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Using ethnography to explore causality in mental health policy and practice

Hannah Jobling
Department of Social Policy and Social Work,
University of York, UK

Abstract

This article discusses the early findings of an on-going ethnographic study which is exploring the implementation of Community Treatment Orders (CTOs) in English mental health services, a process in which social work practitioners are closely involved. CTOs are present in a number of countries, and most recently in 2008 were enacted in England and Wales with the policy purposes of reducing 'revolving door' admissions, increasing the ability of clinicians to manage risk and encouraging recovery. They work by imposing conditions on how mental health service users live in the community as well as providing a mechanism for them to be recalled for treatment in hospital if they fail to meet those conditions. Perhaps unsurprisingly, their introduction has brought with it debate on the ethical implications of extending compulsory treatment into the community. The majority of research on CTOs has tended to ask the question, 'Do they work?' In this article I argue that ethnography may help to address a more ethically engaged and pertinent question for social work practice, namely, 'Who might CTOs work for, in what circumstances and why?' Immersion in service settings over an extended period enabled the incorporation of contextual factors and causal mechanisms into the analysis, which in turn has led to a consideration of the nature of CTO outcomes. This approach draws upon ideas about the role of qualitative research in exploring causality, and consideration is given to how the research may fit within some form of a realist framework.

Keywords

Community Treatment Orders, ethnography, mental health, outcomes, realism, social policy

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Corresponding author:
Hannah Jobling, Department of Social Policy and Social Work, University of York, Heslington, York, YO10 5DD, UK.
Email: hannah.jobling@york.ac.uk

Introduction

Reliance upon evidence hierarchies to determine the validity of knowledge claims has been integral to the rhetoric, if not always the reality, of policy-making processes for some time now. As May (2005: 526) states, in the late 20th century this was represented by 'a central shift towards the primacy of (largely quantitative) knowledge as the foundation for... state intervention across a range of policy fields'. Health and to a lesser extent, social care policy and practice, have been particularly characterized by such an approach. Traditionally in the health domain, research methodologies have been (quasi)experimental, with randomized controlled trials (RCTs) and systematic reviews regarded as the ideal methods for determining the efficacy of intervention programmes and drug/therapeutic treatment (Wessely, 2006). Indeed, it has been argued recently on behalf of the UK Government that the broader policy community should follow the lead of health research in embedding RCTs into the policy-making process (Haynes et al., 2012). This resurgence of interest in the privileging of certain types of evidence for policy-making seems rather anachronistic given the more complex reality of current policy research in health and the social sciences. Qualitative research has been given a more prominent role in the past few years, with for example UK government funders now requiring a qualitative 'process' element to be present in research designs. Byrne et al. (2009) suggest that this incremental move towards an acceptance of plural methodologies is more reflective of how researchers of policy and practice think about knowledge generation and the ways it informs social action within the 'real world' of practice. In this sense Byrne et al. (2009: 3) posit 'there has been a massive turn towards qualitative work across the policy arena, precisely because quantitative approaches have proved inadequate in addressing the issues of context and complex causation which underlie social interventions'. Put simply, only asking 'what works' in the case of policy programmes cannot give a satisfactory answer; instead, we need to ask 'what works for whom, in what circumstances' (Pawson and Tilley, 1997). Incorporating complexity into the research process is also based on the understanding that policy programmes can have multiple outcomes, in terms of both intended and unintended consequences. The moral and political dimensions of research are thus expanded beyond the premise that if a programme is deemed effective by a pre-determined outcome measure it is therefore ethically sound.

Staking a claim for the ability of qualitative research to address questions of causality is often associated with a realist approach, where instead of the positivist conceptualization of causality as a predictive endeavour, it is understood as generative and explanatory in nature, entailing the investigation of context and causal mechanisms. In this sense realist qualitative research bridges positivism and interpretivism, as in its mainstream version it is based on an ontological acceptance of reality but a constructivist epistemology that premises our understanding of the world as imperfect and partial (Bhaskar, 1989; Kazi, 2003; Maxwell, 2012). From a policy research perspective, this involves steering a path between generalization and 'the particulars of specific measures in specific places relating to specific stakeholders' (Pawson and Tilley, 2004: 17). Going further, Hedström and Ylikoski (2010: 61) suggest that theory generated this way is implicitly mid-range in nature (Merton, 1957), because it can be 'used for partially explaining a range of different phenomena, but it makes no pretence of being able to explain all social phenomena, and it is not founded upon any form of extreme reductionism'. In order to build such explanatory models, a realist methodology 'endorses much of hermeneutics, but... also insists on non-discursive, material dimensions to social life' (Sayer, 2000: 17–18). Sayer (1992: 243) describes how this might happen in 'intensive' research designs, where questions might be asked such as 'What produces a certain change?' and 'What did the agents actually do?' The researcher thus seeks to go beyond the perspectives of participants and to find ways of examining the context they are acting within. Ethnography has much to recommend it in seeking to answer such questions, particularly because it focuses on the 'meanings, functions and consequences of human actions and institutional practices, and how these are implicated in... wider contexts' (Hammersley and Atkinson, 2007: 3). However, as Povall (2006) states, ethnographic studies of how frontline workers translate policy into practice are few and far between.

In this article I will discuss some of the findings of such an ethnography, which has taken place in community mental health services in England. My aims in this article are two-fold: firstly to highlight the potential usefulness of a realist ethnographic approach for examining the implications of policy programmes; secondly and more specifically, to describe some of the theoretical considerations about a particular mental health policy, Community Treatment Orders (CTOs), which emerge from the study data. In doing so, I will draw upon some aspects of Pawson and Tilley's (1997) framework for realist policy research which takes a 'configurational' approach to causality by considering context, mechanisms and outcome patterns. CTOs are a good example of a complex policy programme that brings with it a range of ethical dilemmas for the practitioners who implement it, and the ideas presented here go some way towards the formulation of a theory on how CTOs may or may not work for practitioners and service users alike.

