently at the same site found implementation of an employment program began to foster positive changes in care planning practices and service culture (Dawson et al., 2020).

Is an emphasis on the psychosocial enough?

I need to acknowledge that many individuals with a lived experience of mental illness do not think it is possible for mental health services to sufficiently change, and instead call for a reframing of mental distress and the development of lived-experience models (Bouchard, 2019; Chamberlin, 1978; Roper, 2019). This includes scholarship and activism (mad studies) that are led by people with lived experience of mental illness and services in order to support this change (Beresford, 2020). The question therefore is: Will a service emphasis on the psychosocial be enough to address the discrimination that individuals diagnosed with a mental illness or in mental distress face? I found O'Hagan's (1996) paper titled "Two accounts of mental distress" both powerful and shameful to read as a clinician and researcher. Her excerpts of her personal journal entries made during her stay in a psychiatric hospital, placed alongside the psychiatrist's and nursing notes, highlighted the profound mismatch in understandings of her distress. The ongoing dominance of the biomedical model has been found to be a barrier to the implementation of trauma-informed approaches (Sweeney, Clement, Filson & Kennedy, 2016). To address this, some clinicians and researchers suggest moving away from diagnoses altogether. The recently published power–threat–meaning framework (Johnstone et al., 2018) is such an example and provides an alternative framework to the DSM that enables co-development of formulations and care plans between consumers and clinicians. The framework foregrounds what has happened to the person, rather than what is inherently wrong with them, and explores how the operation of power has caused the person harm (including their contacts with mental health services) as a means to understand the person's threat responses (Johnstone et al., 2018; Pilgrim, 2018). Another approach that is being explored to challenge and reform mental health care services is that of reparative truth and reconciliation (T&R) (Spandler & McKeown, 2017). These are complex processes that bring together survivors of services and mental health clinicians, and "aim at forging newly respectful relations and restitution for [psychiatric] harm and wrongdoing" (Spandler & McKeown, 2017, p. 84). While Spandler and Mckeown (2017) acknowledged that some critics believe a change in paradigm requires broader social action, the authors promote T&R as a possible grassroots approach that is complementary to such structural change.

Although it is beyond the scope of this thesis to explore the more radical means of change in detail, it is acknowledged that despite significant evidence of the harms that mental health services perpetuate (Sweeney, et al., 2016), a change in paradigm is yet to occur in mental health care service provision. Finally, a human rights approach highlights the acknowledged need for change in mental health care, the ongoing systemic challenges to this and the need for reform locally as well as globally. The following excerpt, taken from the *Report of the Special Rapporteur to the Human Rights Council* in April 2020, provides a summary of a global problem which was found to be enacted in day-to-day care planning interactions at the study site, but is also likely in many other contexts where the biomedical model continues to dominate the provision of care:

> Despite promising trends, there remains a global failure of the status quo to address human rights violations in mental health-care systems. This frozen status quo reinforces a vicious cycle of discrimination, disempowerment, coercion, social exclusion and injustice. To end the cycle, distress, treatment and support must be seen more broadly and move far beyond a biomedical understanding of mental health. Global, regional and national conversations are needed to discuss how to understand and respond to mental health conditions. Those discussions and actions must be rights-based, holistic and rooted in the lived experience of those left furthest behind by harmful socio-political systems, institutions and practices (UN Human Rights Council, 2020, p. 1).

Regardless of the challenges, there is significant knowledge about how mental health service delivery can viably change, at the study site and beyond. These impacts would positively influence care planning relationships, care experiences and outcomes.

Reframing of identities in the care planning relationship

Identity claims are an important means to understand the culture and power dynamics that are occurring in situ (Carspecken, 2009). The positioning of consumers, their families and clinicians, explored in detail in the findings chapters, highlights the ongoing influence of the biomedical model and psychiatric hegemony. The positionings of each participant group in the care planning relationship were misaligned with recovery-oriented values and approaches (Slade et al., 2014) and contributing to further harm (Gonzales et al., 2015; Nyttingnes et al., 2016). This understanding, however, can be used to identify ways in which power relations can be challenged and overcome in situ (Carspecken, 1996). Implementing the various approaches, processes and interventions explored throughout the discussion would result in changes in the identity claims of consumers, their families and clinicians towards active participants in the care planning relationship, and a realignment of power.

Small actions or gestures (referred to as micro-affirmations) that clinicians make which are imbued with positive meaning have been found to enhance therapeutic relationships and promote recovery (Topor, Bøe & Larsen, 2018). Topor et al. (2018) highlighted the paradox that it is through “being treated in a normal way in an un-ordinary context that the patient becomes a person” (p. 1216). While these micro-affirmations likely occurred more frequently during care contacts away from the study site in the person’s own context, there is scope for encouraging these approaches within the clinical setting. Mental health clinicians need to adopt a “different kind of professionalism” that moves away from being an “implementer” of “technical” care that reduces clinicians’ own person to a risk factor (Topor & Denhov, 2015, p. 235). Clinicians’ loss of being the “expert” in the care relationship would be replaced with an identity that was more aligned with their professional and personal values, and facilitated person-centred care practices. It would be hoped that consumers and their families would experience care planning that focused on their needs, strengths and aspirations, and was relevant, meaningful and supportive of their recovery.

Summary

Given the importance and complexity for all parties of negotiating care using CTOs, it is important to understand how the conflicting concepts of risk and recovery are applied and experienced in clinical practice. This thesis demonstrates how the foregrounding of risk and backgrounding of recovery can have detrimental impacts on care planning for consumers on CTOs. Much of the literature that has been drawn upon to situate the thesis findings pertains to the discrimination faced more broadly by individuals with a mental illness and is not specific to the context of forced care. Voluntary consumers of mental health services also report experiences of coercion in mental health care. Thus, it is considered that while recognising that discrimination experiences are likely compounded by being on a CTO, many of the thesis findings and recommendations are relevant to individuals who are seeking care and treatment from public mental health services regardless of their legal status. The final chapter provides a summary of the thesis findings and recommendations.

CHAPTER TEN
CONCLUSION

Introduction

This thesis has used critical ethnography (Carspecken, 1996) to understand the culture of practice and care planning from the perspectives of consumers on CTOs, their family members and mental health clinicians. Mental health care is unique in that individuals with a mental illness can be placed on treatment orders in the community that require them to comply with treatment plans that they may neither recognise the need for nor want. CTO legislation states that treatment and care should be recovery-focused, although legislation and justification for use are predominantly risk-based. Hence, this thesis is specifically concerned with how the concepts of risk and risk management influenced care provision for individuals on CTOs within the context of service frameworks that were recovery-oriented.

This topic is important given ongoing international criticism of public mental health services highlighting consistent shortfalls in care provision that is promoted as recovery-focused, trauma-informed and inclusive of the person and their nominated carers (UN Human Rights Council, 2017). This issue becomes more significant for those individuals who are forced to receive care and treatment because, in this context, care is often reported to be coercive and poses additional barriers to positive engagement. Negative critiques of mental health services generally, and use of forced care specifically, have come from ex-users of services, carers, clinicians, researchers and, more recently, global organisations including the WHO. In clinical practice, however, clinicians and carers continue to express support for CTOs (Corring et al., 2019) and usage remains high (Light, 2019). Although mental health policy and service models of care prioritise biopsychosocial frameworks that emphasise recovery-oriented and evidence-based practices in mental health care settings, reviews of services frequently highlight an overly clinical focus. This thesis provides a unique and detailed account of the day-to-day care planning practices with individuals on CTOs occurring within a community mental health care setting. The exploration is inclusive of how care planning practices and approaches were culturally situated and structurally reinforced. The subsequent impacts for all participant groups have been presented, with an emphasis on the impacts for those individuals who were forced to receive care and treatment for having a mental illness. This final chapter revisits the research aim and provides a summary of the key findings and recommendations to address the identified problems. Through gaining an in-depth understanding of this issue, this investigation aims to facilitate the improvement of care planning practices for individuals on CTOs and ultimately consumers' care experiences and outcomes.

Revisiting the research questions

This research has answered the following questions:

1. What is the culture of care planning for consumers on CTOs?
2. What are the micro (relational), meso (organisational) and macro (cultural) factors impacting upon the care planning process?
3. How do the concepts of risk and recovery impact upon care planning?

Summary of the findings

This thesis highlights how culturally shaped understandings of mental illness and risk negatively influenced clinicians' attitudes towards consumers, focus of care contacts and care options made available to individuals on CTOs. Risk and the forestalling of risk was central to clinical work and therefore a key component of care planning discussions and care foci. A service focus on risk, however, impeded the development of reciprocal trust, which in turn was devaluing of the therapeutic relationship. As a result, care planning could not be used as intended. Consumers were untrusted as knowers of their experiences and needs. This, as well as consumers' and carers' exclusion from care planning processes, which further positioned them as outside the dominant group, contributed to a service culture that perpetuated disempowerment and discrimination of consumers. Clinicians attempting to work in recovery-oriented ways were disempowered and had limited support from system structures where the biomedical model underpinned and reinforced service culture and care options. Despite this dominance, however, some clinicians worked with the person in their broader context to provide care that was recovery-focused. However, although recovery was possible for consumers on CTOs, overall, care planning relationships and processes were constrained by service structures and systems that emphasised risk.

By examining care planning practices in situ, the findings in this thesis further illuminate the significant negative impacts that a biomedical care focus has for consumers on CTOs in mental health care settings. Given the experiences of coercion (micro- and macro-aggressions) that are consistently reported by consumers during contacts with mental health care services, regardless of legal status, the thesis findings and recommendations are considered relevant to all individuals seeking care and treatment from public mental health services. Importantly, the findings demonstrate that for services to be relevant and supportive of consumers’ recovery, a paradigm change is essential (Bracken et al., 2012). Fortunately, there is a significant evidence base of recovery approaches and interventions that can be drawn upon to support this change in orientation. A summary of these is presented below.

Recommendations

There is a need for a broadening of clinician conceptualisations and understandings of risk.

Clinicians need to develop a broader understanding of the adversities that the person has faced and continues to experience, and thereby have a better understanding of the person’s needs in care planning. Narrow conceptualisations of risk related to harm to self and others should be reconceptualised to include an understanding of the impact that various social determinants have on a person’s mental health and wellbeing. A broader understanding would require joint discussions about risk (reframed as safety or needs) between clinicians, consumers and their families. This would mean joint care planning meetings between consumers, carers and clinicians as usual practice, with justification required for care planning meetings that excluded consumers and their carers. Additionally, to support clinicians to develop broader conceptualisations of risk and need, service consumer–rated tools and outcome measures that explore the person’s perceptions of social inclusion, recovery and citizenship, and the nature of the support that they receive from services, should be implemented. There are various measures and tools that have been developed and validated in the Australian context which should be prioritised for use. Current tools include the Recovery Assessment Scale – Domains and Stages (RAS-DS) (Hancock et al., 2015) and LCQ (Coombs et al., 2016). Inclusion of such tools would address the current gap in service tools and outcome measures, which are predominantly clinician-rated and aligned with the biomedical model. Use of such tools could potentially positively influence clinicians’ views and attitudes towards consumers and enhance their understanding of the discrimination that individuals face. Although use of recovery-oriented tools and measures can be implemented at the service level, higher level policy change, at the national and state/territory levels, emphasising consumer outcomes aligned with recovery and citizenship is considered essential to facilitate uptake. Finally, mental health clinicians need to critically reflect on the impact that the differing paradigms of disease and discrimination have on both care provision and consumer experiences, including the impact of forced care. This critique needs to be incorporated into university and service-facilitated graduate training programs, with individuals with lived experience having a key role in development and provision of such training.

There is a need for routine implementation of interventions and approaches that are recovery-oriented and trauma-informed.

Citizenship and strengths-based frameworks highlight the need for access to opportunities and resources that promote and facilitate a person's recovery. This means that services have responsibilities to implement evidence-based recovery approaches, interventions and programs. Allied health leaders have a key role in facilitating this, as their professional values align with psychosocial frameworks. This requires allied health leaders to uncouple from the dominant biomedical discourse that is linked to risk and instead promote strengths-based approaches that de-emphasise and broaden understandings of risk. It also requires promoting the evidence, value and feasibility of implementation of psychosocial approaches and interventions that are evidence-based. Linking with academics and experts in mental health care service provision is needed to support the alignment of service developments and provision that are based on contemporary evidence. This includes meaningful engagement with advocates, peer workers and researchers with lived experience of mental illness and services. Acknowledgement from leadership of the value of senior clinical staff developing psychosocial programs within services and advocating for community-based resources is an essential component of services that aim to promote recovery and citizenship. At the team level, service managers need to acknowledge the value and time that are required for care coordinators to effectively support linkages with an individual's community and natural supports. This requires service commitment to clinical staff spending time on non-clinical work that aims to develop community resources. Inclusion of lived-experience staff in delivery of community services should be prioritised given its contemporary evidence base regarding enhancing hope, trust and recovery.

There is a need for research on the impacts of implementation of recovery tools and interventions on care planning relationships and processes.

Given the importance of the therapeutic relationship in supporting positive consumer experiences and outcomes, a greater understanding of the impacts of the different recovery tools, measures and interventions on care planning relationships would be beneficial. Specifically, an exploration of the development and presence of trust, an essential component of therapeutic relationships, as well as clinicians' understanding and attitudes towards consumers' needs and strengths, would be valuable and contribute to justifications of the value of what is currently perceived as non-clinical work. Such research should be codesigned with consumers and their carers to ensure a broader lens. Investigations into the impact of implementation of recovery interventions on carers would be helpful given the significant support role that carers in mental health currently have. Finally, further research into what enables some clinicians to work within a recovery focus despite the biomedical dominance would be beneficial in order to further support such approaches in clinical practice. Increased understandings would positively impact on care approaches and options.

These recommendations focus on changes that are considered currently feasible within mental health care services, and are micro-steps towards a reformist agenda that promotes positive change in the culture of practice and care planning for individuals on CTOs. The researcher, however, acknowledges that a more radical reorientation is required to address the power imbalances and perpetuation of discrimination experienced by individuals seeking care and treatment from services. This would be inclusive of increased peer-led services, genuine alternatives to psychiatric diagnoses and the enactment of reparative justice (Spandler & McKeown, 2017).

Concluding comments

The findings of this thesis extend knowledge of the impacts of the continued emphasis on biomedical frameworks in mental health care and contribute to the understanding of possible means for positive change. Sociological theories of risk and trust inform understandings of both the contributing factors to a risk culture and the consequences of this. While care planning that was supportive of individuals' recovery was occurring at the site, care planning was not occurring as intended. Service structures and systems were not aligned with or supportive of recovery approaches and interventions. The deleterious impacts on consumers of service culture and practices that perpetuated stigma and discrimination cannot continue. There is a significant evidence base of approaches and interventions that align with the promotion of recovery and citizenship that have been demonstrated as feasible to implement in clinical settings. Such approaches and interventions should be implemented as a priority within public mental health care settings. Change in culture requires a catalyst. As the following quote highlights, mental health clinicians are likely to reflect on current practices and approaches when alternatives that are aligned with recovery and citizenship are made available:

> As a service we talk about recovery … but mainly what we do is diagnose, medicate, and treat … the whole medicalisation of people's lives, has meant that we have focused on that, and we haven't maybe focused as much on [employment] and that's why we're having to find our way again. Because we lost our way a bit when it came to treating people in the community for mental health conditions, if it meant not just using medication, orders, diagnostic criteria … I think it's [IPS] quite important for those reasons (Dawson et al., 2020, p. 8).