Community Treatment Orders: Policy and research

CTOs have slowly but steadily become the norm for community mental health regimes across the world, and are now present in over seventy different jurisdictions, including the US, Australia, New Zealand, Sweden, Canada, Scotland and Israel. Most recently, CTOs were introduced in England and Wales as part of the 2007 Mental Health Act. There are three main policy drivers behind the introduction of CTOs, namely resource constraints, risk management and recovery. Firstly, CTOs are aimed at breaking the costly cycle of 'revolving door' service users who have a history of non-compliance and who go through rapid and continuous cycles of release, deterioration and re-hospitalization. Secondly, the introduction of CTOs is also linked to a perceived need to monitor some individuals more closely, against a background of public concerns around risk and safety, following high-profile cases of homicides by individuals diagnosed with a severe mental disorder. Thirdly, and perhaps unexpectedly considering the tension between 'control-focused' policies such as CTOs and the well-embedded discourse of self-determination and recovery in mental health, CTOs are associated with the on-going project of deinstitutionalization and the associated goal of supporting people to live meaningfully in the community. Indeed, CTOs can be positioned as the latest in a long line of community care policies in England, stretching back to the early 1990s.

CTOs in England and Wales give mental health practitioners the power to impose conditions on how certain service users live in the community, particularly in regards to medical treatment, and provide a mechanism for detention and treatment enforcement. An individual can only be placed on a CTO immediately following a period of hospitalization under a treatment section of the Mental Health Act 1983 (usually Section 3). The hospital team decide, in conjunction with the community team, whether the service user's history and current presentation merit the use of a CTO. The final decision is formally made by the Responsible Clinician (usually the treating psychiatrist) and an Approved Mental Health Professional (AMHP).[1] Unlike in the US, the criteria for applying a CTO are broad and loosely defined; put briefly, an individual must be suffering from a mental disorder, treatment is necessary for theirs or others' health and safety, such treatment can be provided in a community setting, and the Responsible Clinician requires the power to bring the individual back to hospital for treatment when necessary (this is called recall). When an individual is placed on a CTO, they are given a set of conditions to which they have to adhere. Two mandatory conditions apply, which mean the service user must be available for medical examination when required. Other conditions commonly include adherence to medication and to appointments with the community team (Lepping and Malik, 2013). However, these conditions vary depending on the individual's circumstances (i.e. other examples of conditions are abstinence from drug/alcohol use and residence at a certain address). If the service user breaches a condition, or is deemed to be mentally deteriorating, they may be recalled to hospital for up to 72 hours at the Responsible Clinicians' discretion. At this point, the service user may be discharged back into the community on the CTO, or the CTO may be revoked and they are kept in hospital under their original Section for a longer period of treatment. The initial CTO lasts for six months, at which stage a decision is made by the Responsible Clinician, an AMHP and the community team whether to renew it or not. After a period of a year, the CTO is renewed on a yearly basis, but can be reviewed and discharged at any time. Service users have an automatic right to appeal that correlates with the renewal of the CTO: the appeal is heard in front of a local panel appointed by the area Mental Health Trust; they also have additional rights of appeal to a higher Tribunal. The Care Quality Commission's (2013) latest findings suggest the numbers of successful appeals are very low, with 84 percent of Tribunals in 2010–2012 upholding the CTO.

Within this framework, there is considerable room for practitioner discretion, and prior to the introduction of CTOs in England, opponents campaigned unsuccessfully for them to be subject to tighter legislation (HL Hansard, 2007). More generally, both in England and the wider international community, opinion on CTOs is strongly divided, with opponents fearing that an extension of compulsion into the community may result in unnecessary coercion, a loss of liberty and rights for service users, and the neglect of alternative, less coercive methods of engagement (Brophy and McDermott, 2003; Geller et al., 2006; Pilgrim, 2007). In England, these concerns led to an unprecedented lobbying exercise by the Mental Health Alliance, an umbrella organization expressly formed to temper what was viewed as a 'doggedly authoritarian' piece of legislation (Pilgrim and Ramon, 2009: 278). However, the Government stance was weighted towards supporters of CTOs, who argued that they helped to engage service users who are hard to reach and/or considered a risk, facilitated community-focused care, reduced rates and length of detention, encouraged better treatment, improved clinical outcomes and promoted recovery (Lawton-Smith et al., 2008; Munetz and Frese, 2001; O'Reilly, 2006).

The majority of international research on CTOs has conformed to the typical approach in health policy research by seeking to determine their effectiveness in regards to readmission rates, length of hospital stay and treatment compliance. Most of this research consists of 'before and after' studies (Geller et al., 1997; Muirhead et al., 2006; O'Brien and Farrell, 2005), which in general show a clinical improvement in those made subject to a CTO, but have also been criticised for serious methodological deficiencies (Kisely et al., 2005). Matched (Kisely et al., 2004; Preston et al., 2002) and controlled studies (Steadman et al., 2001; Swartz et al., 2001) have been more equivocal in their findings, concluding that CTOs result in little or no difference in level of service use or service user functioning. The equivocality of the research literature and the consequent claims of both proponents and opponents of CTOs that the overall findings support their particular standpoint, suggests that using experimental methodologies to ascertain causality brings with it significant issues. Indeed, the Steadman et al. (2001) RCT ran into difficulties because they were not able to separate out the 'active' component under study from other factors. More recently, following the introduction of CTOs in England, the Department of Health commissioned a national RCT to investigate the efficacy of CTOs, which found that CTOs did not influence hospitalization rates (Burns et al., 2013), although again, the study encountered methodological challenges. In a broader sense, RCTs that focus on outcomes such as hospitalization rates do not account for more complex CTO outcomes.

Although a small amount of qualitative research on CTOs has taken place (Brophy and Ring, 2004; Gibbs et al., 2006; O'Reilly et al., 2006), this has tended to focus mainly on the perceptions and views of practitioners, service users and carers. Whilst such research provides a valuable insight into how CTOs might be experienced, it does not illuminate what CTO practice looks like, and how subjective experience and actual events interrelate. As Swanson

(2010: 185) states, ‘to understand a topic as important and complex as... OCLs^2... we could use an ethnographic accounting... to situate the story of OCLs in the particular context of social actors and groups and the social matrices of their thought and behaviour’. In addition then to the more general argument that can be made about the potential usefulness of policy ethnographies, the conclusion that may be reached here is that there is also a recognized and specific place for ethnography in the study of CTOs. Therefore the aim of my described study is to discover how CTOs have been enacted and with what effects on service users and practitioners.

The study

Fieldwork took place within two English NHS Mental Health Trusts over a period of eight months, with time being split equally between each Trust. To maintain the familiarity necessary for ethnography, the majority of time was spent embedded within one Assertive Outreach Team in each Trust. I was the sole researcher in the field, and each week was split between the two Teams to ensure consistent and longitudinal contact over the eight-month period. Being a social worker who had little previous experience in mental health practice, I could be described as on the inside ‘out’ (White, 2001: 104), and it took a number of careful preparatory meetings with service users before I felt enough trust had been built to ask them to participate in the research. With practitioners I became aware that I would sometimes slip into ‘coded language and communication’ culturally common to myself and the participant (Kanuha, 2000: 443) and had to consciously remind myself to question what was held as self-evident. The keeping of a personal fieldwork diary and debriefing sessions with colleagues helped me to work through these issues and my sometimes contradictory thoughts and feelings on how I could see CTOs being used.

Because the main purpose of Assertive Outreach Teams is to work with ‘difficult to engage’ service users, they can attract a high volume of CTOs, and thus were selected on the basis that they would provide ample opportunity to observe CTO practice. At the time of fieldwork both teams carried on average a third of their caseload as CTOs. A case study approach was taken, with 18 CTO cases across the teams being tracked over the fieldwork period; this enabled CTO cases to be followed as they unfolded in different ways, thus forming the basis of an analysis of generative mechanisms. CTO cases were chosen to reflect a range of characteristics, perspectives and CTOs at different stages, although this was naturally constrained by concerns with risk and vulnerability. The core of the study data derived from these cases and includes observations of key meetings, taking of notes from case files and semi-structured interviews with the service user, their care coordinator, the social worker and the psychiatrist involved with their case. The research took place in stages. First, the service user at the heart of the case was interviewed near the beginning of the fieldwork, before professional interviews and observations were carried out. This allowed the service user time to consolidate their familiarity with me before the observations took place, and for them to be given an opportunity to voice their views on how the fieldwork might progress. Interviews with service user participants mostly took place within their homes and repeat interviews were carried out with a third of the service users whose legal status changed during the fieldwork period. The second stage involved interviews with practitioners, which took place within their work environment. All interviews were recorded and fully transcribed. On average, two observations of meetings per case (32 altogether) took place, which included attendance at Tribunals, CTO reviews, hospital discharge meetings and other less formal one-to-one meetings between care coordinators and service users in their homes. Due to the ethical restrictions in place, these meetings were not recorded, but hand-written notes were taken both during and after the meetings. Written notes were taken on paper and electronic case files, with information only pertaining to the use of CTOs recorded. Contextual information on the use of CTOs was also collected via key informant interviews with relevant practitioners, field notes of daily team practice and observations of team meetings. Ethics approval was given by the national Social Care Research Ethics Committee and consent was given by all participants for each of the separate aspects of the study.

Participants

Fifty-four participants were involved in the study; 18 were service users, 20 were practitioners working with those service users and 16 practitioners were key informants only, recruited either because they were able to provide an overview on the use of CTOs (e.g. clinical leads/managers), or because they helped to answer interesting questions that were raised during the fieldwork period.

Two-thirds (12) of the service users were male, as reflects the national and international trends on gender and CTOs; almost all (16) identified as White British, which was indicative of the ethnic make-up of the field sites; and most (14) were in their forties or fifties. All of the participants had been involved with services for a number of years and had been diagnosed with some enduring form of psychosis. As might be expected given the well-documented social exclusion and stigma experienced by this group, the majority of the participants were socially isolated, with little in the way of support from family, friends or the wider community. Most participants had only been on one CTO, although a sizeable minority (7) had experienced two or more. The reasons why an individual may experience multiple CTOs are varied, but for these participants, the pattern of being taken off and on a CTO took the form of two distinct pathways. Either participants had been recalled back to hospital, had the original CTO revoked and then a new one instated when they were discharged from hospital, or it had been decided at a CTO review that there was no reason for them to be on a CTO and then subsequently, they relapsed and experienced a hospital admission, at which stage it was decided to place them back on a CTO once discharged to the community. These experiences meant those particular service users were able to describe their experiences of CTOs in some depth, both relating to the present and the past. The length of participants' current CTO ranged from three months to just over two years.

Out of the 36 practitioners, 20 were female and 16 male, and gender was weighted towards women among all professional groupings, except for the psychiatrists. The largest professional group represented was social work (16), with nurses making up the majority of the remainder of participants (12). This was due to a conscious effort to rebalance previous research that has tended to focus more on the psychiatric perspective, and to understand CTOs as embedded in daily practice. A wide range of practice experience was demonstrated, with 40 years being the longest time working in mental health services and one year the least.