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APPENDICES

Appendix A: Search strategy

Community Treatment Orders – Literature search

Databases searched:

- PsycINFO (Ovid)
- Medline (Ovid)
- PubMed (non-Medline content only)
- Scopus
- CINAHL
- ProQuest (Social Sciences and Health subsets only)

Total number of citations before duplicates removed n = 7459

Total number of citations after duplicates removed n = 4283

PsycINFO 1806 to September Week 1 2015

Search executed 9/9/15

#	Searches	Results
1	outpatient commitment/	185
2	(community treatment order* or CTO* or outpatient commitment or outpatient treatment or AOT).tw.	4387
3	(community or outpatient or out-patient).tw.	234174
4	((involuntary or order* or coerc* or compulsory or commitment or legal or law or mandate*) adj3 treatment).tw.	4540
5	3 and 4	1018
6	1 or 2 or 5	4989
7	chronic mental illness/ or chronic psychosis/	1660
8	exp psychosis/ or exp schizophrenia/ or paranoid schizophrenia/	100475
9	mental disorders/ or chronic mental illness/ or personality disorders/ or schizoaffective disorder/ or abnormal psychology/ or borderline states/ or comorbidity/ or psychiatric patients/ or schizophrenogenic family/ or suicide/ or treatment resistant disorders/	157705
10	(mental* or psychos* or psychot* or psychiatr* or schizo* or personality disorder* or suicid*).tw.	807207
11	or/7-10	828710
12	6 and 11	3067
13	limit 12 to english language	2686
14	limit 13 to yr="2000 - 2015"	1667

Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 1946 to Present

Search executed 9/9/15

#	Searches	Results
1	"Community Mental Health Services"/	17527
2	lj.fs. or mandated programs/ or coercion/ or commitment of mentally ill/	237744
3	1 and 2	1174
4	(community treatment order* or CTO* or outpatient commitment or outpatient treatment or AOT).tw.	8162
5	(community or outpatient or out-patient).tw.	451689
6	((involuntary or order* or coerc* or compulsory or commitment or legal or law or mandate*) adj3 treatment).tw.	7553
7	5 and 6	812
8	3 or 4 or 7	9594
9	mental disorders/ or exp mood disorders/ or exp personality disorders/ or exp "schizophrenia and disorders with psychotic features"/	383743
10	Mentally Ill Persons/	5624
11	suicide/ or suicidal ideation/ or suicide, attempted/	48677
12	(mental* or psychos* or psychot* or psychiatric or schizo* or personality disorder* or suicid*).tw.	666577
13	or/9-12	824893
14	8 and 13	2736
15	limit 14 to (english language and yr="2000 - 2015")	1451

PubMed

Searched 9/9/15

N=42

(community treatment order*[tiab] OR CTO*[tiab] OR ((community treatment[tiab] OR community care treatment[tiab] OR outpatient treatment[tiab] OR out-patient treatment[tiab] OR AOT or outpatient commitment[tiab] OR out-patient commitment[tiab]) AND (involuntary[tiab] OR order*[tiab] OR coerc*[tiab] OR compulsory[tiab] OR commitment[tiab] OR legal[tiab] OR law[tiab] OR mandate*)) AND (mental*[tiab] OR psychos*[tiab] OR psychot*[tiab] OR psychiatric[tiab] OR schizoid*[tiab] OR schizophreni*[tiab] OR personality disorder*[tiab] OR suicid*[tiab]) AND English[la] AND 2000:2015[dp]) NOT Medline[sb]

CINAHL

9/9/15

#	Query	Limiters/Expanders	Results
S1	(MH "Community Mental Health Services") OR (MH "Community Mental Health Nursing") OR (MH "Social Work, Psychiatric")	Search modes - Boolean/Phrase	8,310
S2	((MH "Involuntary Commitment") OR (MH "Medical Orders") OR (MH "Patient Compliance") OR (MH "Coercion")) OR MW legislation	Search modes - Boolean/Phrase	119,727
S3	S1 AND S2	Search modes - Boolean/Phrase	687
S4	TI ("community treatment order*" OR CTO*) OR AB ("community treatment order*" OR CTO* OR "outpatient commitment" or "outpatient treatment" or AOT)	Search modes - Boolean/Phrase	1,051
S5	TI (community OR outpatient OR "out-patient") OR AB (community OR outpatient OR "out-patient")	Search modes - Boolean/Phrase	133,313
S6	TI (((involuntary OR order* OR coerc* OR compulsory OR commitment OR legal OR law OR mandate*) N3 treatment)) OR AB (((involuntary OR order* OR coerc* OR compulsory OR commitment OR legal OR law OR mandate*) N3 treatment))	Search modes - Boolean/Phrase	1,842
S7	S5 AND S6	Search modes - Boolean/Phrase	375
S8	S3 OR S4 OR S7	Search modes - Boolean/Phrase	1,860
S9	(MH "Psychiatric Patients") OR ((MH "Mental Disorders") OR (MH "Behavioral and Mental Disorders") OR (MH "Mental Disorders, Chronic") OR (MH "Psychotic Disorders") OR (MH "Affective Disorders, Psychotic") OR (MH "Bipolar Disorder+") OR (MH "Paranoid Disorders") OR (MH "Postpartum Psychosis") OR (MH "Schizoaffective Disorder") OR (MH "Schizophrenia") OR (MH "Personality Disorders+")) OR ((MH "Suicide") OR (MH "Suicide, Attempted") OR (MH "Suicidal Ideation"))	Search modes - Boolean/Phrase	68,183
S10	TI (mental* OR psychos* OR psychot* OR psychiatr* OR schizo* OR "personality disorder*"	Search modes - Boolean/Phrase	142,360

	OR suicid*) OR AB (mental* OR psychos* OR psychot* OR psychiatr* OR schizo* OR "personality disorder*" OR suicid*)		
S11	S9 OR S10	Search modes - Boolean/Phrase	165,165
S12	S8 AND S11	Limiters - Published Date: 20000101-20151231; English Language Search modes - Boolean/Phrase	713

Scopus

Searched 9/9/15

N=1991

(TITLE-ABS-KEY (("community treatment order*" OR cto* OR "outpatient commitment" OR "outpatient treatment" OR aot OR ((community OR outpatient OR "out-patient") AND (involuntary OR order* OR coerc* OR compulsory OR commitment OR legal OR law OR mandate*) W/3 treatment))) AND SUBJAREA (mult OR medi OR nurs OR vete OR dent OR heal OR mult OR arts OR busi OR deci OR econ OR psyc OR soci) AND PUBYEAR > 1999 AND PUBYEAR < 2016) AND (TITLE-ABS-KEY (mental* OR psychos* OR psychot* OR psychiatr* OR schizo* OR "personality disorder*" OR suicid*) AND SUBJAREA (mult OR medi OR nurs OR vete OR dent OR heal OR mult OR arts OR busi OR deci OR econ OR psyc OR soci) AND PUBYEAR > 1999 AND PUBYEAR < 2016) AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re") OR LIMIT-TO (DOCTYPE , "cp") OR LIMIT-TO (DOCTYPE , "ip"))

ProQuest

Searched 9/9/15

N=1595

all("community treatment order*" OR CTO* OR "outpatient commitment" OR "outpatient treatment" OR aot OR ((community OR outpatient OR "out-patient") AND ((involuntary OR order* OR coerc* OR compulsory OR commitment OR legal OR law OR mandate*) NEAR/3 treatment))) AND all(mental* OR psychos* OR psychot* OR psychiatric OR schizo* OR "personality disorder*" OR suicid*)

Limited to English, Scholarly journals, and January 2000 to September 2015

Appendix B: Details of included studies

Quantitative studies					
Author and Date	**Year**	**Aim/Objective**	**Context/Setting**	**Methods and Methodology**	**Findings related to the review**
DeRidder, R., Molodynski, A., Manning, C., McCusker, P., Rugka˚sa, J. Community treatment orders in the UK 5 years on: a repeat national survey of psychiatrists	2016	To establish psychiatrists experiences and current opinions of using CTOs and to compare findings with a previous survey conducted in 2010.	UK	Survey. Statistical and descriptive analysis conducted.	The opinions of psychiatrists in the UK have not changed since 2010 despite recent evidence questioning the effectiveness of CTOs. This was viewed as concerning. Clinical factors (the need for engagement and treatment adherence, and the achievement of adherence and improved insight) remain the most important considerations in initiating and discharging a CTO.
Rugkåsa, J., Molodynski, A., Yeeles, K., Montes, M., Visser, C., Burns, T. Community treatment orders: Clinical and social outcomes, and a subgroup analysis from the OCTET RCT	2015	To test the effect of community compulsion on wider clinical and social outcomes and on patients' experiences of services and the use of treatment pressure and explore differential effects in different groups of patients.	UK, 336 eligible patients were randomised, with data collected for 333 patients. Eligible participants were patients in adult services (18–65 years) with a diagnosis of psychosis, considered appropriate for	Non-blinded RCT of CTO effectiveness. Hospitalisation data and data on medication from medical records. Symptoms, social functioning and patient-rated outcomes from interviews at baseline, 6 and 12 months.	Compelling patients to adhere to treatment does not have benefits for consumers on a wide range of clinical and social outcomes. One finding (of difference) was those in CTO arm of trial showed a smaller increase over time than controls in their agreement that pressure in services could be helpful.

		Reporting on OCTET.	CTO by their clinical team and able to give informed consent		
Newton-Howes, G., Banks, D. The subjective experience of community treatment orders: Patients' views and clinical correlations	2014	To assess patients' perspectives of CTOs in order to identify correlations between clinical and demographic variables and a positive experience of CTOs.	NZ 79 adults subject to a CTO for at least 6 months (on May 2010) and anyone subject to a CTO for a min of 6 months prior to this date and cared for a secondary services.	Questionnaires (self-report measures).	53% felt they were on balance better off when treated informally in the community; patients described greater coercion and less satisfaction with care when subject to a CTO- these factors and being in employment identified patients whom felt harmed by CTOs 61% of the time.
Newton-Howes, G., Lacey, CJ., Banks, D. Community treatment orders: The experiences of non-Maori and Maori within mainstream and Maori	2014	To compare views of Maori consumers and non-Maori consumers about CTOs.	NZ 79 adults subject to a CTO for at least 6 months (on May 2010) and anyone subject to a CTO for a min of 6 months prior to this date and cared for a secondary services.	Questionnaires (self-report measures).	There were few differences in views of Maori compared to non-Maori consumers and no difference in views of Maori consumers cared for by mainstream compared to culturally specialist MHS.

mental health services					
Newton-Howes, G. A factor analysis of patients' views of compulsory community treatment orders: The factors associated with detention	2013	To examine the views of patients currently or previously detained under a CTO.	NZ 79 adults subject to a CTO for at least 6 months (on May 2010) and anyone subject to a CTO for a min of 6 months prior to this date and cared for secondary services.	Self-report measures were used to identify patients' views on compulsory treatment.	Three overlapping factors were identified: interpersonal difficulties; intrapsychic threat and a safety factor associated with detention.
Fahy, GM., Javaid, S., Best, J. Supervised community treatment: Patient perspectives in two Merseyside mental health teams	2013	To explore patient perspectives subject to CTOs.	UK, NHS, 2 mental health teams. 17 patients from and an early intervention team and assertive outreach teams currently under Supervised Community Treatment, from point of hospital d/c.	Survey. Structured interview with Likert scale.	Majority of patients believed TO facilitated earlier hospital d/c but felt uninvolved in the process. A significant proportion lacked motivation or ability to understand verbal and written info pertaining to legal rights at the time it was given. All felt they must strictly abide by conditions to remain in the community. There was a lack of knowledge of harm criteria and ability for recall.

Coyle, D., Macpherson, R., Foy, C., Molodynski, A., Biju, M., Hayes, J. Compulsion in the community: Mental health professionals' views and experiences of CTOs	2013	To explore the views and experiences of MH professionals (including psychiatrists) re the use of CTOs.	UK, NHS, Oxford. 288 surveys completed (response rate of 48%).	Surveys.	48 (83%) psychiatrists and 142 (67%) MH professionals were in favour of CTOs. Decision-making regarding CTOs was overwhelmingly clinically orientated for all professional groups. There were significant differences in views between groups re. effects of bureaucracy, infringement of human rights and coercion. MDT involvement is crucial in decisions regarding CTOs and may protect against poor practice. Further training and support for staff is needed.
Manning, C., Molodynski, A., Rugkåsa, J., Dawson, J., Burns, T, Community treatment orders in England and Wales: national survey of clinicians views and use	2011	To ascertain views and experiences of psychiatrists in England and Wales of CTOs.	UK, Wales. 566 Psychiatrists responded (29% response rate)	Survey.	Respondents were generally positive, reported decision-making regarding compulsion was based largely on clinical grounds. Authors call for MDT input into DM.

Patterson, T., Mullen, R., Gale, C., Gray, A. Compulsory community treatment and patients' perception of recovery in schizophrenia	2011	To examine whether patients perceptions of recovery differed for those receiving treatment under a CTO compared to those who were not.	NZ, Dunedin. 86 participants with a diagnosis of Schizophrenia or schizoaffective disorder.	Interview with battery of measures covering indices of mental & physical health, quality of life, insight, ethnicity and recovery.	There was no association between being under a CTO and recovery beliefs. The majority of patients (irrespective of if they were on an order) reported recovery as possible and ½ reported they were in recovery.
Christy, A., Petrila, J. Involuntary outpatient commitment in Florida: Case information and provider experience and opinions	2009	To examine key characteristics of the first 50 IOCs in Florida. To obtain the experiences and opinions of Florida Mental health professionals about IOC, including incentives and disincentives for using the statute.	Florida, USA. 498 licensed mental health professionals.	Online survey.	Respondents indicated various issues had reduced the use of IOC including difficulties in applying the statute, inadequate clinical resources and scepticism regarding the effect of IOCs on positive clinical outcomes.

Rolfe, T., Sheehan, B., Davidson, R. Are consumers on community treatment orders informed of their legal and human rights? A West Australian study	2008	To collect information from consumers who were currently or had recently been on CTOs as to their perceptions of whether they had been fully informed of their rights under the West Australian Mental health Act.	Western Australia. 86 consumer participants with experience of being on a CTO in the area of the study.	Postal survey.	Mental health clinicians need to make significant improvements in providing information to consumers. This may impact positively on consumer engagement and therapeutic relationships and lead to improved health outcomes and CTO compliance.
McKenna, BG., Simpson, AIF., Coverdale, JH. Outpatient commitment and coercion in New Zealand: A matched comparison study	2006	To determine the level of coercion perceived by those under outpatient commitment in New Zealand.	NZ, Auckland. 69 consumers under OC and 69 matched consumers who were voluntary.	A cross-sectional comparative study. Face: face structured interviews.	Though the level of coercion for involuntary outpatients was relatively low, it was significantly higher than that experienced by voluntary outpatients. Emotional responses of the consumer impacted upon their perception of coercion and the use of persuasion during treatment resulted in higher levels of perceived coercion.

Greenberg, D., Mazar, J., Brom, D., Barel, YC. Involuntary Outpatient Commitment: A naturalistic study of its use and a consumer survey at one community mental health center in Israel	2005	To evaluate the effectiveness of IOC as a means of ensuring continuing psychiatric treatment, and reducing hospitalizations. To ascertain patients and psychiatrists views on the IOC and its effect on their relationship.	Israel. 13 patients and 17 psychiatrists were interviewed.	Survey conducted via interview.	Majority of patients perceived the commitment in negative terms, although not all thought it had a negative impact on their relationship with the psychiatrist. Psychiatrists were often sensitive to the patient's wishes, not all considered they were providing optimum treatment and the involuntary aspect of care was not always pursued.
Romans, S., Dawson, J., Mullen, R., Gibbs, A. How mental health clinicians view community treatment orders: A national New Zealand survey	2004	To determine New Zealand mental health clinicians' views about community treatment orders, indications for their use, their benefits, problems and impact on patients and therapeutic relationships.	New Zealand. Psychiatrists (n= 202) and community MHPs (n=82), largest group nurses (n=35).	Survey A national survey of New Zealand psychiatrists and regional survey of community mental health professionals for comparison.	Majority of psychiatrists prefer to have CTOs an option. Consider they are used properly in most cases, can enhance priority for care, provide structure for treatment, support continuing contact and produce a period of stability allowing other therapeutic changes. They consider CTOs can harm therapeutic relationships, especially in the short term, but when used appropriately overall benefits outweigh coercive impact. MHPs surveyed had similar views with a minority of clinicians not supporting use.

Dawson, J., Romans, S. Uses of community treatment orders in New Zealand: Early findings	2001	To assess the uses of Community Treatment Orders (CommTOs) in New Zealand.	New Zealand.	Retrospective study of patients’ records of mental health legislation and a survey of psychiatrists.	There was a high level of agreement amongst psychiatrists that, when used appropriately, the benefits of CommTOs outweigh their coercive impact on patients. The most strongly supported indicator for use was the promotion of medication compliance.

Qualitative studies					
Author and Date	**Year**	**Aim/Objective**	**Context/Setting**	**Methods and Methodology**	**Findings related to the review**
Banks, LC., Stroud, J., Doughty, K. CTOs: exploring the paradox of personalisation under compulsion	2016	To understand how factors associated with person-centred support are experienced in the context of compulsory treatment and to identify good practice in relation to assessment for and management of CTOs.	UK, 1 NHS trust. Findings based on data from 2 studies. Participants included service users, relatives and practitioners across teams and the region.	Interviews.	Service users were often inadequately informed about CTO and rights and offered little or no opportunity to make choices or have involvement in CTO process and conditions. Retrospectively they often felt restrictions were beneficial to recovery and reported greater involvement in decisions at review stage.