Analysis

A combination of thematic and narrative analysis were employed, in recognition of the need to create a network of patterns across cases but also to represent the ways that individual participants experienced and understood the progress of CTOs over time (Floersch et al., 2010). Atkinson et al. (2003: 108) comment that 'the strict dualism between "what people do" and "what people say"' is not conducive to creating an authentic account of their lives; instead narratives help make agency meaningful (Merrill, 2007). This aligns with an understanding of causation as constituted by the interplay of context and action, or in theoretical terms, structure and agency. Within the research, this meant that when service users talked about their past experiences, for example of forced medication, those structurally constituted events informed how that person made sense of their treatment in the present, which in turn yielded consequential realities for service delivery in the near future. Thus, key to the analysis was the process of connecting participant meaning-making about past and present experiences with CTO mechanisms as they occurred, in order to delineate causal pathways. Vollmer (2005: 204, original emphasis) makes such a point about the sequencing of narratives when he argues 'our self stories are about things that took place in real historical situations and in encounters with real other people *before* appearing in our autobiographies. These are things that our stories interpret and make sense of, but do not *create*'.

By using both thematic and narrative analytical approaches, CTO 'story-lines' became apparent, where similar narratives were clustered along the lines of contextual, interpersonal and individual factors. I managed this process by drawing on McCracken's (1988) suggestions for analysis, which involves a close line by line reading of texts to understand first order concepts before moving on to develop second order concepts which have been developed into a thematic framework, made up of concept groups. As a practitioner I felt more 'at home' with professional perspectives and so began this process by analysing service user interviews so that I could explore the data from a less familiar starting point. Once I had developed a foundational framework from this data, I repeated the process firstly with practitioner interviews, and then with the observations, thus moving from first person viewpoints through to enactments of the CTO process. At the same time, I created and built up configurational 'maps' of CTO narratives (Sayer, 1992), filtered through the themes emerging out of the three sets of data and illustrated by the progress of individual cases through CTO 'turning points'. In this way, by moving through time and between first person and observational data, I was able to see how the factors that surfaced during the thematic analysis crystallized in the process of individuals interacting with CTO mechanisms, thus leading to the formation of a CTO typology. In turn, following the narratives highlighted the kinds of outcomes that came of these interactions. Just as importantly, returning to the interview data shed light on how those outcomes were perceived in partial and differential ways by practitioners and service users. In summary, I was able to develop a typology of CTOs, that explained how practitioners and service users interacted with CTO mechanisms, and the factors that influenced those interactions, thus forming distinct causal pathways.

Findings: CTOs in practice

Whilst I will not attempt to represent CTOs in all their complexity, the findings presented here will highlight some of the significant facets of their use and present them not as a singular event, but a dynamic process. Despite what the policy framework suggests about how and why CTOs should be used, the reality of CTO practice differed considerably in both the range of purposes CTOs were put to and how they were enacted by practitioners and service users. Although service users do not have to formally consent to being placed on a CTO, the Department of Health (2008) suggests it is best practice for service users to be prepared to co-operate with treatment; in both field sites this was not always the case. An observation of general and case-specific practice supported by the interview data, led to the development of a typology of CTO cases that captured the ways that individuals might respond to the CTO taking into account contextual factors, and how practitioners in turn managed the progress of the CTO. The typology has been developed in terms of two dimensions: active/passive and acceptance/resistance. Passive acceptance refers to a situation where the individual may not actively invest in the CTO, but places faith in professional judgement. Passive resistance occurs when an individual may express 'low-level' unhappiness about being on a CTO, but does not attempt to defy CTO mechanisms. Both of these categories point to factors such as current and prior experiences of authority and institutionalization, as well as problematizing professional expectations that the CTO will generate motivation, engagement and a sense of responsibility. Two other categories were also created: (1) ambivalence, which refers to individuals who vacillated between the dimensions and who therefore raised particular dilemmas around the possibility of 'never-ending' CTOs; and (2) subversion, where individuals 'played the CTO game' in order to create outcomes that suited them, in opposition to practitioner wishes and in such a way as to create a sense of opaqueness and uncertainty for practitioners in understanding their actions.

With the aim of exploring in relative depth how service users and practitioners positioned themselves within my proposed typology, I will focus upon the categories of ‘active acceptance’ and ‘active resistance’. The latter categories were chosen because they provide the sharpest contrast of the potential CTO pathways.

Active acceptance

Those participants who could be categorized as ‘actively accepting’ had clear ideas of what purposes the CTO held for them and accepted the CTO framework of regular antipsychotic medication and meeting with practitioners as helping them realize those purposes. Actively accepting participants’ conceptualizations of CTO purpose were aligned with professional understanding of the CTO (promoting recovery, responsibility, managing risk) and/or personal beliefs about the advantages the CTO brought (protection of rights, security). The following examples demonstrate that becoming actively accepting of the CTO was a process dependent on certain factors. James had shaped the CTO by placing himself at the centre and taking ‘ownership’; one telling observation of this was at James’ care review where the psychiatrist wondered whether the CTO was a ‘security blanket’ for James, and James after a long pause, carefully responded ‘it’s like a ring (pointing to his finger). I’ve made a promise and it was a choice for me to do that’. James did not see the CTO as being ‘done’ to him, and he demonstrated considerable agency in making the reality of the CTO fit with his conception of it. The role of medication and the ways it is administered were central to both how the CTO works and how it is perceived. CTOs generally work by practitioners taking charge of medication decisions, which caused considerable feelings of dissonance for James. By choosing to have his medication given by his community-based physician (GP), instead of by the team, James made the decision to take back control of his medication. He explained,

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

James’ creative resolution of the tension between his perception of the CTO and how it was practiced highlights the importance of meaningful medication choice within the CTO framework to support positive outcomes. For James, making this choice was a recovery-orientated step which supported him ‘settling down’ and achieving stability.