Lawn, S., Delaney, T., Pulvirenti, M., Smith, A., McMillan, J. A qualitative study examining the presence and consequences of moral framings in patients' and mental health workers' experiences of community treatment orders	2015	This paper reports on the moral framing that emerged from the data collected for a broader study of the experience of CTOs from patients' and workers' perspectives.	CMHT in Adelaide, South Australia 8 consumers (currently or previously) on CTOs, 10 MH professionals	In-depth interviews.	Experiences of CTOs are multi-layered. Moral framing was used by patients to understand and make sense of the CTO experience and by workers to justify forced care. Empathy and reflection on what is done and how is done is needed.
Stuen, HK., Rugkåsa, J., Landheim, A., Wynn, R. Increased influence and collaboration: A qualitative study of patients' experiences of community treatment orders within an assertive	2015	To report on patients experiences with informal and formal strategies used to promote continued treatment engagement, and to gain insight into how CTOs impact their daily lives.	Norway, 2 urban and 3 rural teams 15 patients seen by an ACT team & on a CTO for at least 6 months.	Qualitative interviews. Methods drew on grounded theory, inspired by constructivist and interpretative framework.	Patients reported mixed responses to CTOs, including a sense of security and feeling violated and controlled. Benefits of support provided by ACT approach were highlighted, including impact of worker and patient relationship on perception of coercion.

community treatment setting					
Light, E., Robertson, M., Boyce, P., Carney, T., Rosen, A., Cleary, M., Hunt, G., O'Connor, N., Ryan, CJ., Kerridge, I. The Many faces of risk: a qualitative study of risk in outpatient involuntary treatment.	2015	To derive a model of risk in involuntary outpatient treatment that is meaningful amongst different stakeholders (consumers, carers, MHPs and legal decision makers).	NSW, Australia. 5 patients (currently or previously on a CTO), 6 carers, 12 mental health review tribunal members, 15 clinicians. Clinicians from outpatient & inpatient across youth, adult, older persons and Aboriginal MH.	In depth semi-structured interviews. Analysis used grounded theory & inductive methods. Utilised a stakeholder reference group.	There were overlaps among all stakeholders on all discourses on risk in regard to actual harm; social adversity; the system. Clinicians however were influenced by actual harm and questions of risk quantification and carers/consumers with distress of mental illness and related disadvantages.
Light, E., Kerridge, I., Robertson, M., Boyce, P., Carney, T., Rosen, A., Cleary, M., Hunt, G., O'Connor, N., Ryan, C. Involuntary psychiatric treatment in	2015	GPs emerged as a factor in 16 IVs with participants. This paper examines stakeholder perspectives on the GPs role in the area of involuntary treatment.	NSW, Australia. 2009-2012 5 patients (currently or previously on a CTO), 6 carers, 12 mental health review tribunal members, 15 clinicians	In depth semi-structured interviews. Analysis used grounded theory & inductive methods. Utilised a stakeholder reference group.	GPs, as primary caregivers, have a significant role in CTOs and value in care provision for people with SMI, though were ‘outsiders’. The lack of integration of GPs in the care of people on CTOs is a shortcoming.

the community: general practitioners and the implementation of community treatment orders		The larger study examined clinical and legal DM and patient and carer lived experiences aiming to identify potential improvements to CTO processes	Of the above participant pool: 16 participants (4 clinicians, 2 patients, 6 carers and 4 MHRT member) spoke specifically about GPs		
Stensrud, B., Hoyer, G., Granerud, A., Landheim, AS. “Life on hold”: a qualitative study of patient experiences with outpatient commitment in two Norwegian counties	2015	To examine patients experiences of living with Outpatient Commitment (OC).	2 counties in Norway. 16 patient participants currently on a OC and with at least 6 months experience of OC.	Grounded theory. Interviews.	The main finding was that of ‘Life on Hold’ reflecting participants’ perceptions that OC prevented them from taking control of their own lives. This was based on perceived coercion; dependence on health care providers & constrained social interaction. The medical context was perceived as an obstacle to recovery. Some positive experiences identified e.g. feeling safe and secure and easy access to MH staff and services.

Stroud, J., Banks, L., Doughty, K. CTOs: learning from experiences of service users, practitioners and nearest relatives	2015	To identify significant issues and good practice in relation to CTOs.	UK, NHS. 72 participants including: service users; care coordinators; responsible clinicians; approved MHPs; service providers & nearest relatives.	Case study. Semi-structured interviews.	Key themes: 1. A CTO provides a legal recognition of need for care 2. CTO provides structure & containment for 'right' user 3. Care is defined as predominantly medical 4. There are misunderstanding regarding power and conditions of CTOs This paper details 1 & 2.
Sullivan, WP., Carpenter, J., Floyd, DF. Walking a tightrope: case management services and outpatient commitment	2014	To explore case management practice and case manager perceptions of serving involuntary clients on outpatient commitment orders. This study was part of a larger qualitative study focused on the role of hopefulness in helping.	USA, Mid-western community mental health service. 19 experienced case managers.	Interviews using an ethnographic method.	Themes included 'Recipient demand', 'OC as a positive tool', 'OC as a negative tool' and 'minimizing coercive practice'. The authors suggested advance psychiatric directives and SDM processes can reduce the need for coercive practice.

Mfoafa-M’Carthy, M. CTOs and the experiences of ethnic minority individuals diagnosed with SMI in the Canadian MHS	2014	Lived experience of individuals from ethnic minority backgrounds who have been subject to CTOs.	Canada, Toronto 24 consumers from an ethnic minority background, currently, or previously on a CTO.	Phenomenology. Semi-structured interviews.	Positive experiences (affirmation of experiences, improved rapport with case managers & clinical team; increased medication compliance; empowerment) and negative experiences (feeling of coercion and stigma) were reported.
Light, E., M. Robertson, MD., Boyce, P., Carney, T., Rosen, A., Cleary, M., Hunt, GE., O'Connor, N., Ryan, C., Kerridge, IH. The lived experience of involuntary community treatment: A qualitative study of mental health consumers and carers	2014	To describe the lived experience of people subject to CTOs and their carers.	NSW, Australia. 5 patients (currently or previously on a CTO), 6 carers, 12 mental health review tribunal members, 15 clinicians. Clinicians from outpatient & inpatient across youth, adult, older persons and Aboriginal MH.	In depth semi-structured interviews. Analysis used grounded theory & inductive methods. Utilised a stakeholder reference group.	Lived experience of CTOs is complex. Reported distress was in part experience of mental illness but also from communication gaps, difficulty getting optimal care and difficulty accessing MHS. It was acknowledged that whilst CTOs are coercive and constrain autonomy they may also be beneficial. This led to an ambivalence about CTOs.

Riley, H., Hoyer, G., Lorem, GF. 'When coercion moves into your home'--a qualitative study of patient experiences with outpatient commitment in Norway	2014	To explore patients experiences with Outpatient Commitment (OC) and how routines in care and health services affects patients' everyday living.	Norway, 11 participants on CTOs for at least 3 months.	In-depth interviews with a narrative approach to interviews and thematic analysis.	Participants generally complied with OC requirements because of a clear and secure framework, but also because of belief that the alternative would be involuntary hospitalisation. Coercion was experienced as a limitation of freedom of action through excessive control and little patient influence of participation in their own treatment.
Canvin, K., Rugkåsa, J., Sinclair, J., Burns, T. Patient, psychiatrist and family carer experiences of community treatment orders: Qualitative study	2014	To examine psychiatrists, patients and family carers experiences of CTOs.	UK. Part of the OCTET research programme. 75 participants including 26 patients, 25 psychiatrists and 24 family carers. Participants inclusive of forensic teams.	Grounded theory. In-depth interviews. Data analysed using constant comparative analysis.	All 3 groups perceived main purpose of CTOs as medication enforcement and that the legal clout was central to achieving this. Understanding of CTO mechanisms varied- uncertainty was expressed about criteria for recall and enforceability of discretionary conditions. There is no single experience or view of CTOs.

Ridley, J., Hunter, S. Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003	2013	To explore the experiences and views of individuals who had been treated under the MHCT Act.	Scotland, 49 service users, self-selected who had been under a Care & TO. Participants included those under inpatient as well as outpatient Care & TOs. 35% clearly community Care & TOs.	Cohort study. Semi-structured interviews. Interviews were conducted in 2 stages with 80% agreeing to 2nd interview (designed to be 12 months apart).	Legislation had a limited impact on participation in the process of compulsion or change in the dominant psychiatric paradigm. Though service users felt there was increased opportunity for their voices to be heard, this did not result in increased influence over professional decision-making, especially in relation to medication. Fundamental shifts in practice are needed both in terms of the nature of therapeutic relationships, and in embracing more holistic and recovery perspectives.
Gjesfjeld, C., Kennedy, M. Outpatient commitment on the ground: Listening to consumers and providers.	2011	To explore the perspectives of consumers and MH providers who are impacted by outpatient commitment.	USA. 9 consumers and 8 service providers (psychiatric nurses, case managers, psychosocial rehabilitation counsellors).	Semi-structured interviews.	Consumers voiced an ambiguous sense of personal control in the context of OPC orders, though reported improvement in their life after being on OPC; consumers and workers had inconsistent understandings of OPC.

Schwartz K, O'Brian AM, Morel V, Armstrong M, Fleming C, and Moore P. Community treatment orders: the service user speaks exploring the lived experience of community treatment orders	2010	To examine the lived experience of one group of service users on CTOs.	Canada. 6 service users with a SMI and on CTOs. Included consumers seen by 2 ACT teams.	Semi-structured interviews.	There was a lack of focus on conditions & provision of CTO. Issues for participants were less about the CTO and more about labels, control & discrimination associated with SMI.
Ridley, J., Hunter, S., Rosengard, A. Partners in care?: Views and experiences of carers from a cohort study of the early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003	2010	To explore carers views on the range of compulsory orders. Part of a larger study to evaluate implementation of the MHCT Act by exploring experiences and perceptions consumers, carers,	Scotland. 33 carers from three Health Board areas of Scotland as well as the State Hospital. Carers- predominantly women and parents, 3 were spouses.	Focus groups and individual interviews were conducted with carers at two stages approximately 12 months apart. 8 carers participated at both stages, and 25 carers participated once only.	Many carers felt isolated and unsupported and were critical of the lack of consultation and involvement. Few were aware of carers assessments and many sceptical if this would result in any changes.

		MH professionals and advocates.			
Gibbs, A. Coping with compulsion: Women's views of being on a CTO	2010	To present the experiences of 10 women either currently or previously on a CTO. To explore benefits & limitations of being on a CTO, support & relationships & d/c experiences.	NZ, Otago. 10 women	Interviews. Case note review conducted to provide further information about the women. General inductive approach taken for data analysis.	Women experienced benefits and limitations though considered the overall advantages of CTOs to outweigh the disadvantages. Advantages included greater access to treatment and hospital care and an increased sense of safety and reassurance for them & their families. Disadvantages included: some restrictions, such as where they resided; stigma; and having to comply with treatment with the threat of going to hospital if they did not. Overall, CTOs made a significant impact on their lives and allowed them to remain out of hospital, rebuild lives and maintain close relationships.
Dawson, J., Mullen, R. Insight and use of community treatment orders	2008	To explore the role played by judgements about patients' insight in reasoning concerning the use of CTOs in NZ.	NZ, Otago. 42 patients with experience or on CTOs, their clinicians (psychiatrists and key workers/case managers) and carers (when possible)	Interviews. Post-hoc analysis of limited data. General inductive approach taken for data analysis.	Lack of insight was an important indicator for compulsory treatment due to perceived link with treatment compliance. Common perception that patients could progressively gain insight during sustained treatment on a CTO. Good insight was not necessarily an indicator for d/c from a CTO if patient posed continuing risks of harm or had a rapid or severe relapse profile.

			22 patients were on a CTO at the time of IV 90 IVs were conducted with MH professionals (mostly experienced CPNs). 42 with Psychiatrists.		Potential for treatment compliance appeared to be the primary focus of involuntary treatment decisions.
Mullen, R., Gibbs, A., Dawson, J. Family perspective on community treatment orders: a New Zealand study	2006	To explore family members views of use of CTOs.	NZ, Otago. 27 family members. 25 were a spouse or 1st degree relative and 2 were a close friend who had a caring role.	Interviews. General inductive approach taken for data analysis.	Family were generally in favour of CTOs. They perceived positive influences on their relative, themselves, family relationships and relations with the clinical team. Families were aware of ethical and other dilemmas regarding CTO use.

Mullen, R. Dawson, J. Gibbs, A. Dilemmas for clinicians in use of Community Treatment Orders	2006	Clinicians views of the use of CTOs in specific cases in which they were recently or currently involved.	NZ, Otago. Clinicians refer to Psychiatrists (n= 42) who were the ‘responsible clinicians’.	Interviews. General inductive approach taken for data analysis.	Dilemmas were compared with previous literature. The clinicians in the study experienced well known dilemmas such as determining the right for a person’s d/c from CTO, but seemed less troubled by other difficulties than expected as they considered CTOs the best treatment option and best way to manage risks. Further dilemmas identified concerned proper scope of clinical authority over patients on CTOs and decision to revoke CTOs.
Gibbs, A. Dawson, J. Mullen, R. Community treatment orders for people with serious mental illness: A New Zealand study	2006	To examine the views of service users, family members and MHPs about the impact of the CTO regime.	NZ, Otago. 159 participants including service users, their family and treating MHPs.	Semi-structured interviews. General inductive approach taken for data analysis.	Most service users believed the main purpose of CTOs was to ensure medication was taken. They also believed CTOs provided better access to other treatments, supported accommodations and care from MHPs. Families reported CTOs provided relief and a supportive structure for relatives care. MHPs found the orders useful for engaging service users in a continuing therapeutic relationship and for promoting treatment adherence. In each group, the majority viewed CTOs as generally positive, whilst acknowledging

					restrictions it imposed on the persons freedom.
O'Reilly, RL., Keegan, DL., Corring, D., Shrikhande, S., Natarajan, D. A qualitative analysis of the use of community treatment orders in Saskatchewan	2006	To compare views on mandatory outpatient treatment of patients and other stakeholders in Canada with the view of stakeholders from other jurisdictions.	Canada, Saskatchewan. 2 mental health centres. 78 individuals: 14 consumers (12 on CTOs at time of interview), relatives (mostly parents) and MHPs (predominantly nurses).	In-depth interviews and focus groups.	Patients had contradictory feelings about CTOs. Most experienced some degree of coercion while on the orders but many believed that CTOs provided necessary structure to their lives. Clinicians were more consistently positive but recognised the difficult choices in balancing right to self-determination with benefits of CTOs. Family members viewed CTOs as necessary to control a chaotic situation caused by the persons limited insight.

Gibbs, A., Dawson, J., Ansley, C., Müllen, R. How patients in New Zealand view community treatment orders	2005	To explore the views of patients with recent experience of CTOs.	NZ, Otago. 42 patients on CTOs, 22 on CTO at time of interview.	Semi-structured interviews. General inductive approach taken for data analysis.	Majority of patients were generally supportive of the CTO, especially if the alternative was hospital. Many valued access to services and sense of security obtained, and attributed improvements in their health to treatment under the order. Experienced reduced choice about medication and restrictions on residence and travel. For a minority this meant they were strongly opposed to CTO, but for most the restrictions did not unduly hinder them. Majority viewed CTO as helpful step towards community stability.
Gibbs, A., Dawson, J., Forsyth, H., Mullen, R., Tonu Tanga, TO. Maori experience of community treatment orders in Otago, New Zealand	2004	To consider the impact of CTOs on Maori patients and their whanau (extended family) and the associated views of MHPs.	NZ, Otago. IVs with 8 Maori patients under compulsory care, their family members and MHPs. Paper inclusive of 39 IVs.	Semi-structured interviews. General inductive approach taken for data analysis.	Both benefits and drawbacks were identified by patients and family. CTOs were considered helpful in increasing patient safety and whanau security and in promoting access to services. Favoured over hospilitisation, forensic care and homelessness. Drawbacks included sense of external control imposed on both patients and staff, particularly regarding medication and restrictions on choices.

Mixed methods studies					
Author and Date	**Year**	**Aim/Objective**	**Context/Setting**	**Methods and Methodology**	**Findings related to the review**
Brophy, L., McDermott, F. Using SW theory and values to investigate the implementation of Community Treatment Orders	2013	To develop an understanding of good practice from different stakeholder perspectives that inform MH practice with people on CTOs.	Australia, Victoria. 4 consumers, 2 carers, 4 case managers, 4 doctors, MHRB members, senior managers, executive & policy advisors	Different data collection against values of de-individualisation; diversity; equality; empowerment; partnership; social justice & citizenship enabling. Cluster analysis of 164 people on CTOs; 4 in-depth case studies; semi-structured group interviews.	Importance of carers/family; need for establishment of strong therapeutic relationship; diversity & difference among CTO recipients & purposes or goals of CTO. 5 principles of good practice identified: 1. Use & develop direct practice skills 2. Take a human rights perspective 3. Focus on goals & desired outcomes 4. Aim for quality of service delivery 5. Enhance & enable the role of key stakeholders

Taylor, JA., Lawton-Smith, S., Bullmore, H. Supervised community treatment: Does it facilitate social inclusion? A perspective from approved mental health professionals (AMHPs)	2013	To set out the views of AMHPs on the impact of supervised community treatment on their work and their patients' lives in the community.	UK, 2010 13 AMHPs.	CTO activity, consumer characteristics and conditions of CTO were reviewed. Questionnaires to 8 AMHPs Focus group- 5 AMHPs	AMHPs were undecided about benefits of CTOs to their patients. Majority agreed CTOs could benefit patients by earlier identification of relapse, improving access to housing and reducing the risk of harm to self and others. Majority also agreed CTOs had not improved access to employment, education, training or recreational activities, nor helped the stigma and discrimination faced.
Brophy, L., Ring, D. The efficacy of involuntary treatment in the community: consumer and service provider perspectives	2004	To offer a voice to consumers and service providers about their experiences and views of current practice and policy implementation re CTOs.	Australia, Rural Victoria and Melbourne. 30 consumers and 18 health professionals from a range of professional backgrounds and services participated in interviews/focus groups.	Mostly qualitative approach- focus groups and interviews. Quantitative data included demographic characteristics of participants and survey responses from health professionals.	Findings suggest that CTOs involve complex decision-making that tests professionals' ability to make judgements about legal and clinical processes. Consumers were generally dissatisfied with many aspects of the use of CTOs and both groups tended to view CTOs as stigmatising and disempowering. There were a variety of views expressed about the process of admission, discharge, and community supports.

Owens, N., Brophy, L. Revocation of Community Treatment Orders in a mental health service network	2013	An investigation of CTO revocations in a Victorian area MHS.	Australia, Victoria 2008-2010. Participants included consumer advisory group, local carers and mental health staff.	Data extraction from clinical database; file audit and semi-structured interviews with key-stakeholders. Two different time periods were compared.	CTOs are commonly revoked within 3 months of d/c from inpatient units. Multiple service providers and family/carers have varying involvement that appears to depend on the timing of the referral to the crisis assessment & treatment team. In the qualitative data there was minimal divergence amongst stakeholder groups. Issues related to care-planning, family involvement and support type were discussed.