Becoming actively accepting of the CTO was not only associated with individuals being able to negotiate medication decision-making, but also with them holding a collaborative relationship with professionals. These aspects reinforced each other. For example, Sarah had been on two CTOs and distinguished her current (positive) experience from her last CTO, which ended in re-hospitalization. That CTO had been experienced by Sarah as a traumatic, coercive, highly negative event, associated with being made to have an antipsychotic injection for the first time, and having her views ignored: ‘the first time they put me on an injection with the CTO I begged them not to, I didn’t really want it at all, the side effects were really bad’. Through conducting interviews with Sarah and her care coordinator, it was evident that the current CTO was based on a ‘mutuality of accounts’ (O’Neill, 1994) developed through ongoing explanation, discussion and reassurance about what the CTO would mean. Hence even though there were disagreements about diagnosis and treatment, a joint recovery-focused aim of creating stability for Sarah was emphasized, as she explained to me, ‘I’m quite happy to take this… it’s an oral medication, I haven’t had it before and I’m assured that the side-effects are better. It’s something to keep me out of hospital, that’s the main aim for the team and myself’. This interplay between contextual experiences and the way in which the CTO was explained and negotiated by practitioners in the present was a significant aspect of the causal pathway a CTO might take. All participants recounted negative experiences of services in the past, but James and Sarah, who were actively accepting of the CTO, had managed to ‘bracket off’ (Brown and Calnan, 2012) such experiences by developing mutual positive regard with the professionals working with them. Subsequently this cultivated trust that the CTO would work in their favour.

Although individuals who actively accepted the CTO were seen as the least ‘problematic’ by practitioners, one issue that did arise throughout the fieldwork period was how to manage discharge in such cases. It has been noted that CTOs can bring dilemmas around discharge (Mullen et al., 2006), as one social worker phrased it succinctly, ‘if you’re doing well on meds, you stay on, if you keep being recalled, you stay on’. However, policy guidance (Department of Health, 2008) states that practitioners should use CTOs the least restrictive way with service users. In case discussions I noted a pattern of uncertainty in practitioner discussion of individuals who actively wanted to remain on the CTO, in terms of how and if to bring about CTO discharge. Because the CTO is compulsory, if service users were happy with their treatment and had good relationships with professionals, practitioners found it difficult to see what role the CTO played and were concerned that it could lead to further dependency; at the same time they recognized it offered meaningful security to service users. A psychiatrist remarked how in such cases it became ‘quite a battle to convince them the CTO had run its course’. With individuals who actively accept CTOs, there is the possibility of a reverse relationship between compulsion and coercion, where respect for autonomous decision-making might mean maintaining the CTO. Observation of care reviews suggested that careful and tactful negotiation was needed in these circumstances to persuade service users that discharge should occur.

Active resistance

By way of contrast, for service users who I categorized as ‘actively rejecting’ of the CTO there was little overlapping of their position with that of professionals, as they rejected the drivers behind the use of CTOs and consequently the institutional means it signified. Active rejection was enacted in two ways: working within the system, by using every legal avenue available to challenge the CTO, and working outside the system, by acting like the CTO did not exist (avoiding appointments, disregarding notices of recall to hospital and eventually being recalled by the police). Individuals who actively rejected the CTO were the least represented out of the participants due to the negative view they held of any activity associated with services. However, observation of daily team practice and discussion with practitioners suggested that such cases repeatedly raised significant ethical and practical issues for the teams. For a defined group of cases in both field sites, the recall mechanism of the CTO was used on a monthly basis to hospitalize individuals for compulsory medical treatment. In practical terms, coordinating recall could be a difficult and time-consuming task where practitioners in both sites often struggled to convince other agencies, such as the police, of the role they should play in the process. Ethically, repeat recalls raised issues for practitioners on what the CTO was supposed to be used for. As a nurse put it in a team meeting, constant recall was, ‘against the spirit of the CTO, it should be about managing things differently, so if we’re recalling all the time that’s not a good thing is it, because collaboration should be at the heart of CTO care planning’. Here we can see that contrary to what may be expected of CTO practice, attempting to work alongside service users within its framework was important to practitioners. Broader institutional issues influenced the nature of recall and thus helped to reinforce cycles of active resistance. Bed numbers in mental health units in the UK have steadily decreased whilst compulsory admissions have continued to rise (Keown et al., 2011) and in the field sites this was reflected in a fast recall turnaround for those who were ‘regulars’. A social worker in one of the teams commented,

> If you recall someone often there should really be a review to ask why it’s not working and figure something out: that would be best practice. But what actually happens is someone gets recalled, gets their meds, a brief review by inpatients and then they’re out.

Such discomfort with how CTOs could be used highlights the more fundamental consequences policy tools like CTOs can have for ways of working. Assertive Outreach is premised on working with individuals in their environment, meeting frequently over a sustained period of time, using a needs-focused approach (The Sainsbury Centre, 2001). Within this context, a team psychiatrist worried that CTOs ‘can be deskilling for the team, because it can make us lazy, we don’t have to try and engage’. Although CTOs could be seen as a ‘natural fit’ for the individuals who accessed Assertive Outreach services, they could also represent more of an emphasis on 'surface' practice (Howe, 1994) based on legal rather than relational work.

Professional decision-making in these cases depended on how practitioners perceived the balance between the harm they believed CTO-related coercion was causing versus the aims they felt it was achieving. This bioethical framework for practice was constituted not only around risk management but also a paternalistic concern for protection, as can be seen in the following case. After a particularly fraught Tribunal hearing when Sheila had tried and failed to be taken off her CTO, her care coordinator justified the Tribunal's decision to me in terms of,

> She's not a risk to others or really to herself, but it's a really tight-knit community where she lives and everyone knows her. She'd only just built up trust again there and now ... So I think it's about supporting her in the community really.