Opinion papers

Author and Date	Year	Aim/Objective	Context/Setting	Methods and Methodology	Findings related to the review
Mfoafo-M'Carthy, M., Shera, W. Beyond community treatment orders: Empowering clients to achieve community integration	2012	To review effectiveness of CTOs internationally and specifically in Toronto, Canada.	Canada, Review of literature re history of CTO implementation - brief summaries specific to countries including Australia.	Opinion paper	Advance directives, intensive case management and recovery-orientated service reform are viable empowering alternatives to CTOs.

O'Reilly, R., Dawson, J., Burns, T. Best practices in the use of involuntary outpatient treatment	2012	To describe clinicians' views of IOT and reported practices in England, Canada, Australia, and New Zealand.	Draws on research to explore best practice from Commonwealth clinician perspective.	Brief opinion paper	Overall clinicians prefer to mandate only Rx that is known to work and can be delivered with min coercion. Best practice discussed e.g. recall powers, family involvement, service context should be linked, MOUs, resources to provide required services. D/C indicators discussed & reasons for CTOs.
Magnus Mfoafo-M'Carthy, M., Williams. CC. Coercion and community treatment orders (CTOs): One step forward, two steps back?	2010	To contribute to a discussion of coercion and its role in Community MH care, and how it may co-exist with recovery in the implementation of CTOs.	Toronto, international literature discussed in this context.	Opinion paper.	Authors argue that CTOs may not have a place in a recovery-oriented MH care system, though they seem to be a fixed element in current policy. Suggest ways in which they are executed can change to be more recovery-orientated in practice. This includes: consulting with clients about use of the CTO and use to inform recovery plans and advance directives; broaden CTOs to include contractual agreements between clients and workers to include activities to achieve client-determined goals and equal commitment from MHS.

Brophy, L., Campbell, J., Healy, B. Dilemmas in the case manager's role: Implementing involuntary treatment in the community	2003	To explore the current role of case managers in mental health review board processes, with a particular emphasis on the system in Victoria.	Australia, Victoria.	Opinion paper, augmented with views from case managers from different MHS and different professional backgrounds, carers, policy makers and legal advocates. Views also sought of attendees at a conference on this theme.	Mental health workers often experience tensions between legal and organisational expectations of their role, their professional orientation and wider understandings of social justice and consumer rights. Case managers in Victoria currently have a limited role within the mental health review board process. Greater involvement of the case manager may enhance the decision-making process of the reviews.
Dawson, J., Romans, S., Gibbs, A., Ratter, N. Ambivalence about community treatment orders	2003	Why, despite the gathering momentum of use, does there remain such widespread ambivalence about their use? What are the reasons for this ambivalence?	NZ.	Opinion paper	Summary and critique of literature/empirical evidence. Lack of efficacy and ethical concerns contribute to ambivalence about CTOs. Additional phenomena impacting upon ambivalence include: • Paradoxes of design • Dilemma of discharge • Volunteers for compulsion

Appendix C: Updated literature search

August 26 2020

Database	Result	Date
Medline	644	26/8/2020
PsycINFO	674	26/8/2020
CINAHL	501	26/8/2020
Scopus	835	26/8/2020
Proquest	843	26/8/2020
PubMed	67	26/8/2020
Total	3564	
After De-Duplication	2702	

Appendix D. Included studies in updated literature review

1. Brophy, L., Kokanovic, R., Flore, J., McSherry, B., & Herrman, H. (2019). Community treatment orders and supported decision-making. *Frontiers in Psychiatry 10*, 414. doi:10.3389/fpsyt.2019.00414

2. Corring, D., O'Reilly, R., & Sommerdyk, C. (2017). A systematic review of the views and experiences of subjects of community treatment orders. *International Journal of Law and Psychiatry, 52*, 74-80. doi:10.1016/j.ijlp.2017.03.002

3. Corring, D., O'Reilly, R., Sommerdyk, C., & Russell, E. (2018). What families have to say about community treatment orders (CTOs). *Canadian Journal of Community Mental Health, 37*(2), 1-12. doi:10.7870/cjcmh-2018-008

4. Corring, D., O'Reilly, R. L., Sommerdyk, C., & Russell, E. (2018). What clinicians say about the experience of working with individuals on community treatment orders. *Psychiatric Services, 69*(7), 791-796. doi:10.1176/appi.ps.201700492

5. Corring, D., O'Reilly, R., Sommerdyk, C., & Russell, E. (2019). The lived experience of community treatment orders (CTOs) from three perspectives: a constant comparative analysis of the results of three systematic reviews of published qualitative research. International Journal of Law and Psychiatry, 66, 101453. doi:10.1016/j.ijlp.2019.101453

6. de Waardt, D. A., van der Heijden, F., Rugkåsa, J., & Mulder, C. L. (2020). Compulsory treatment in patients' homes in the Netherlands: what do mental health professionals think of this? BMC Psychiatry, 20(1), 80. doi:10.1186/s12888-020-02501-7

7. Francombe Pridham, K., Nakhost, A., Tugg, L., Etherington, N., Stergiopoulos, V., & Law, S. (2018). Exploring experiences with compulsory psychiatric community treatment: A qualitative multi-perspective pilot study in an urban Canadian context. *International journal of law and psychiatry*, *57*, 122–130. doi.org/10.1016/j.ijlp.2018.02.007

8. Haynes, P., & Stroud, J. (2019). Community treatment orders and social factors: complex journeys in the mental health system. *Journal of Social Welfare and Family Law, 41*(4), 463-478. doi:10.1080/09649069.2019.1663017

9. Klassen, A. L. (2017). Spinning the revolving door: the governance of non-compliant psychiatric subjects on community treatment orders. *Theoretical Criminology, 21*(3), 361-379. doi:10.1177/1362480616646623

10. Lawn, S., Delany, T., Pulvirenti, M., Smith, A., & McMillan, J. (2016). Examining the use of metaphors to understand the experience of community treatment orders for patients and mental health workers. *BMC Psychiatry, 16*. doi:10.1186/s12888-016-0791-z

11. Light, E., Robertson, M., Kerridge, I., Boyce, P., Carney, T., Rosen, A., . . . O'Conner, N. (2016). Reconceptualizing involuntary outpatient psychiatric treatment: from "capacity" to "capability". *Philosophy, Psychiatry, and Psychology, 23*(1), 33-45. doi:10.1353/ppp.2016.0005

12. Light, E., Robertson, M., Boyce, P., Carney, T., Rosen, A., Cleary, M., . . . Kerridge, I. (2017). How shortcomings in the mental health system affect the use of involuntary community treatment orders. *Australian Health Review, 41*(3), 351-356. doi:10.1071/ah16074

13. McMillan, J., Lawn, S., & Delany-Crowe, T. (2019). Trust and community treatment orders. *Frontiers in Psychiatry, 10*, 349. doi:10.3389/fpsyt.2019.00349

14. Mfoafo-M’Carthy, M., Grosset, C., Stalker, C., Dullaart, I., & McColl, L. (2018). Exploratory study of the use of community treatment orders with clients of an Ontario ACT team. *Social Work in Mental Health, 16*(6), 644-661. doi:10.1080/15332985.2018.1476283

15. Moleón, R. A., & Fuertes, R. J. C. (2020). Psychiatrists' opinion about involuntary outpatient treatment. *Revista espanola de sanidad penitenciaria, 22*(1), 39-45. doi:10.18176/resp.0006

16. Nakhost, A., Sirotich, F., Pridham, K. M. F., Stergiopoulos, V., & Simpson, A. I. F. (2018). Coercion in outpatients under community treatment orders: a matched comparison study. *Canadian Journal of Psychiatry 63*(11), 757-765. doi:10.1177/0706743718766053

17. Riley, H., Lorem, G. F., & Høyer, G. (2018). Community treatment orders - what are the views of decision makers? *Journal of Mental Health, 27*(2), 97-102. doi:10.1080/09638237.2016.1207230

18. Rugkåsa, J., & Canvin, K. (2017). Carer involvement in compulsory out-patient psychiatric care in England. *BMC Health Services Research, 17*(762). doi:10.1186/s12913-017-2716-z

19. Stensrud, B., Hoyer, G., Beston, G., Granerud, A., & Landheim, A. S. (2016). "Care or control?": a qualitative study of staff experiences with outpatient commitment orders. *Social Psychiatry and Psychiatric Epidemiology, 51*(5), 747-755. doi:10.1007/s00127-016-1193-8

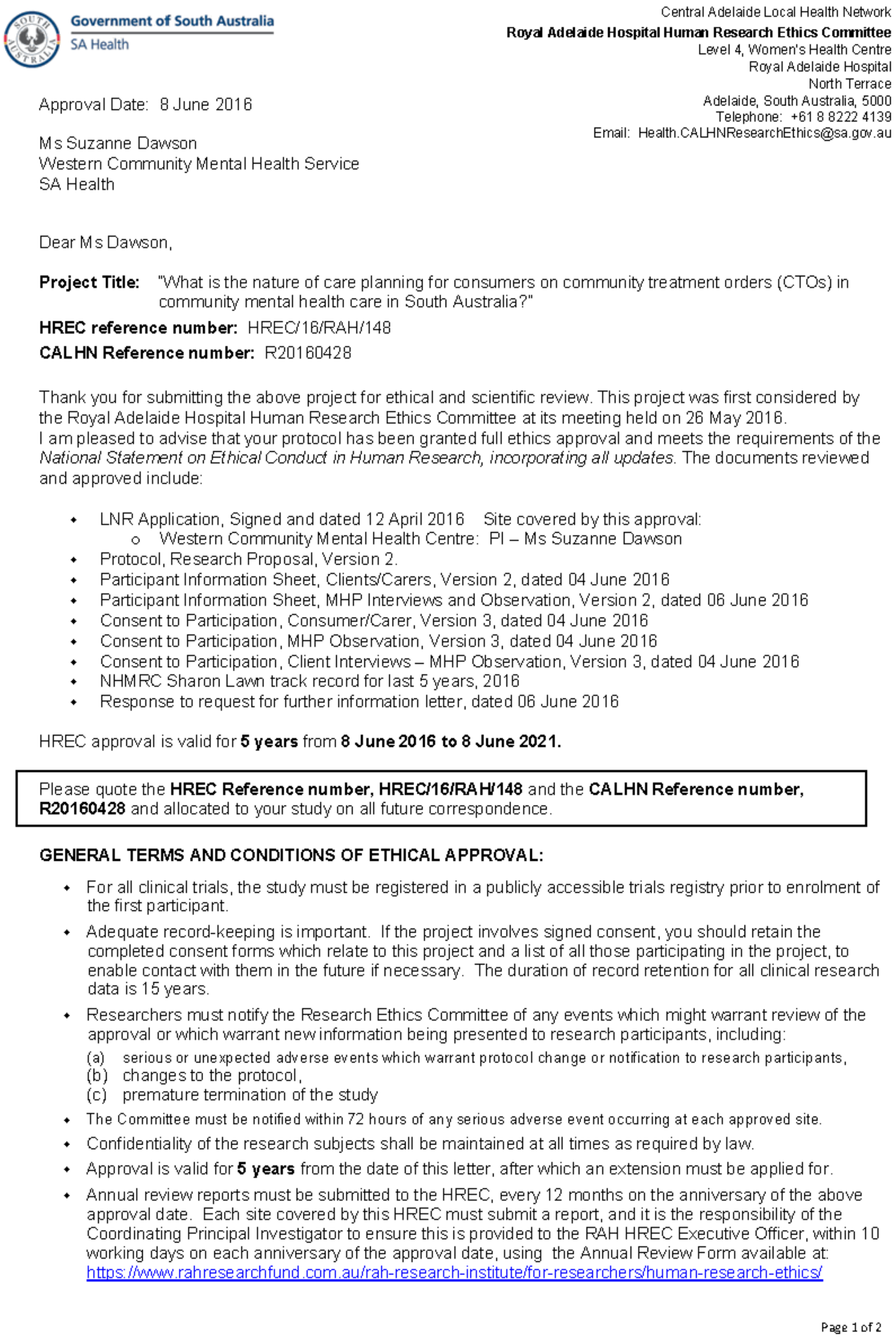
20. Stensrud, B., Høyer, G., Granerud, A., & Landheim, A. S. (2015). "Responsible, but still not a real treatment partner": a qualitative study of the experiences of relatives of patients on outpatient commitment orders. *Issues in Mental Health Nursing, 36*(8), 583-591. doi:10.3109/01612840.2015.1021939

21. Stuen, H. K., Landheim, A., Rugkåsa, J., & Wynn, R. (2018). How clinicians make decisions about CTOs in ACT: a qualitative study. *International Journal of Mental Health Systems 12*, 51. doi:10.1186/s13033-018-0230-2

22. Stuen, H. K., Landheim, A., Rugkåsa, J., & Wynn, R. (2018). Responsibilities with conflicting priorities: a qualitative study of ACT providers' experiences with community treatment orders. *BMC Health Services Research, 18*(1), 290. doi:10.1186/s12913-018-3097-7

23. Vine, R., Turner, S., Pirkis, J., Judd, F., & Spittal, M. J. (2016). Mental health service utilisation after a community treatment order: a comparison between three modes of termination. *Australian and New Zealand Journal of Psychiatry, 50*(4), 363-370. doi:10.1177/0004867415599847

Appendix E: Ethics approval for the study



Government of South Australia
SA Health

Central Adelaide Local Health Network
Royal Adelaide Hospital Human Research Ethics Committee
Level 4, Women's Health Centre
Royal Adelaide Hospital
North Terrace
Adelaide, South Australia, 5000
Telephone: +61 8 8222 4139
Email: Health.CALHNResearchEthics@sa.gov.au

Approval Date: 8 June 2016

Ms Suzanne Dawson
Western Community Mental Health Service
SA Health

Dear Ms Dawson,

Project Title: "What is the nature of care planning for consumers on community treatment orders (CTOs) in community mental health care in South Australia?"

HREC reference number: HREC/16/RAH/148

CALHN Reference number: R20160428

Thank you for submitting the above project for ethical and scientific review. This project was first considered by the Royal Adelaide Hospital Human Research Ethics Committee at its meeting held on 26 May 2016.
I am pleased to advise that your protocol has been granted full ethics approval and meets the requirements of the *National Statement on Ethical Conduct in Human Research, incorporating all updates*. The documents reviewed and approved include:

- LNR Application, Signed and dated 12 April 2016 Site covered by this approval:
    - Western Community Mental Health Centre: PI – Ms Suzanne Dawson
- Protocol, Research Proposal, Version 2.
- Participant Information Sheet, Clients/Carers, Version 2, dated 04 June 2016
- Participant Information Sheet, MHP Interviews and Observation, Version 2, dated 06 June 2016
- Consent to Participation, Consumer/Carer, Version 3, dated 04 June 2016
- Consent to Participation, MHP Observation, Version 3, dated 04 June 2016
- Consent to Participation, Client Interviews – MHP Observation, Version 3, dated 04 June 2016
- NHMRC Sharon Lawn track record for last 5 years, 2016
- Response to request for further information letter, dated 06 June 2016

HREC approval is valid for **5 years** from **8 June 2016 to 8 June 2021.**

Please quote the **HREC Reference number, HREC/16/RAH/148** and the **CALHN Reference number, R20160428** and allocated to your study on all future correspondence.

GENERAL TERMS AND CONDITIONS OF ETHICAL APPROVAL:

- For all clinical trials, the study must be registered in a publicly accessible trials registry prior to enrolment of the first participant.
- Adequate record-keeping is important. If the project involves signed consent, you should retain the completed consent forms which relate to this project and a list of all those participating in the project, to enable contact with them in the future if necessary. The duration of record retention for all clinical research data is 15 years.
- Researchers must notify the Research Ethics Committee of any events which might warrant review of the approval or which warrant new information being presented to research participants, including:
  (a) serious or unexpected adverse events which warrant protocol change or notification to research participants,
  (b) changes to the protocol,
  (c) premature termination of the study
- The Committee must be notified within 72 hours of any serious adverse event occurring at each approved site.
- Confidentiality of the research subjects shall be maintained at all times as required by law.
- Approval is valid for **5 years** from the date of this letter, after which an extension must be applied for.
- Annual review reports must be submitted to the HREC, every 12 months on the anniversary of the above approval date. Each site covered by this HREC must submit a report, and it is the responsibility of the Coordinating Principal Investigator to ensure this is provided to the RAH HREC Executive Officer, within 10 working days on each anniversary of the approval date, using the Annual Review Form available at: https://www.rahresearchfund.com.au/rah-research-institute/for-researchers/human-research-ethics/

- The REC must be advised with a final report or in writing, and a copy of any published material, within 30 days of completion.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at any site until separate authorisation from the Chief Executive or delegate of that site has been obtained. For any queries, please contact the CALHN Governance Office: Health.CALHNResearchGovernanceIP&Contracts@sa.gov.au

This Committee is constituted in accordance with the NHMRC's *National Statement on the Ethical Conduct of Human Research (2007)* incorporating all updates.

Should you have any queries about the HREC's consideration of your project, please contact Mrs Heather O'Dea, Executive Officer on 08 8222 4139, or Health.CALHNResearchEthics@sa.gov.au.

The HREC wishes you every success in your research.