The team had successfully made the argument to the Tribunal that the continuation of the CTO was necessary, not because Sheila was a risk to herself or others, but because it protected her from acting in such a way that led to her being stigmatized. Sheila had developed a converse view of the CTO, which was strongly grounded in her experiences of services over the years and her rejection of a biomedical model of mental illness and associated treatment; over the fieldwork period, I attended three (unsuccessful) appeals that Sheila brought and witnessed the anger and distress the CTO caused her. She had been on and off a CTO since they were first introduced five years earlier and to her it represented the stigma of being 'under the Mental Health Act', which she felt stopped her from 'getting on with my life like a normal person would get on with their life'. The CTO was perceived by Sheila as a significant block to her strongly felt desire of having no further contact with mental health services. Sheila's care coordinator had accepted that the CTO meant Sheila could not see her as 'on my side' and their relationship would remain strained as a result. In this sense, the CTO could act to reinforce the distrust and relational barriers that already existed between actively resistant service users and practitioners. Even so, for practitioners who were working with service users like Sheila, the CTO was seen as the de facto choice, due to the perceived inevitable consequences of not using the CTO (disengagement, heightened risk and/or vulnerability) and the 'short-cut' the CTO provided to compulsory admission if needed, as recall has a lower threshold than a formal Mental Health Act assessment. In those cases, such factors outweighed the distress the CTO caused to the individual and discharge was not discussed with any hope by either practitioners or service users. Conversely, in other cases of active resistance where professionals had developed meaningful and functional ways of connecting with individuals prior to the CTO being used, the advent of the CTO was construed as the cause of resistance and associated disengagement. Rebuilding a mutual sense of trust and moving the relationship away from a 'surface' focus on monitoring, involved practitioners disassociating themselves from the CTO[3] and discharging from it as soon as possible. Craig was discharged from his CTO during the fieldwork period and

I observed there was a notable difference in the way he and his care coordinator interacted with each other in meetings before and after discharge. In a later interview his care coordinator reflected on the effect of the CTO on their developing relationship and the decision to discharge:

> The CTO decimated his relationship with services, it's a sledgehammer to crack a nut. He just became really lacking in trust and really defensive, every time I'd visit him he'd have a notepad there, writing everything you said. So we decided to take a different approach and give him back some control; we worked out a bit of an advanced decision together ... It's about positive risk-taking and being honest and managing it together.

For Craig having a 'fresh start' without the CTO meant for him that 'we've turned it around pointing in the right direction for once' towards a place where he felt he had more choice over medication. In a mirror image to how practitioners worked with service users who accepted the CTO, discharging the CTO could act as a way for practitioners and resistant service users like Craig to find a 'mutual account' within which they could work together.

Discussion

Drawing on Pawson and Tilley's (1997, 2004) framework for policy evaluation we can understand how the findings of this study may support knowledge generation on the ways CTOs might or might not work (mechanisms), with who, in what circumstances (context), and with what consequences (outcomes). The typology can thus be seen as a gateway to understanding how the interplay between structure and agency in CTO pathways informs a conception of generative causality. More specifically, it can be said that context affects the way individuals respond to the programme concept, which in turn influences the ways they interact with programme intervention strategies, which then delineates outcomes. As has been suggested in the findings, the constituting power of individual response and subsequent action in shaping outcomes refers not only to service users, but also to practitioners.

Pawson and Tilley (2004: 8) warn that 'context should not be confused with locality. Depending on the nature of the intervention, what is... significant may not only relate to place but also to systems of interpersonal and social relationships'. Therefore, what is deemed contextually salient refers both to the characteristics of those individuals made subject to a policy programme and the institutional and micro-social factors that mediate their experiences. Individual responses to the CTO are influenced by complex interactions between personal values and beliefs, and past and present experiences of services, medication and relationships with professionals. A key factor that influences individual response to the CTO is how medication is managed and negotiated. Research has suggested that there is a correlation between CTOs and the increased use of antipsychotic injections (Care Quality Commission, 2010), which are likely to be experienced by service users as more coercive than oral medication (Patel et al., 2010). Through observing decision-making on how CTOs were to be enacted, it appeared that practitioners believed that putting service users on an injection as part of their conditions was central to making the CTO 'work'. However as the findings suggest, for service users, actively accepting the CTO and making it 'work' in their terms could depend on medication choices remaining broad and practitioners acting in concordance with them, instead of expecting compliance. Conversely, for individuals who were actively resistant to the CTO, medication had become a point of conflict, characterized by cyclical power struggles. Underpinning both responses is the nature of the relationship service users hold with practitioners and how that may mitigate or exacerbate responses to compulsion, a finding which reflects the body of research (see Newton-Howes, 2010) on how the experience of coercion can be alleviated by interactive processes. In this study, practitioners broadly held the view that with a small group of actively resistant service users, their beliefs on mental health and how best to manage it would always place them at odds with mental health services. Even so, it was demonstrated that with skilled work, practitioners and service users could construct a mutually conducive narrative of how the CTO might meet shared goals, or in the case of some actively resistant individuals, accept together that the CTO was inhibiting rather than helping bring positive change. As Longhofer and Floersch (2012: 508, original emphasis) suggest, 'Discourse… *enables and limits* social work action as meaning is continuously produced and communicated in the structured dynamics among and between practitioners and clients'. In this sense, the connection practitioners and service users did or did not make with each other was a central generative driver of how and why the CTO was manifested.

How CTOs are responded to by those made subject to them affects the ways in which CTOs are operationalized; programme mechanisms are the '*process* of how individuals interpret and act upon the intervention strategies' in order to generate change (Pawson and Tilley, 2004: 6, original emphasis). As a programme, the CTO deploys a number of intervention strategies, the most prominent after medication administration being the ability to recall individuals to hospital when deemed necessary. What the findings suggest is that there is an intervention paradox at the heart of CTO use for the two categories of actively accepting and resisting service users, which brings with it dilemmas for practitioners. The underlying premise of recall is to compel individuals to behave in a certain way, but such compulsion is unlikely to be necessary for those the CTO is perceived to be working best for, and works least well for those who are deemed to need the CTO most. Mechanisms thus can help to explain a policy programme's failure as well as its success, or indeed as with the persistent use of recall, potentially a mixture of both. In a broader sense, we can infer that not only does context act on programme mechanisms, but the way mechanisms are used may also shape context. It has long been argued that a preoccupation with risk has become central to mental health practice (Kemshall, 2002), but the practitioners I spoke to saw their work in Assertive Outreach as 'deep' practice necessitating relational skills. The potential for recall was seen as supportive of such practice if used judiciously, but could also reinforce 'shallow' practice and limit the use of alternative strategies. Outcomes of policy programmes can thus be seen as not only applying to those on the receiving end of interventions.