Yours sincerely,

Digitally signed on behalf of the
Research Ethics Committee
Royal Adelaide Hospital
Time: 2016.07.05 17:48:10 CST

A/Prof A Thornton
CHAIRMAN
RAH HUMAN RESEARCH ETHICS COMMITTEE

Central Adelaide Local Health Network

LNR Ethics and Governance Application Form

Government of South Australia
SA Health

Please note: responses must be typed into this form – **do not** write responses by hand
Submit via email to: CALHNResearchLNR@sa.gov.au

Project full title	What is the nature of care planning for consumers on community treatment orders (CTOs) in community mental health care in South Australia?	
Term of the study	Start date: 1/08/2016	End date: 1/08/2017
Principal investigator	Name: Suzanne Dawson Department: School of Nursing & Midwifery, Flinders University Employer: CALHN, SA Health Work email: Suzanne.dawson@flinders.edu.au Telephone: 0435 716 477	
Reviewing Human Research Ethics Committee (HREC)	☒RAH Research Ethics Committee ☐Southern Adelaide Clinical HREC ☐Women's and Children's Health Network HREC	☐TQEH/MH/LMH HREC ☐Aboriginal Health HREC ☐SA Health HREC ☐Other:
Other Committee approvals	☐Animal Ethics Committee ☐Institutional Biosafety Committee	☐Radiation Safety Report ☐Other:
Type of application	☒Low Risk ☐Negligible Risk	☐Access Request ☐Other:
SA Health sites involved in study e.g. CALHN – BHI, RAH, TQEH, SA Pathology, Hampstead	Western Community Mental Health Centre, CALHN Port Adelaide Team West Adelaide Team	
Non SA Health Organisations involved in the study e.g. SAHMRI, University, Sponsor	South Australian Civil and Administrative Tribunal, SACAT	
Conflicts of interest	☒ Yes ☐ No If yes, please provide details in the protocol	
Existing data (further details to be provided in the protocol)	Will access to patient data be required in the study? ☐ Yes ☒ No Has participant consent been obtained? ☐ Yes ☒ No If access is required outside of your normal duties attach approval from person / department responsible for authorising access	
New Data collection (further details to be provided in the protocol)	Will there be collection of data? ☒ Yes ☐ No Will participant consent be obtained? ☒ Yes ☐ No Will a databank be established? ☒ Yes ☐ No	
Existing tissue/samples (further details to be provided in the protocol)	Will access to tissue / samples be required in the study? ☐ Yes ☒ No Are the tissue/samples held within your department? ☐ Yes ☒ No Has participant consent been obtained? ☐ Yes ☒ No	

	If access is required outside of your department attach approval from person /department responsible for access to tissue/sample e.g. manager of tissue bank
New sample collection (further details to be provided in the protocol)	Will there be collection of samples? ☐ Yes ☒ No Will a tissue bank be established? ☐ Yes ☒ No Will participant consent be obtained? ☐ Yes ☒ No
Peer review (e.g. grant application)	☒ Yes ☐ No The PhD supervisory panel has provided critical review of this research which has been approved. A letter is attached.
Funding	☐**In-kind.** Provide details; personnel and hours of support for CALHN staff. Attach approval from appropriate Business Manager. **This study is undertaken by a PhD candidate from Flinders University with no associated funding.**
	☐**Internal department funding** If yes, CALHN ☐ / University ☐ / SAHMRI ☐ / Other ☐ Provide details of funding and cost centre for CALHN only
	☐ **External Funding** ☐Grant ☐Company sponsored ☐Research Services Provide details of funding to be provided to or from CALHN
Budget	If funds are to be paid to or from CALHN, attach approved budget
Agreement	If funds are to be paid to or from CALHN an agreement must be in place. Will there be an agreement associated with this study? ☐ Yes ☐ No If yes please attach
Non SA Health investigators	Where the project is being conducted within CALHN or accessing CALHN participants, their tissue or data: Are all members of the project team employees of SA Health? ☒ Yes ☐ No If No, confirmation of Admin/HR/Laboratory Manager that non-SA Health investigators have approval to be on CALHN site(s) is required If not previously submitted to this Research Office please attach
	If the project involves team members who are not SA Health employees, confirmation of insurance and indemnity cover for the study by the non SA Health organisation is required
CV	A copy of a CV for all researchers / students involved in the study must be registered with the Research Office. If not previously submitted this to the Research Office please attach See attached CVs for Suzanne Dawson and Professors Eimear Muir-Cochrane and Sharon Lawn.

Study Protocol	Attach the Study Protocol and all additional documents (Patient Information and Consent Forms, questionnaires, recruitment flyers etc).
Additional information to assist with the review:	

costs of conducting research at the site.

My signature indicates that I support this project being carried out using the required resources, based on the information provided by the principal investigator.

Name of department	CALHN Mental Health		
Name of head of department	Dr Kathryn Zeitz		
Signature		Date	12/04/2016

OFFICE USE ONLY

Declaration by Research Office

Project title:

Our Reference
HREC: HREC/16/RAH/148
SSA: SSA/17/RAH/58
EGA:
MyIP: 6855

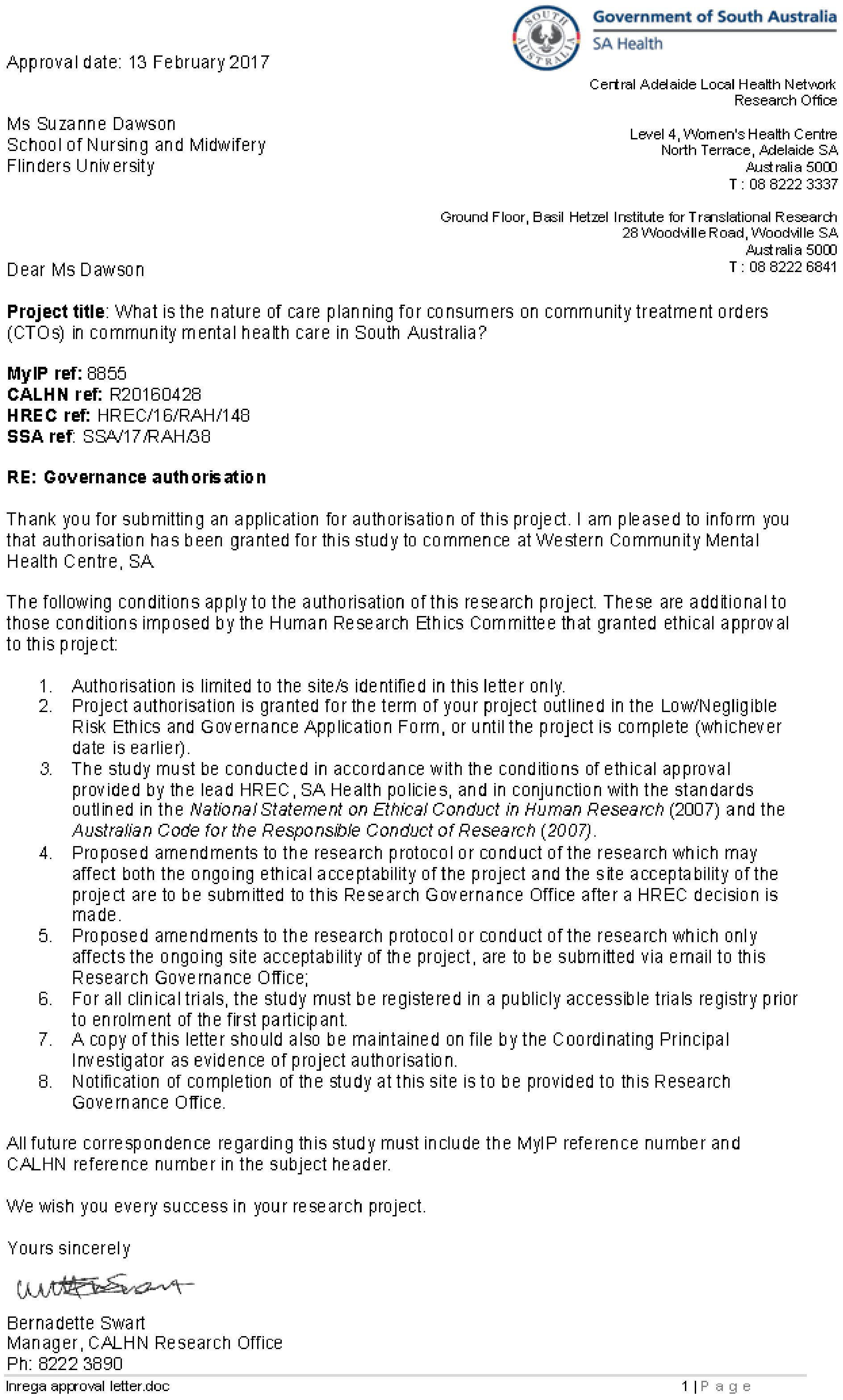
This application has been reviewed and is:
☑Supported
☐Not Supported

Name	Bernadette Swart		
Position	Manager, Research Office Central Adelaide Local Health Network		
Signature		Date	13|2|17
Comments			

Final Authorisation

Noting the endorsement provided above, I hereby recommend this project is:
☑Authorised
☐Not Authorised

Name	Dr Sally Tideman		
Position	Acting Director of Medical Services		
Signature		Date	13.2.17
Comments			



Government of South Australia
SA Health

Central Adelaide Local Health Network
Research Office

Level 4, Women's Health Centre
North Terrace, Adelaide SA
Australia 5000
T : 08 8222 3337

Ground Floor, Basil Hetzel Institute for Translational Research
28 Woodville Road, Woodville SA
Australia 5000
T : 08 8222 6841

Approval date: 13 February 2017

Ms Suzanne Dawson
School of Nursing and Midwifery
Flinders University

Dear Ms Dawson

Project title: What is the nature of care planning for consumers on community treatment orders (CTOs) in community mental health care in South Australia?

MyIP ref: 8855
CALHN ref: R20160428
HREC ref: HREC/16/RAH/148
SSA ref: SSA/17/RAH/38

RE: Governance authorisation

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to commence at Western Community Mental Health Centre, SA.

The following conditions apply to the authorisation of this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval to this project:

1. Authorisation is limited to the site/s identified in this letter only.
2. Project authorisation is granted for the term of your project outlined in the Low/Negligible Risk Ethics and Governance Application Form, or until the project is complete (whichever date is earlier).
3. The study must be conducted in accordance with the conditions of ethical approval provided by the lead HREC, SA Health policies, and in conjunction with the standards outlined in the *National Statement on Ethical Conduct in Human Research* (2007) and the *Australian Code for the Responsible Conduct of Research (2007)*.
4. Proposed amendments to the research protocol or conduct of the research which may affect both the ongoing ethical acceptability of the project and the site acceptability of the project are to be submitted to this Research Governance Office after a HREC decision is made.
5. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted via email to this Research Governance Office;
6. For all clinical trials, the study must be registered in a publicly accessible trials registry prior to enrolment of the first participant.
7. A copy of this letter should also be maintained on file by the Coordinating Principal Investigator as evidence of project authorisation.
8. Notification of completion of the study at this site is to be provided to this Research Governance Office.

All future correspondence regarding this study must include the MyIP reference number and CALHN reference number in the subject header.

We wish you every success in your research project.

Yours sincerely

Bernadette Swart
Manager, CALHN Research Office
Ph: 8222 3890

Appendix F: Participant information sheets

Flinders
UNIVERSITY

School of Nursing & Midwifery
Flinders University
GPO Box 2100
Adelaide SA 5001
Tel: 08 8201 3337
Fax: 08 8276 1602
suzanne.dawson@flinders.edu.au

Participant Information Sheet
Clients/Carers

Title of the project
What is the nature of care planning for consumers on community treatment orders (CTOs) in community mental health care in South Australia?

Researcher
Hello, my name is Suzanne Dawson. I am an Occupational Therapist at the Western Community Mental Health Centre and am undertaking this research as a PhD Candidate at Flinders University.

Invitation to participate
I am inviting people who are currently on a community treatment order (CTO) and have a care plan to participate in this research. This is to allow me to find out more about people's experiences of care planning when on a CTO. This information sheet has been given to you by your mental health worker and your name has not been given to me.

It is up to you to decide to join the study. You do not have to be involved and you are free to withdraw at any time, without giving a reason. This will not affect the care you receive, nor will it impact in any way on other aspects of your care such as the review of your CTO.

I would also like to interview a family member/or carer whom you consider important to your care, to find out more about their experiences of care planning. I will only contact family with your permission, and will not meet with family members if this is your preference.

Aims of the project
The aim of this study is to explore your experience of care planning, including what facilitates and hinders good experiences and how the care planning process could be improved. I hope that understanding this will assist mental health workers and services to provide treatment and care that better assists people with mental illness that are on a CTO.

Summary of procedures
If you decide to participate, I would like to interview you for about 30-60 minutes at most to ask about your experiences of receiving treatment and support from western mental health services while on a Community Treatment Order. The interview will be held at a location convenient to you. This could be your home, a private room at the western community mental health services, or another public location if you prefer. If you would like someone to accompany you during the interview, this is fine too.

I hope to audio record the interview so that I can type it up after the interview as a record of our conversation. However, if you do not want this to occur, I will only take notes by hand to record what you have told me during the interview.

I would also like to observe any care planning meetings you may have with your treating doctor and case manager over a 3-6 month period. This would likely be 3-4 meetings.

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Benefits, Risks and Adverse Effects
I hope that you will find this project interesting and personally rewarding by talking and thinking about your experiences of being on a Community Treatment Order, and to feel heard.

I do not think there are any risks involved in this study. Some people may become upset when recounting experiences related to their contact with services.You are reminded that your participation is entirely optional and you are free to stop the interview at any time.

If needed, you will be offered support to contact your case manager if you wish to, or other support person of your choosing. This may be a family member, carer or friend. You will also be provided with details of the 24 hour crisis mental health contact, should you feel you need to talk to someone about how you are feeling.

Compensation
Participants in this study are insured under the Flinders University Indemnity Scheme. If you suffer injury as a result of participation in this research or study, compensation might be paid without litigation. However, such compensation is not automatic.

Confidentiality and Data Security
This project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research.
All personal information will remain confidential and no information which could lead to your identification will be released.
Also, anything you tell me will be treated in confidence unless I am concerned about your safety or the safety of someone else, or if I become aware of professional malpractice, in which case I would have to discuss my concerns with you and your medical team.

All recorded interviews will transcribed verbatim. Any audio recording will be destroyed after it has been transcribed and your name will be replaced with a pseudonym, meaning that the data is de-identified. All recordings and transcriptions will be stored on a password protected computer file on the personal drive of the researcher at Flinders University and only the researcher and researcher's supervisors will have access to this data. Any notes taken during interviews or observation will be recorded in a paper journal and stored in a locked cabinet at the researcher's home or University.
At the completion of the project, all hardcopy data will be placed in the research unit's secure storage. Electronic transcripts will be destroyed upon completion of the project. All data will be stored for 15 years after conclusion of the project, as required by SA Health. After 15 years, all electronic and hardcopy data will be destroyed using Flinders University secure waste service.

In addition to the processes described above, data may otherwise be discoverable through processes of law or for assessing compliance with research procedures.
You have a right to access the information collected and stored by researchers about you. You also have a right to request that any information with which you disagree be corrected.
You have a right to ask that any stored specimens be destroyed but should be aware that data which has already been derived from those specimens may not be able to be destroyed.

Publication
A summary of the project's results will be provided to you as a summary report at your request.

The results may be published in conference papers or journals. However, no information that could personally identify you will appear in any of these papers.

Withdrawal
Your participation in this project is entirely voluntary and you have the right to withdraw from the project at any time without giving a reason. If you decide not to participate in this project, or if you withdraw from the project, you may do so freely, without affecting your relationship with the service where you receive support. If you decide to withdraw, I would like to use information already collected unless you ask for it to be withdrawn from the project.

Expenses and payments:
You will receive a $30 voucher as compensation for reasonable travel and parking costs and time spent participating in the interview.

Complaints
This study has been reviewed by the RAH Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact the Executive Officer, RAH Research Ethics Committee on 8222 4139 or email Health.CALHNResearchEthics@sa.gov.au.

What do I do now?
If you have any questions or concerns please contact the primary researcher, Suzanne Dawson. Contact details are below. If you are undecided, you may wish to discuss whether to take part in the study with your case manager, a family member or friend.

If you have fully understood the information and would like to take part in the study, please contact me as below by telephone or email. I will then arrange to obtain signed consent from you and undertake the interview with you at an agreed time.

If you do not wish to take part in the study, you do not need to do anything else.

Thank you very much for your time and interest.

Suzanne Dawson (Occupational Therapist/PhD Candidate)

Contact
If you would like further information about this project at any time, you may contact Suzanne Dawson on Ph. 7425 3800 or on email suzanne.dawson@flinders.edu.au .

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Participant Information Sheet
Mental Health Professional Interviews and Observation

Title of the project
What is the nature of care planning for consumers on community treatment orders (CTOs) in community mental health care in South Australia?

Researcher
Hello, my name is Suzanne Dawson. I am an Occupational Therapist at Western Community Mental Health Centre and am undertaking this research as a PhD Candidate at Flinders University.

Invitation to participate
You are invited to participate in this research on CTOs and care planning.
You do not have to be involved. Whether you wish to or not, this is entirely up to you. Your decision will not affect your standing with mental health services or your employment in any way.

Aims of the project
The aim of this study is to explore the experience of care planning, including what facilitates and hinders good experiences and how the care planning process could be improved. I hope that understanding this will assist mental health workers and services to provide treatment and care that better assists people with mental illness that are on a CTO.

Summary of procedures
If you decide to participate, I would like to interview you for about 60 minutes at most to ask about your experiences of delivering treatment and care to people on CTOs as part of your role with mental health services. The interview will be held at a location convenient to you. This could be a private room at the WCMHC, or another public location if you prefer.