As has been alluded to throughout this discussion, outcome-patterns constitute both the intended and unintended consequences of policy programmes and arise from the relationship between programme mechanisms and contexts (Pawson and Tilley, 2004). However, what is also clear is that it is important to explore what outcomes are deemed as 'positive' or 'negative'. During the fieldwork there was substantial variation in how different participants, across both practitioner and service user groups, perceived outcomes. For those individuals whose active resistance to the CTO regularly triggered the recall mechanism, practitioners might think of it as a 'failed CTO' because it has exacerbated rather than mitigated the 'revolving door' cycle, leaving individuals with less stability in the community, and costing time and resources. Certainly, the usual outcome measure used in CTO research of hospitalization rates would not be deemed a success with this particular group. An alternative view was if repeat recalls means service users are regularly taking medication and staying relatively well, then the CTO is working in lowering their risk to themselves and others. By thinking about outcomes in this way, we are able to both elucidate the variety of outcomes that can occur through context-mechanisms interactions, but also consider outcomes in more complex and partial terms, taking into account the ethical balancing act practitioners may face.

Conducting an ethnographic study has enabled the causal pathways that CTOs might take to be illuminated. This is not to suggest the approach taken does not have limitations; immersion in practice settings by its nature, combined with my own identity as a social worker, means that I developed an understanding of policy that was more from the standpoint of practitioners than service users. In addition, the CTO process is spatially disparate and it was not always possible for me to access certain events or people which would have helped to cultivate a fully rounded conception of CTOs. Despite this, returning to a point made in the introduction, creating an account of causality from a realist perspective is essentially generative and based on explanatory power, but does not claim to be the final or full account of phenomena. Through incorporating a range of methods in a longitudinal and intensive research design however, ethnographers can produce a thick description (Geertz, 1973) which creates a sense of verisimilitude (Denzin, 1989). For social work therefore, realist ethnographies of policy implementation can draw attention to the myriad influences and processes practitioners negotiate when enacting policy, as well as the responses of service users who are affected by the policy and how this in itself shapes the pathways that policy-in-action might take.

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Notes

1. AMHPs are most often social workers who have additional statutory powers. They provide a social perspective to counterbalance the medical influence in formal decision-making, most commonly in deciding whether to commit an individual to hospital under a Section of the Mental Health Act.
2. The terms used for CTOs vary from country to country. In the US, one term used is Outpatient Commitment Laws (OCLs).
3. This is possible in England and Wales as the original decision to place a CTO is ultimately taken by the inpatient Responsible Clinician. Best practice is deemed to be involving the community team in the decision, but this does not always occur.

References

Atkinson P, Coffey A and Delamont S (2003) *Key Themes in Qualitative Research*. Walnut Creek, CA: Alta Mira.

Bhaskar R (1989) *Reclaiming Reality: A Critical Introduction To Contemporary Philosophy*. London, UK: Verso.

Brophy L and McDermott F (2003) What's driving involuntary treatment in the community? The social, policy, legal and ethical context. *Australasian Psychiatry* 11(1): 84–88.

Brophy L and Ring D (2004) The efficacy of involuntary treatment in the community: consumer and service provider perspectives. *Social Work in Mental Health* 2: 157–174.

Brown P and Calnan M (2012) *Trusting on the Edge: Managing Uncertainty and Vulnerability in the Midst of Mental Health Problems*. Bristol, UK: The Policy Press.

Burns T, Rugkasa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, et al (2013) Community Treatment Orders for patients with psychosis (OCTET): A randomised controlled trial. *The Lancet* 381: 1–7.

Byrne D, Olsen W and Duggan S (2009) Causality and interpretation in qualitative policy related research. In: Byrne D and Ragin C (eds) *The Sage Handbook of Case-Based Methods*. London, UK: SAGE, pp. 511–521.

Care Quality Commission (2010) *Monitoring the Use of the Mental Health Act in 2009/2010*. London, UK: Care Quality Commission.

Care Quality Commission (2013) *Monitoring the Use of the Mental Health Act in 2011/2012*. London, UK: Care Quality Commission.

Denzin N (1989) *Interpretive Interactionism*. Newberry Park, CA: SAGE.

Department of Health (2008) *Code of Practice: Mental Health Act 1983*. London, UK: The Stationary Office.

Floersch J, Longhofer J, Kranke D and Townsend L (2010) Integrating thematic, grounded theory and narrative analysis: A case study of adolescent psychotropic treatment. *Qualitative Social Work* 9(3): 407–425.

Geertz C (1973) *Interpretation of Cultures*. New York, NY: Basic Books.

Geller J, Fisher W, Grudzinskas A, Clayfield J and Lawlor T (2006) Involuntary outpatient treatment as 'deinstitutionalised coercion': The net-widening concerns. *International Journal of Law and Psychiatry* 29(6): 551–562.

Geller JL, McDermeit M, Grudzinskas Jr AJ, Lawlor T and Fisher WH (1997) A competency-based approach to court-ordered outpatient treatment. *New Directions for Mental Health Services* 75: 81–95.

Gibbs A, Dawson J and Mullen R. (2006) Community Treatment Orders for people with serious mental illness: A New Zealand study. *British Journal of Social Work* 36: 1085–1100.

Hammersley M and Atkinson P (2007) *Ethnography: Principles in Practice* (3rd edn). London, UK: Routledge.

Haynes L, Service O, Goldacre B and Torgerson D (2012) *Test, Learn, Adapt: Developing Public Policy with Randomised Controlled Trials*. London, UK: The Cabinet Office.

Hedström P and Ylikoski P (2010) Causal mechanisms in the social sciences. *Annual Review of Sociology* 36: 49–67.