I hope to audio record the interview so that I can type it up after the interview as a record of our conversation. However, if you do not want this to occur, I will only take notes by hand to record what you have told me during the interview.

I would also like to observe care planning meetings (with consumers and/or carers who have volunteered to participate) and clinical review meetings over a 3-6 month period.

Benefits, Risks and Adverse Effects
I hope that you will find this project interesting and personally and professionally rewarding, as part of talking and reflecting on your experiences of delivering care to people on a CTO.

Some participants may become upset when recounting experiences related to their contact with service users. At the end of the interview, each participant will be offered support to contact their service manager if they wish to, or other support person of their choosing.

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They will also be reminded of the Employee Assistance Program that offers support to SA Health employees (list of providers available at http://www.eapaa.org.au/index.php/providers/providers_sa/).

Compensation

Participants in this study are insured under the Flinders University Indemnity Scheme. If you suffer injury as a result of participation in this research or study, compensation might be paid without litigation. However, such compensation is not automatic.

Confidentiality and Data Security

This project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research.

All personal information will remain confidential and no information which could lead to your identification will be released, except as required by law.

All recorded interviews will transcribed verbatim. Any audio recording will be destroyed after it has been transcribed and your name will be replaced with a pseudonym, meaning that the data is de-identified. All recordings and transcriptions will be stored on a password protected computer file on the personal drive of the researcher at Flinders University and only the researcher and researcher's supervisors will have access to this data. Any notes taken during interviews or observation will be recorded in a paper journal and stored in a locked cabinet at the researcher's home or University.

At the completion of the project, all hardcopy data will be placed in the research unit's secure storage. Electronic transcripts will be destroyed upon completion of the project. All data will be stored for 15 years after conclusion of the project, as required by SA Health. After 15 years, all electronic and hardcopy data will be destroyed using Flinders University secure waste service.

In addition to the processes described above, data may otherwise be discoverable through processes of law or for assessing compliance with research procedures.

You have a right to access the information collected and stored by researchers about you. You also have a right to request that any information with which you disagree be corrected.

You have a right to ask that any stored specimens be destroyed but should be aware that data which has already been derived from those specimens may not be able to be destroyed.

Publication

A summary of the project's results will be provided to you as a summary report at your request.

The results may be published in conference papers or journals. However, no information that could personally identify you will appear in any of these papers.

Withdrawal

Your participation in this project is entirely voluntary and you have the right to withdraw from the project at any time without giving a reason. If you decide not to participate in this project, or if you withdraw from the project, you may do so freely, without affecting your relationship with the mental health service. If you decide to withdraw, I would like to use information already collected unless you ask for it to be withdrawn from the project.

Expenses and payments:

There is no financial reimbursement for participating in this project.

Contact

If you would like further information about this project at any time, you may contact Suzanne Dawson on Ph. 8404 2321 or on email suzanne.dawson@flinders.edu.au .

Complaints

This study has been reviewed by the RAH Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact the Executive Officer, RAH Research Ethics Committee on 8222 4139 or email Health.CALHNResearchEthics@sa.gov.au.

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Participant Information Sheet
Carers

Title of the project
What is the nature of care planning for consumers on community treatment orders (CTOs) in community mental health care in South Australia?

Researcher
Hello, my name is Suzanne Dawson. I am an Occupational Therapist at the Western Community Mental Health Centre and am undertaking this research as a PhD Candidate at Flinders University.

Invitation to participate
I am inviting carers who have had experience of a family member on a community treatment order (CTO) and received care at the Western Community Mental Health Centre (WCMHC) to participate in this research. The purpose is to find out more about your experiences of care planning when on a CTO. Your family member's mental health worker has said that you might be interested in participating.

It is up to you to decide to join the study. You do not have to be involved and you are free to withdraw at any time, without giving a reason. This will not affect the care your family member receives, nor will it impact in any way on other aspects of their care such as the review of their CTO.

Aims of the project
The aim of this study is to explore your experience of care planning, including what facilitates and hinders good experiences and how the care planning process could be improved. I hope that understanding this will assist mental health workers and services to provide treatment and care that better assists people with mental illness that are on a CTO.

Summary of procedures
If you decide to participate, I would like to invite you to attend a small focus group for about 30-60 minutes at most to ask about your experiences of your family member receiving treatment and support from western mental health services while on a Community Treatment Order. The focus group will be held directly after the Western Carer's forum held at the Broca's, 111 Woodville Rd, St Clair SA 5011.

I hope to audio record the focus group so that I can type it up after as a record of our conversation. However, if the consensus is that participants do not want this to occur, I will only take notes by hand to record what you have told me during the focus group.

Benefits, Risks and Adverse Effects
I hope that you will find this project interesting and personally rewarding by talking and thinking about your experiences of a family member being on a Community Treatment Order, and to feel heard.

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I do not think there are any risks involved in this study. Some people may become upset when recounting experiences related to their contact with services. You are reminded that your participation is entirely optional and you are free leave the focus group at any time.

If needed, you will be offered support to contact a support person of your choosing. This may be a family member, carer or friend. You will also be provided with details of the 24 hour crisis mental health contact, should you feel you need to talk to someone about how you are feeling.

Compensation
Participants in this study are insured under the Flinders University Indemnity Scheme. If you suffer injury as a result of participation in this research or study, compensation might be paid without litigation. However, such compensation is not automatic.

Confidentiality and Data Security
This project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research.
All personal information will remain confidential and no information which could lead to your identification will be released.
Also, anything you tell me will be treated in confidence unless I am concerned about your safety or the safety of someone else, or if I become aware of professional malpractice, in which case I would have to discuss my concerns with you and your medical team.

All recorded interviews will transcribed verbatim. Any audio recording will be destroyed after it has been transcribed and your name will be replaced with a pseudonym, meaning that the data is de-identified. All recordings and transcriptions will be stored on a password protected computer file on the personal drive of the researcher at Flinders University and only the researcher and researcher's supervisors will have access to this data. Any notes taken during interviews or observation will be recorded in a paper journal and stored in a locked cabinet at the researcher's home or University.
At the completion of the project, all hardcopy data will be placed in the research unit's secure storage. Electronic transcripts will be destroyed upon completion of the project. All data will be stored for 15 years after conclusion of the project, as required by SA Health. After 15 years, all electronic and hardcopy data will be destroyed using Flinders University secure waste service.

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You have a right to access the information collected and stored by researchers about you. You also have a right to request that any information with which you disagree be corrected.
You have a right to ask that any stored specimens be destroyed but should be aware that data which has already been derived from those specimens may not be able to be destroyed.

Publication
A summary of the project's results will be provided to you as a summary report at your request.
The results may be published in conference papers or journals. However, no information that could personally identify you will appear in any of these papers.

Withdrawal
Your participation in this project is entirely voluntary and you have the right to withdraw from the project at any time without giving a reason. If you decide not to participate in this project, or if you

withdraw from the project, you may do so freely, without affecting your relationship with the service where you receive support. If you decide to withdraw, I would like to use information already collected unless you ask for it to be withdrawn from the project.

Expenses and payments:
A buffet will be provided to acknowledge your time spent participating in the focus group.

Complaints
This study has been reviewed by the RAH Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact the Executive Officer, RAH Research Ethics Committee on 8222 4139 or email Health.CALHNResearchEthics@sa.gov.au.

What do I do now?
If you have any questions or concerns please contact the primary researcher, Suzanne Dawson. Contact details are below. If you are undecided, you may wish to discuss whether to take part in the study with your family members case manager, a family member or friend.

If you have fully understood the information and would like to take part in the study, please contact me as below by telephone or email. I will arrange to obtain signed consent from you when we meet at the focus group.

If you do not wish to take part in the study, you do not need to do anything else.

Thank you very much for your time and interest.

Suzanne Dawson (Occupational Therapist/PhD Candidate)

Contact
If you would like further information about this project at any time, you may contact Suzanne Dawson on Ph. 7425 3800 or on email suzanne.dawson@flinders.edu.au .

Appendix G: Consent Forms

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CONSENT TO PARTICIPATION IN RESEARCH – Consumer/Carer

HREC reference number: HREC/16/RAH/148
CALHN reference number: R20160428
Primary Investigator: Suzanne Dawson
Location: Western Community Mental Health Centre

I, ... give consent to my
(first or given names) *(last name)*

involvement in the research project*: **What is the nature of care planning for consumers on community treatment orders in community mental health care in South Australia?***

I acknowledge that the details of the following has been explained to me, including indications of risks; any discomfort involved; anticipation of length of time; and the frequency with which they will be performed:

1. Participation in one interview with a PhD candidate researcher from Flinders University for approximately 30-60 minutes
2. Observation of my usual care planning meetings (with the treating doctor or case manager) by a PhD candidate researcher

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.
I have had an opportunity to ask questions and I am satisfied with the answers I have received.
The nature, purpose and risks of the research project have been explained to me. I understand them and agree to take part.
I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future health care.
I understand that I will be given a signed copy of this document to keep.

Name of Participant (please ______________________________

Signature ______________________ Date ______________________

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CONSENT TO PARTICIPATION IN RESEARCH – Mental health professionals
HREC reference number: HREC/16/RAH/148
CALHN reference number: R20160428
Primary Investigator: Suzanne Dawson
Location: Western Community Mental Health Centre

I, ... give consent to my
(first or given names) *(last name)*

involvement in the research project: ***What is the nature of care planning for consumers on community treatment orders in community mental health care in South Australia?***

I acknowledge that the details of the following has been explained to me, including indications of risks; any discomfort involved; anticipation of length of time; and the frequency with which they will be performed:

1. Observation of usual care planning meetings with a PhD candidate researcher conducting observation
2. Participation in one interview with a PhD candidate researcher from Flinders University for approximately 30-60 minutes

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.
I have had an opportunity to ask questions and I am satisfied with the answers I have received.
The nature, purpose and risks of the research project have been explained to me. I understand them and agree to take part.
I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future health care.
I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) ______________________________

Signature ____________________ Date ____________________

Declaration by Senior Researcher†

I have given a verbal explanation of the research project, its procedures and risks, and the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of
Senior Researcher† (please print) ______________________________

Signature ____________________ Date ____________________

† A senior member of the research team must provide the explanation of, and information concerning, the research project.
Note: All parties signing the consent section must date their own signature
Consent to participate MHP Observation V3 04.06.2016

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Appendix H: Excerpts from the fieldwork journal

02/10/17

I was invited today by one of the psychiatrists to sit in a medical review with someone who was on a CTO. This was followed up by the doctor requesting that I engage with the consumer in my role as an OT to explore his engagement in activity/occupations. The doctor was wanting to offer the consumer more than he was able to in his role. I approached the care coordinator about this discussion, but they felt that they had "done all that" already.

How much work is hidden from other team members? How much ongoing effort is made to engage the person in broader domains?

31/10/17

Today was the first time that I have been with a client (for this study) who became very angry and upset about being on a CTO during the session (medical review). Tom spoke about being forced to take medication for 20 years to reduce the voices that he hears that he believes are spiritual. I was writing minimal notes as Tom was regularly checking me during the appointment, then I stopped altogether as it felt intrusive to continue. I also felt on edge. On speaking to the doctor after the appointment, he said that Tom always gets very angry in the session, then settles and apologies. Tom apologised at the end of the session today. He also spoke about the trauma that he had experienced from being in hospital and being restrained by police. My emotions shifted a lot in the session from being a little frightened (Tom is a large man and he was shouting) to feeling sad about the situation. Today's meeting was a painful clash of understandings of Tom's voices and the treatment needed: medical model versus spiritual.

07/11/17

Reflecting on the discussions that are occurring in clinical reviews, it's clear that the use of illicit drugs impacts on workers views regarding the persons responsibility and service responsibility. Mental health service staff feel frustrated that there are diminishing drug and alcohol services, and do not see people with drug use as the primary problem as "core business".

21/03/18

The psychiatrist was almost apologetic when discussing the content that needs to be covered in the CTO hearing with Mark today. He talked about wanting to be transparent so that there were no surprises for him at the hearing and said he would have to list all the events and risks that have occurred. There was no actual discussion of what these were today in the session. Mark was accepting of this. He has been on multiple CTOs. But what impact does this have on the person and the relationship?

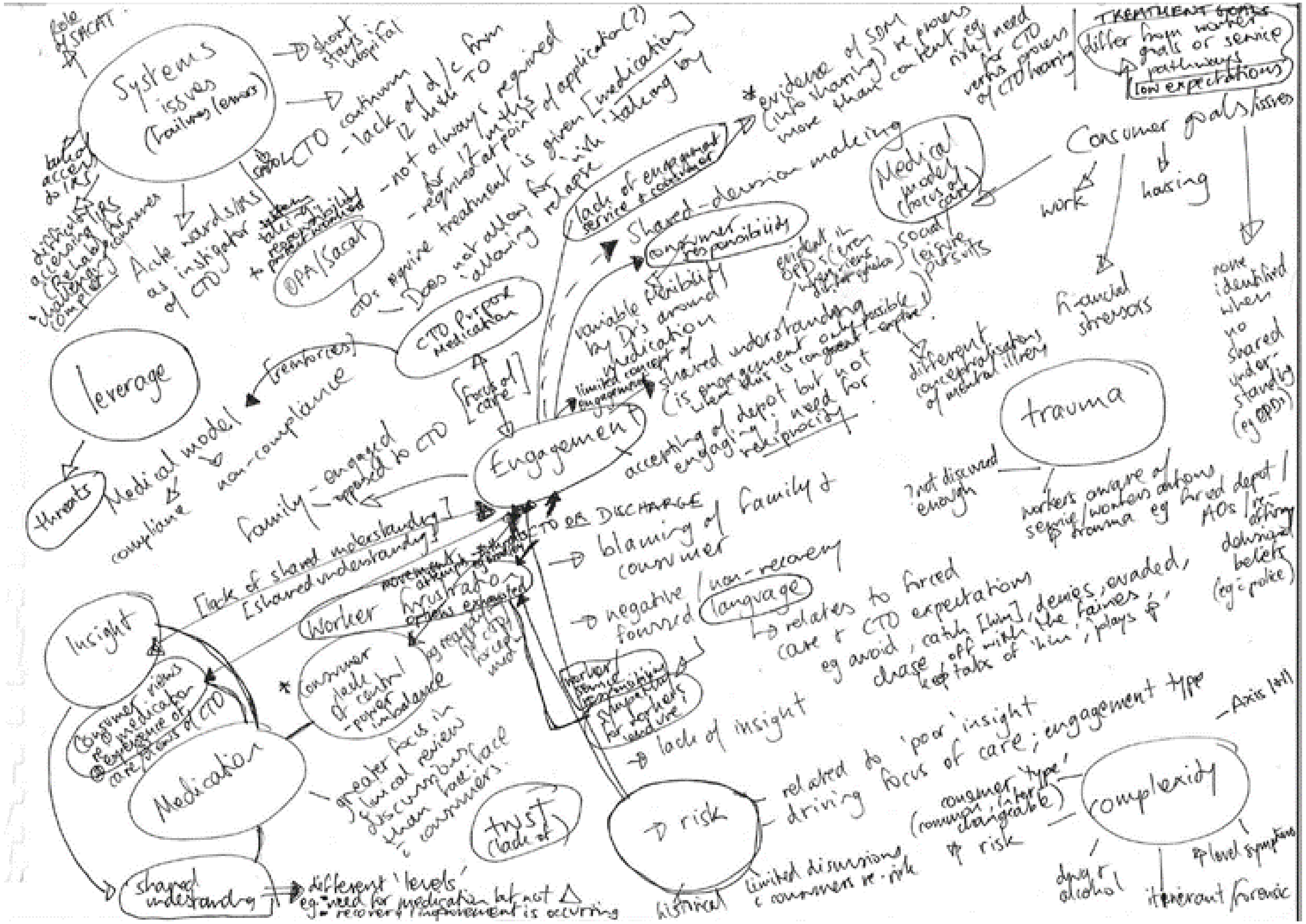
24/03/18

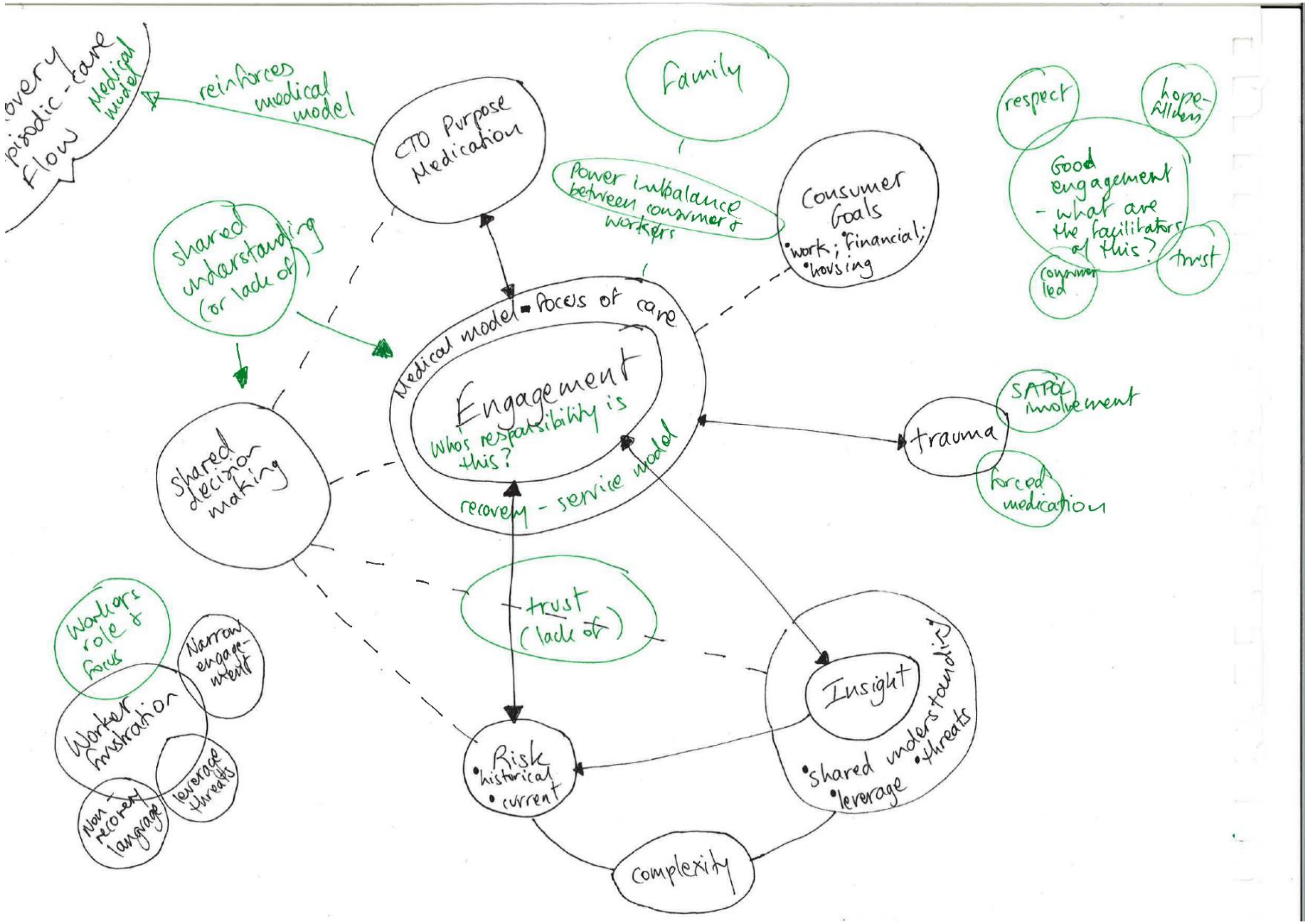
Consumers who actively disengage with the services are seen by the services as “dis-engaging” and “lack of compliance”, though this could instead be conceptualised as a way of the person taking back control and showing self-determination. Need to look for discrepancies between staff and consumers around this issue. For example, consumers not wanting to go to a CTO hearing because they experience no power in the situation.