HL Hansard (2007, January 17) Vol. 688, col. 701–703.

Howe D (1994) Modernity, postmodernity and social work. *British Journal of Social Work* 24(5): 513–532.

Kanuha VK (2000) 'Being' native versus 'going native': Conducting social work research as an insider. *Social Work* 45(5): 439–447.

Kazi M (2003) *Realist Evaluation in Practice: Health and Social Work*. London, UK: SAGE.

Kemshall H (2002) *Risk, Social Policy and Welfare*. Buckingham, Open University Press.

Keown P, Weich S, Bhui KS and Scott J (2011) Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England: Ecological study. *British Medical Journal* 343: 196.

Kisely SR, Campbell LA and Preston NJ (2005) *Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders*. Available at: http://www.cochrane.org/reviews/en/ab004408.html (accessed 17 December 2009).

Kisely SR, Xiao J and Preston NJ (2004) Impact of compulsory community treatment on admission rates: Survival analysis using linked mental health and offender databases. *British Journal of Psychiatry* 184: 432–438.

Lawton-Smith S, Dawson J and Burns T (2008) Community Treatment Orders are not a good thing. *The British Journal of Psychiatry* 193: 96–100.

Longhofer J and Floersch J (2012) The coming crisis in social work: Some thoughts on social work and science. *Research on Social Work Practice* 22: 499–518.

Lepping P and Malik M (2013) Community treatment orders: Current practice and a framework to aid clinicians. *The Psychiatrist* 37: 54–57.

McCracken G (1988) *The Long Interview*. Qualitative Research Methods Series 13, Newberry Park, CA: SAGE.

Maxwell J (2012) The importance of qualitative research for causal explanation in education. *Qualitative Inquiry* 18: 655–661.

May C (2005) Methodological pluralism, British sociology and the evidence-based state: A reply to Payne et al. *Sociology* 39(3): 519–528.

Merrill J (2007) Stories of narrative: On social scientific uses of narrative in multiple disciplines. *Colorado Research in Linguistics* 20: 1–25.

Merton R (1957) *Social Theory and Social Structure*. New York, NY: Free Press.

Muirhead D, Harvey C and Ingram G (2006) Effectiveness of community treatment orders for treatment of schizophrenia with oral or depot antipsychotic medication: Clinical outcomes. *Australian and New Zealand Journal of Psychiatry* 40: 596–605.

Mullen R, Dawson J and Gibbs A (2006) Dilemmas for clinicians in the use of Community Treatment Orders. *International Journal of Law and Psychiatry* 29: 535–550.

Munetz MR and Frese FJ (2001) Getting ready for recovery: Reconciling mandatory treatment with the recovery vision. *Psychiatric Rehabilitation Journal* 25(1): 35–42.

Newton-Howes G (2010) Coercion in psychiatric care: Where are we now, what do we know, where do we go? *The Psychiatrist* 34: 217–220.

O'Brien AM and Farrell SJ (2005) Community Treatment Orders: Profile of a Canadian experience. *Canadian Journal of Psychiatry* 50(1): 27–30.

O'Neill J (1994) *The Poverty of Post-Modernism*. London, UK: Routledge.

O'Reilly R (2006) Community Treatment Orders: An essential therapeutic tool in the face of continuing deinstitutionalization. *Canadian Journal of Psychiatry* 51: 686–688.

Patel M, de Zoysa N, Berandt M, Bindman J and David A (2010) Are depot antipsychotics more coercive than tablets? The patient's perspective. *Journal of Psychopharmacology* 24(10): 1483–1489.

Pawson R and Tilly N (1997) *Realistic Evaluation*. London, UK: SAGE.

Pawson R and Tilly N (2004) *Realist Evaluation*. London, UK: Cabinet Office.

Pilgrim D (2007) New 'mental health' legislation for England and Wales: Some aspects of consensus and conflict. *Journal of Social Policy* 36(1): 79–95.

Pilgrim D and Ramon S (2009) English mental health policy under New Labour. *Policy and Politics* 37(2): 273–288.

Povall S (2006) Policy ethnography: Exploring the local processes of public policy implementation. *Current Developments in Ethnographic Research in the Social and Management Sciences Symposium*, The University of Liverpool Management School, Liverpool, pp. 20–35.

Preston NJ, Kisely S and Xiao J (2002) Assessing the outcome of compulsory psychiatric treatment in the community: Epidemiological study in Western Australia. *British Medical Journal* 324(7348): 1244.

Sayer A (1992) *Method in Social Science: A Realist Approach* (2nd edn). London, UK: Routledge.

Sayer A (2000) *Realism and Social Science*. London, UK: SAGE.

Steadman HJ, Gounis K, Dennis D, Hopper K, Roche B, Swartz M and Robbins PC (2001) Assessing the New York City Involuntary Outpatient Commitment Pilot Program. *Psychiatric Services* 52: 330–336.

Swanson J (2010) What would Mary Douglas do? A commentary on Kahan et al., 'Cultural cognition and public policy: The case of outpatient commitment laws'. *Law and Human Behaviour* 34(3): 176–185.

Swartz M, Swanson J, Hiday V, Wagner H, Burns B and Borum R (2001) A randomised controlled trial of outpatient commitment in North Carolina. *Psychiatric Services* 52: 325–329.

The Sainsbury Centre for Mental Health (2001) *Mental Health Topics: Assertive Outreach*.

Vollmer F (2005) The narrative self. *Journal for the Theory of Social Behavior* 35(2): 189–205.

Wessely S (2006) Randomised, controlled trials. In: Slade M and Priebe S (eds) *Choosing Methods in Mental Health Research: Mental Health Research from Theory to Practice*. London, UK: Routledge, pp. 85–98.

White S (2001) Auto-ethnography as reflexive inquiry: The research act as self-surveillance. In: Shaw I and Gould N (eds) *Qualitative Research in Social Work*. London, UK: SAGE, pp. 100–115.