28/09/18

There was a sense of guilt expressed by the carers attending the focus group today, and on reflection this has been a part of all if not most discussions with carers. The carers today were not so bothered about being included in decision-making but were concerned about the lack of service interest in the person’s physical health and well-being. Several carers have spoken about the awareness that their child is likely to die younger from side-effects of medication and lack of attention to physical health. Issues discussed were everyday issues, including balancing contact and involvement with their other children (of which some also expressed feeling guilt).

Appendix I: Early data




overy
pisodic-care
Flow
Medical model
reinforces medical model
CTO Purpose Medication
Family
Power imbalance between consumer & workers
Consumer Goals
•work; •financial;
•housing
respect
hope-fillders
Good engagement - what are the facilitators of this?
consumer led
trust
shared understanding (or lack of)
Medical model ▪ Process of care
Engagement
Who's responsibility is this?
recovery - service model
trauma
SAPOL involvement
forced medication
shared decision making
trust (lack of)
Workers role & focus
Narrow engagement
Worker frustration
Non-recovery language
leverage threats
Risk
•historical
•current
Insight
•shared understanding
•threats
•leverage
complexity

Early findings and areas to explore more in interviews:

1. ***Shared decision making: Trauma informed care: Recovery focussed***

- Difference seen in clinical reviews and face: face contacts
- How does this sit within the leverage of being on a CTO and having treatment imposed on the individual

2. ***Insight/or 'lack of': explore/problematize***

- Concept that someone cannot be on a CTO due to lack of insight/unwillingness to engage with recommended treatment e.g. depot
- CTO (and engagement with treatment) or discharge (driven by risk as well as wishing to preserve the relationship for the future)
- What does insight mean? It's a term that is frequently used to justify CTOs, though someone may actively seek medication and therefore take responsibility but not agree that they have a MI

3. ***Complexity***

- Behaviour impacted upon or driven by illicit drugs OR 'personality' factors- a sense of workers having little ability to help facilitate change; Illicit drugs: not MHS primary responsibility
- Trauma history and impact of this on the individual

4. ***Engagement & Recovery Paradox for consumers on a CTO & workers*-*expectation that individuals take more responsibility***

- Discourse re leverage (enforcing of CTO) from workers which is contradictory to expectation that consumers' should be taking more self-responsibility (recovery)
- What does engagement mean? Who's responsibility is it?
- How would engagement look if care was assertive rather than forced? Can these occur in parallel?

Clinical Reviews	**Face to Face**
Low expectations Discharge or CTO Non-recovery language Use of leverage/force Focus on risk and insight Worker frustration Worker attempts to engage Service driven pathways	Consumer voice Family involvement Communication: respectful, strengths based, transparent Psychosocial focus Medication discussed Decision-making (transparent) Consumer and parent attitude to CTO (variation)

Appendix J: Interview Schedules

Interview Schedule: Consumers and Carers

Tell me a little bit about yourself, what you do, what's important to you, your living situation.

Who are your main supports?

ENGAGEMENT

How long have you had contact with MHS, who do you see at WCMHS?

Can you describe the current contacts you have with MHS? (frequency, location, type)

What is your experience of contact with our services?

- What has been helpful? *can you give an example?*
- What has been unhelpful? *can you give an example?*
- What could we do better?

Can you tell me about how you would like mental health services to help you?

UNDERSTANDING OF CTO

What is your understanding of the reason that you are on a CTO?

What do you think/feel about this?

Has it been helpful in any way, if so how?

If you weren't on a CTO what contact/support would you want from MHS?

SHARED DECISION MAKING

Can you tell be about your involvement in decisions about your care with your care coordinator/treating doctor? (*e.g choice of medications*)

Do you think you have much choice in relation to your care? *If not why not?*

Overall, what are the most important issues for you with regards to your mental health and care and treatment from MHS?

Is there anything else you would like to add in relation to the care and contacts you have with WCMHS?

Interview Schedule: Mental Health Professionals

Some introductory questions re focus of study and demographics (age, profession, years working in MH)

ENGAGEMENT

Tell me about [the consumer] and your role as CC/treating doctor…..

What is the primary focus of your care contacts with [the consumer]?

How do you go about it? e.g. what facilitates and hinders engaging with [consumer]?

If there is minimal engagement, how do you work with this?

What impact does being on a CTO have on engagement with [consumer]?

What is important to [the consumer]?

How do you reconcile the concept of care being recovery focussed for [consumer] and in general for individuals on CTOs (where they are forced to receive care)?

What broader things impact upon the work you can do with [the consumer]?

INSIGHT/CAPACITY

What is your understanding of [the individuals] insight?

How does this impact on how you engage with them?

Tell me about their capacity/ability to make decisions about their own care?

RISK

What is your understanding of [the consumers] risk?

Discuss the impact of risk on engagement with [a consumer] and type of support offered/provided

What is their understanding of their assessed risk?

How do you manage the balance between risk and recovery with consumers?

SHARED DECISION MAKING

What does this mean for individuals on CTOs?

Can you give examples of what it looks like in practice: specifically, give example of when it worked well, not so well and why you thought this was the case?

How can SDM occur when there is a lack of congruency in belief in illness or need for medication?

How do you manage discrepancies amongst different health professionals as well as differences between the treating team's goals and the consumers goals? Can you give an example when this may have arisen and how you navigated it?

How can care planning be consumer led for individuals who are on CTOs? Can you provide examples.

What is the family role/input into the persons care?

Appendix K: An example of data analysis

a. Determining meaning fields [bracketed] and conducting low level coding

Data from a clinical review	Low level coding
Psychiatrist: If you want to do that 'wake-up call' you should get someone else to do this to preserve your relationship. When you do the hard stuff you will distance yourself further. Let Mental Health, whatever this amorphous thing is, do this	Importance of worker-consumer relationship Loss of trust
[Suggestion to use the 'system' to enforce the CTO so that the relationship with the worker has a better chance of being preserved]	'System' as enforcer of CTOs
SW 1: I'm not too concerned about losing rapport; I've had a gut full to be honest.	worker fatigue worker irritation
[worker fatigue/burden/irritation]	
Psychiatrist: You could use your bosses as authority	'System' as enforcer of CTOs
He asked about the risk of stopping medication	Risk
SW: Amotivated, delusions about the family, so they become a little afraid of her	Risk as determining workers decision-making
SW 2: OK, so risk to others is later (in the process of relapse)	
[the risk comes in time, it is not immediate risk]	
SW 1: But there's a CTO	Consequences of CTOs CTO purpose
[we should be enforcing treatment, we are bound by an order to do something]	CTO purpose Option for less restrictive
SW 2: It doesn't matter. A CTO is what we decide it to be (with regards to treatment). If we leave her and link with Dad, and get involved if she deteriorates.	
[challenges the need to enforce the order, we can decide what to do as a team, we could take a less restrictive approach and involve the family, she could be left to deteriorate before we enforce treatment]	Workers as expert Lack of family engagement
SW 1: I guess I don't think they (the family) are reliable [punitive!; the family will not be helpful] Some discussion about the pending marriage (scheduled for Dec 2017)	
SW 3: So how will they explain to the husband that she's off with the fairies? How will they conceptualise her mental illness?	Family's formulation of mental illness Madness
[language; 'off with the faries.' What will the families explanation be to her future husband?]	

RMO: They've asked if she has Cancer or HIV? They think she had a headache and now it's cured. [The family don't understand the concept of mental illness, it is not within their framework] Medication options were discussed	Stigma Lack of insight
Nurse: I think it's the stigma [The impact of stigma and shame on the family is raised here again]	Worker awareness of family shame
RMO: Her extent of understanding is she had a headache and now it's gone away	Worker fatigue/ /Lack of insight
SW 2: Another issue is she lives near someone (another consumer) who is fuelling the fire [Another consumer is possibly making the situation worse]	'Negative' influence of other consumers
SW 1: Honestly we've tried everything [worker fatigue, we are out of options, we've put in a lot of effort to no avail]	Options are exhausted
SW 2: I do think it's us that is the problem culturally [moving the problem back to the services/the system/the workers approach]	Disparity in worker views
RMO: I don't know who else we try? She says she doesn't need a CTO [we are out of options, Isla does not share our view, likely many consumers do not see the need for a CTO or they would not be on one, issue of service view of insight]	Feeling stuck
Psyciatrist: My gut feeling is we've exhausted all options [the consultant agrees that all options have been tried/attempted]	Worker frustration

b. Supervision/Reflection on data

Culture is missing from the analysis

Possible normative-evaluative: their culture and (perceived lack of) education invalidated the family and consumer rights

The doctor does not want her to have a relapse/though this denies consumer risk taking/choice

Areas for horizon analysis: Risk, consumer voice, power & control

Normative evaluative is the focus for cultural norms

Normative- accepted by the group as a process and in the concept of the CTO; e.g. It’s acceptable to over-ride consumer rights.

Can take entire or excerpt from dialogue to create and PHA

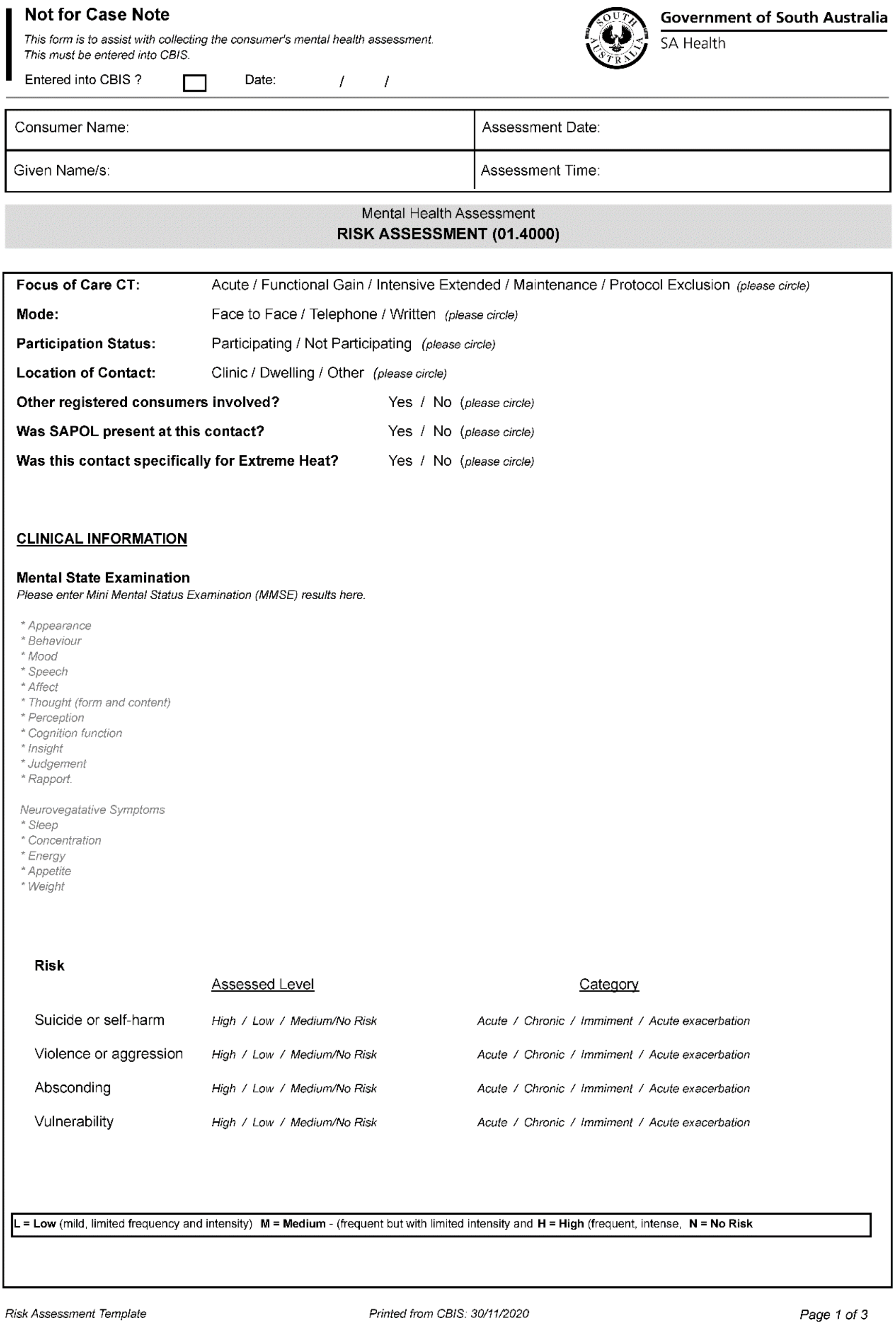
Normative claims are collectively constructed, individual professionals will reflect their cultural group e.g. the CC who feels responsible for enforcing and ensuing medication is taken

Difference in opinion between professionals is important as demonstrates tension that is occurring

c. Conducting validity horizon analysis

Possible Objective Claims	Possible Subjective Claims	Possible Normative-Evaluative Claims
Most foregrounded There are risks if [the consumer] does not receive the depot. The consumer is not going to agree to the recommended treatment [having the depot]. The consumer has no insight (into her illness, need for medication, or risks) The family are ambivalent regarding medication.	**Most foregrounded** I'm fed-up. We've attempted to engage and build rapport, but it is not leading to treatment adherence. We've exhausted all options around engagement with services. I don't believe the options are exhausted.	**Most foregrounded** There is a CTO in place to ensure treatment. Lack of insight increases risk.
Less foregrounded Treatment will be experienced as coercive by [the consumer] and her family which will impact upon future rapport/engagement. Treatment is required to prevent deterioration in mental state/preserve function and minimise risk.	**Less foregrounded** I'm the clinician responsible for ensuring the CTO requirements are met. I think we can still decide 'the best treatment' option and take a less restrictive stance (i.e. NOT enforce the depot). Working with the family around engagement is not going to be helpful in this situation. We need to avoid a relapse.	**Less foregrounded** The consumer and her family should adhere to our recommendations regarding treatment. The allocated workers, and service, are responsible for ensuring treatment is received as agreed under the MH Act.
Background/remote At this stage [the consumer] has no choice regarding treatment.	**Background/remote** We (I) are (am) the expert(s) regarding best treatment. I/We are the responsible clinicians who will be held to account in an adverse event.	**Background/remote** There would be consequences to the service if there was an adverse event and we had not enforced treatment as mandated by the MH Act. It's acceptable to override an individuals' human rights in the context of a CTO. The family cultural background and their (perceived lack of) education invalidates the family and consumer rights

Appendix L: Service risk assessment, care plan and outcome measures



Not for Case Note

This form is to assist with collecting the consumer's mental health assessment.
This must be entered into CBIS.

Entered into CBIS ? ☐ Date: / /

Government of South Australia
SA Health

Consumer Name:	Assessment Date:
Given Name/s:	Assessment Time:

Mental Health Assessment
RISK ASSESSMENT (01.4000)

Focus of Care CT: Acute / Functional Gain / Intensive Extended / Maintenance / Protocol Exclusion *(please circle)*

Mode: Face to Face / Telephone / Written *(please circle)*

Participation Status: Participating / Not Participating *(please circle)*

Location of Contact: Clinic / Dwelling / Other *(please circle)*

Other registered consumers involved? Yes / No *(please circle)*

Was SAPOL present at this contact? Yes / No *(please circle)*

Was this contact specifically for Extreme Heat? Yes / No *(please circle)*

CLINICAL INFORMATION

Mental State Examination
Please enter Mini Mental Status Examination (MMSE) results here.

** Appearance*
** Behaviour*
** Mood*
** Speech*
** Affect*
** Thought (form and content)*
** Perception*
** Cognition function*
** Insight*
** Judgement*
** Rapport.*

Neurovegatative Symptoms
** Sleep*
** Concentration*
** Energy*
** Appetite*
** Weight*

Risk

	Assessed Level	Category
Suicide or self-harm	*High / Low / Medium/No Risk*	*Acute / Chronic / Immiment / Acute exacerbation*
Violence or aggression	*High / Low / Medium/No Risk*	*Acute / Chronic / Immiment / Acute exacerbation*
Absconding	*High / Low / Medium/No Risk*	*Acute / Chronic / Immiment / Acute exacerbation*
Vulnerability	*High / Low / Medium/No Risk*	*Acute / Chronic / Immiment / Acute exacerbation*

L = Low (mild, limited frequency and intensity) **M = Medium** - (frequent but with limited intensity and **H = High** (frequent, intense, **N = No Risk**

Risk Assessment Template *Printed from CBIS: 30/11/2020* *Page 1 of 3*

***This form is to assist with collecting the consumer's mental health assessment.
This must be entered into CBIS. This form is not for inclusion in the case note.***

Risk Summary
See Attached for Prompts

***** Please enter or confirm appropriate CBIS Alerts for the safety of both consumer and your colleagues *****

NOTIFICATIONS AND MANDATORY REPORTING

Firearm / Weapon Safety Concerns? Yes / No (*please circle*)

Firearm Notification Lodged? Yes / No (*please circle*)

***** Please enter or confirm appropriate CBIS Alerts for the safety of both consumer and your colleagues *****

Children's Safety Concerns?

Are there children under 18 years old or other dependent persons in the househould? Yes / No (*please circle*)

Has Families SA been notified? Yes / No (*please circle*)

***** Please enter or confirm appropriate CBIS Alerts for the safety of both consumer and your colleagues *****

RECOMMENDATION / PLAN

Clinical Impression - key issues, working diagnosis

Management and Risk Reduction Plan - trigger/precipitating factors, early warning signs, plan to manage these (effective approaches if known), links to services and whether these have been formalised

Time taken (minutes): ....

This form is to assist with collecting the consumer's mental health assessment.
This must be entered into CBIS. This form is not for inclusion in the case note.

RISK SUMMARY PROMPTS:
Please explain what the identified risks are and include further details (static and dynamic factors).
This should then be formulised as a management and treatment plan (e.g. high imminent risk of sellf harm=admit to ward).

RISK SUMMARY PROMPTS - STATIC FACTORS **SUICIDE/SELF HARM** **Static** **- Previous suicide attempt or self harm** **- Family history of suicide and/or self harm** **- History of serious physical illness or disability (e.g. multiple sclerosis, malignancy)** **- Male between 25 and 50 or over 70 years** **- Lives in rural setting (especially males 15 - 24 years)** **- History of abuse (especially sexual)** **- Member of a minority group** **- Identifies as lesbian, gay, bisexual or transgender** **- Migrant** **- CALD/Indigenous**	**RISK SUMMARY PROMPTS - DYNAMIC FACTORS** **SUICIDE/SELF HARM** **Dynamic** **- Intent** **- Plans (preparation/rehearsal)** **- Settling of affairs (giving away possessions, writing will)** **- Thoughts (frequency/duration)** **- Recent suicide attempt** **- Suicide note** **- Impulsivity** **- Increase in Alcohol/Drug use** **- Problem gambling/gambling addiction** **- Access to means (medications/weapons/rope/poisons etc.)** **- Deterioration in serious physical illness** **- Physical pain** **- Psychological pain (hurt, anguish, misery)** **- Stress (feeling pressured/overwhelmed)** **- Agitation (emotional urgency)** **- Hopelessness (expectation that things will not get better)** **- Self hate** **- Shame** **- Guilt** **- Relationship problems/divorce/separation/custody issues** **- Psychotic symptoms** **- Command hallucinations** **- Recent discharge from hospital (within last 28 days)** **- Social isolation/lack of any support group** **- Unwillingness to accept help** **- Works in construction/mining industry** **- Unemployed**
VIOLENCE/AGGRESSION/CRIMINAL ACTIVITY **Static** **- Under 25yrs** **- History of violence/sexual offence** **- Criminal/forensic history** **- Conduct disorder** **- History of substance abuse**	**VIOLENCE/AGGRESSION/CRIMINAL ACTIVITY** **Dynamic** **- Impulsivity** **- Anger** **- Fear/anxiety over contact with MHS** **- Intoxication/withdrawal** **- Cognitions supporting violence** **- Recent threats** **- Recent aggressive actions or thoughts** **- Carries weapon/access to firearms** **- Psychotic symptoms** **- Command hallucinations** **- Content of delusional beliefs** **- At risk of sexually abusing others**
SELF NEGLECT/EXPLOITATION/VULNERABILITY **- At risk of being sexually abused by others** **- At risk of domestic/family violence** **- At risk of being financially abused by others** **- At risk of self neglect** **- Cognitive impairment** **ABSCONDING** **- History of absconding** **- Poor adherence to psychiatric treatment** **- Frustration regarding hospital treatment** **- Lack of insight** **- Command hallucinations** **- Fear associated with being in hospital**	

Not for Case Note

This form is to assist with developing the consumer's care plan. The care plan must be entered into CBIS.

Entered into CBIS ☐ Date: / /

Government of South Australia
SA Health

Name and Title			
UR NO		**D.O.B.**	

	Yes	No
Is there a shared care agreement with a GP?		
Is the consumer aware of their Wellness Plan and have they agreed to its content by signing a printed and dated copy?		

Advance Directive or Ulysses Agreement

This is what I would like to happen if I become unwell:

Employment Status	1 - Full Time	2- Part Time	**Education Status**	1 – Not in education	2- In Full Time Education
	3- Unemployed (seeking)	4 - Not in labour force		3- In Part Time Education	

Jobs or Courses the Consumer is interested in	

Social Cultural Considerations

Forensic Issues

Who is involved in my care?

Agency	Name	Contact Details	How does this support assist me?	Consent for a copy of this plan?

This form is to assist with developing the consumer's care plan. The care plan must be entered into CBIS. This form is not for inclusion in the case note.

Things I would like to happen if I become unwell
Things I <u>would not</u> like to happen if I become unwell
Who needs to be contacted?
Things I will need support to organise if I become unwell
Consumer's parenting responsibility

This form is to assist with developing the consumer's care plan. The care plan must be entered into CBIS. This form is not for inclusion in the case note.

Consumer's Wellbeing Matrix	
Things that my mental illness doesn't stop me doing	**Things that impact on my wellbeing**
What is my understanding of my emotional and mental health?	**What is my family's (including children) understanding of my emotional and mental health?**
What are the first things that I/others notice when I am feeling unwell?	**What have I done in the past that makes me feel better?**
Things that haven't helped or have made me feel worse	**Things I do regularly to stay well**

This form is to assist with developing the consumer's care plan. The care plan must be entered into CBIS. This form is not for inclusion in the case note.

Consumer's Wellness Plan ***(maximum of three goals to be identified)***		
My Most Important Goal	**Goal Number 2**	**Goal Number 3**
My strengths to address	**My strengths to address**	**My strengths to address**
Actions	**Actions**	**Actions**
Expected Outcomes	**Expected Outcomes**	**Expected Outcomes**
People Responsible	**People Responsible**	**People Responsible**
Timeframe	**Timeframe**	**Timeframe**
Consumers Wellness Plan – Other Issues		
Goals I have already achieved		
Issues I would like to address at another time		

This form is to assist with developing the consumer's care plan. The care plan must be entered into CBIS. This form is not for inclusion in the case note.

Physical Wellness and Wellbeing

My Physical Wellness and Wellbeing Health Plan

Medication Information

Generic Name	Purpose	Dose	Route	Freq	Prescriber & Phone No	Last Modified

The benefits of medication to me

The side effects of medication to me

This form is to assist with developing the consumer's care plan. The care plan must be entered into CBIS. This form is not for inclusion in the case note.

Why would I continue taking this medication?

What medication has helped in the past?

What medication has not helped in the past?

Medication Monitoring is done by?

Medication Supply –Who What Where How?

Family / Carer's Plan

Children's Safety Care Plan

This form is to assist with developing the consumer's care plan. The care plan must be entered into CBIS. This form is not for inclusion in the case note.

Service Plan – 'What is the service doing for the consumer?'

Shared Care Agreement – All parties are to sign

Last review date		**Name of Clinician assisting with plan**	
Next review date			

I am aware of my mental health care plan and agree to its contents.

Consumer's Signature

Advocate's Signature **Date**

Health of the Nation Outcomes Scales

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The Kessler–10+ (K-10+)

The K-10+ LM

Instructions

The following ten questions ask about how you have been feeling in the **last four weeks**. For each question, mark the circle under the option that best describes the amount of time you felt that way.

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
1.	In the last four weeks, about how often did you feel tired out for no good reason?	○	○	○	○	○
2.	In the last four weeks, about how often did you feel nervous?	○	○	○	○	○
3.	In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4.	In the last four weeks, about how often did you feel hopeless?	○	○	○	○	○
5.	In the last four weeks, about how often did you feel restless or fidgety?	○	○	○	○	○
6.	In the last four weeks, about how often did you feel so restless you could not sit still?	○	○	○	○	○
7.	In the last four weeks, about how often did you feel depressed?	○	○	○	○	○
8.	In the last four weeks, about how often did you feel that everything was an effort?	○	○	○	○	○
9.	In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10.	In the last four weeks, about how often did you feel worthless?	○	○	○	○	○

The next few questions are about how these feelings may have affected you in the **last four weeks.**

You need not answer these questions if you answered ‘None of the time’ to all of the ten questions about your feelings

11.	In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?	_____ (Number of days)
12.	[Aside from those days], in the last 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?	_____ (Number of days)
13.	In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings?	_____ (Number of consultations)
14.	In the last 4 weeks, how often have physical health problems been the main cause of these feelings?	None of the time ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time ○

Thank you for completing this questionnaire.

Please return it to the staff member who asked you to complete it.

Professor Ronald C Kessler of the Department of Health Care Policy, Harvard Medical School is thanked for the use of research on the K10 funded by US Public Health Service Grants RO1 MH46376, R01 MH52861, RO1 MH49098, and K05 MH00507 and by the John D and Catherine T MacArthur Foundation Network on Successful Midlife Development (Gilbert Brim, Director)."

SOURCE: *Mental Health National Outcomes and Casemix Collection: Overview of clinician-rated and consumer self-report measures, Version 1.50.* Department of Health and Ageing, Canberra, 2003

Abbreviated Life Skills Profile (LSP-16)

Assess the patient's general functioning over the past three months, taking into account their age, social and cultural context. Do not assess functioning during crises when the patient was ill or becoming ill. Answer all 16 items by circling the appropriate response.

		0	1	2	3
1	Does this person generally have any difficulty with initiating and responding to conversation?	No difficulty	Slight difficulty	Moderate difficulty	Extreme difficulty
2	Does this person generally withdraw from social contact?	Does not withdraw at all	Withdraws slightly	Withdraws moderately	Withdraws totally or near totally
3	Does this person generally show warmth to others?	Considerable warmth	Moderate warmth	Slight warmth	No warmth at all
4	Is this person generally well groomed (eg, neatly dressed, hair combed)?	Well groomed	Moderately well groomed	Poorly groomed	Extremely poorly groomed
5	Does this person wear clean clothes generally, or ensure that they are cleaned if dirty?	Maintains cleanliness of clothes	Moderate cleanliness of clothes	Poor cleanliness of clothes	Very poor cleanliness of clothes
6	Does this person generally neglect her or his physical health?	No neglect	Slight neglect of physical problems	Moderate neglect of physical problems	Extreme neglect of physical problems
7	Is this person violent to others?	Not at all	Rarely	Occasionally	Often
8	Does this person generally make and/or keep up friendships?	Friendships made or kept up well	Friendships made or kept up with slight difficulty	Friendships made or kept up with considerable difficulty	No friendships made or none kept
9	Does this person generally maintain an adequate diet?	No problem	Slight problem	Moderate problem	Extreme problem
10	Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?	Reliable with medication	Slightly unreliable	Moderately unreliable	Extremely unreliable
11	Is this person willing to take psychiatric medication when prescribed by a doctor?	Always	Usually	Rarely	Never
12	Does this person co-operate with health services (eg, doctors and/or other health workers)?	Always	Usually	Rarely	Never
13	Does this person generally have problems (eg, friction, avoidance) living with others in the household?	No obvious problem	Slight problems	Moderate problems	Extreme problems
14	Does this person behave offensively (includes sexual behaviour)?	Not at all	Rarely	Occasionally	Often
15	Does this person behave irresponsibly?	Not at all	Rarely	Occasionally	Often
16	What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?	Capable of full time work	Capable of part time work	Capable only of sheltered work	Totally incapable of work

LSP-16 item elaboration and clarification

The following item clarifications were developed as part of the training materials for the *Victorian Mental Health Outcomes Strategy* and are offered as a useful adjunct to the basic LSP-16.

1 **Does the person generally have difficulty with initiating and responding to conversation**? Measures the ability to begin and maintain social interaction, ensuring the flow of conversation; taking turns in conversation, silence as appropriate.

2 **Does the person generally withdraw from social contact**? Does the person isolate themselves when part of a group? Does the person participate in leisure activities with others? Spend long hours alone watching TV or videos?

3 **Does the person generally show warmth to others?** Does the individual demonstrate affection, concern or understanding of situation of others?

4 **Is this person generally well groomed (eg, neatly dressed, hair combed)?** Does the person use soap when washing, shave as appropriate/ use make-up appropriately, use shampoo?

5 **Does this person wear clean clothes generally, or ensure that they are cleaned if dirty?** Does the person recognise the need to change clothes on a regular basis? Are clothes grimy, are collars and cuffs marked, are there food stains?

6 **Does this person generally neglect her or his physical health?** Does the person have a medical condition for which they are not receiving appropriate treatment? Does the person lead a generally healthy lifestyle? Does the person neglect their dental health?

7 **Is this person violent to others?** Does the person display verbal and physical aggression to others?

8 **Does this person generally make or keep friendships?** Does the person identify individuals as friends? Do others identify the person as a friend? Does the person express a desire to continue to interact with others?

9 **Does this person generally maintain an adequate diet?** Does the person eat a variety of nutritious foods regularly? Do they watch their fat and fibre intake?

10 **Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?** Does the person adhere to their medication regimen as prescribed? The right amount at the right time on a regular basis? Does the person need prompting or reinforcement to adhere to their medication regimen?

11 **Is this person willing to take prescribed medication when prescribed by a doctor**? Does the person express an unwillingness to take medication as prescribed, bargain or inappropriately question the need for continuing medication?

12 **Does this person cooperate with health services (eg, doctors and/or other health workers)**? Is the person deliberately obstructive in relation to treatment plans? Do they attend appointments, undertake therapeutic homework activities?

13 **Does this person generally have problems (eg friction, avoidance) living with others in the household?** Is the person identified as 'difficult to live with'? Do they have difficulty establishing or keeping to "house rules" or are they always having arguments about domestic duties?

14 **Does this person behave offensively (includes sexual behaviour)?** Does the person behave in a socially inept or unacceptable way demonstrating inappropriate social or sexual behaviours or communication?

15 **Does this person behave irresponsibly?** Does the person act deliberately in ways that are likely to inconvenience, irritate or hurt others? Does the person neglect basic social obligations?

16 **What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?** What level of assistance/guidance does the individual require to undertake occupational activities?

LSP-16 scoring and subscales

All items are answered on an anchored four-point scale, with higher scores indicating a greater degree of disability. In the 16-item version, a score of 3 represents greater dysfunction and a score of 0 represents good functioning . Specific anchor points are provided for each item. For example, in relation to the medication compliance item, the specific anchor points are (0) “reliable with medication”, (1) “slightly unreliable”, (2) “moderately unreliable” and (3) “extremely unreliable”.

A total LSP scale score is calculated by adding individual scores for the whole scale together. Therefore, for the LSP-16, the total score can range from 0 to 48. Items with missing data are excluded from the calculation.
Four subscale scores can be also be calculated by adding together the scores for the items that form each subscale as shown in below.

The Four LSP-16 subscales and their component items

Subscale and brief item name	**Item scores**	**Subscale scores**
A Withdrawal		0–12
1 Difficulty in conversation	0–3	
2 Withdraw from social contact	0–3	
3 Shows warmth	0–3	
8 Maintain friendships	0–3	
B Self-care		0–15
4 Well groomed	0–3	
5 Clean clothes	0–3	
6 Neglect health	0–3	
9 Adequate diet	0–3	
16 Work capability	0–3	
C Compliance		0–9
10 Look after own prescribed medication	0–3	
11 Willing to take prescribed medication	0–3	
12 Co-operate with health services	0–3	
D Anti-social		0–12
7 Violent	0–3	
13 Problems with others	0–3	
14 Offensive behaviour	0–3	
15 Irresponsible behaviour	0–3	
E Total score (1–16)	0–48	