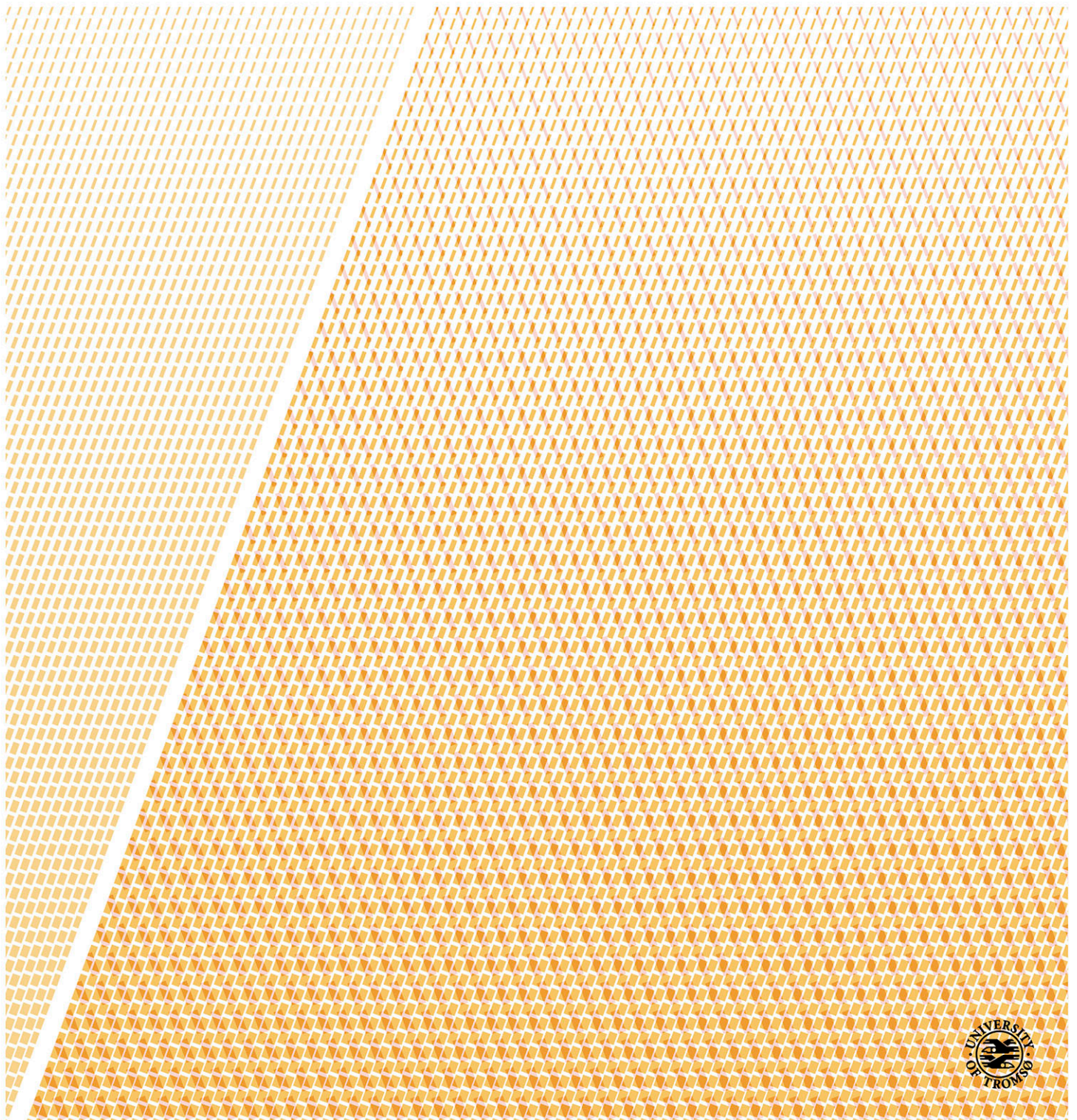


**Community treatment orders in an Assertive
Community Treatment setting:** a qualitative study of
experiences of patients, care providers and responsible
clinicians

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Hanne Kilen Stuen

A dissertation for the degree of Philosophiae Doctor – June 2019



Community treatment orders in an Assertive Community Treatment setting: a qualitative study of experiences of patients, care providers and responsible clinicians

A Dissertation of the Degree of Philosophiae Doctor (PhD) 2019

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Summary

Since 2007, 14 assertive community treatment (ACT) teams have been established in Norway. ACT is a well-established intensive community-based mental health service delivery model to support individuals diagnosed with severe mental illness. Among the 338 patients that were enrolled in ACT during the teams' first year of operation, 38% were subject to community treatment orders (CTOs). The purpose of this study was to investigate how patients', care providers' and responsible clinicians' experienced CTOs in the context of the relatively newly established ACT teams.

CTOs, which is a legal tool to compel patients with severe mental illness to adhere to treatment in the community, have been widely used since the implementation of the Norwegian Mental Health Care Act in 1961. Although patients consider CTOs as a less restrictive intervention than involuntary hospital admissions, recent Norwegian and international studies show that many patients on CTOs feel stuck in a patient role, and many patients report that clinicians' one-sided focus on medication impedes their recovery and transition to a more ordinary life situation. Few studies have explicitly investigated patients' and clinicians' experiences with CTOs and CTO decision making within an ACT setting.

The thesis has a qualitative approach and a descriptive and explorative design, and is part of the research-based evaluation of the 12 first Norwegian assertive community treatment teams. In this study, 15 patients recruited from four ACT teams were interviewed. We also interviewed 8 responsible clinicians (RCs) and conducted four focus group interviews with 20 ACT providers from the same four teams. Case file reviews and observations of selected treatment planning meetings served as a reference point for the interviews, and were also used to validate analyses, but not used as primary data sources.

The focus in the interviews with patients was their descriptions of their daily life, the content of CTOs and experiences with the ACT team's follow-up services. In the individual interviews with the RCs and the focus group interviews, the focus was on the ACT providers' and the RCs' descriptions of their roles and responsibilities in CTO decisions, the enactment of CTOs and the ACT team's follow-up services. The analysis of the interviews and the transcripts from the treatment planning meetings were based on constructivist grounded theory. The results have been published in three papers.

Paper 1 shows that patients have mixed views of CTOs, and that the length of CTOs was a major concern. Although some patients were negative toward the CTO and the need to take medication, some also emphasized that the benefits of receiving practical support and coordinated services from the ACT team outweighed the disadvantages. The ACT team's availability, the flexible combination of interventions, continued care, support and possibility to make choices were described as important improvements compared to traditional (office-based) community mental health services.

In our second paper, we show that the ACT providers and the RCs considered CTOs as a clinical tool to provide continued treatment. CTO follow-up responsibility involves dilemmas and difficult professional judgments. The ACT approach was considered helpful in that it afforded comprehensive and patient-centred support and opportunities to build rapport.

Our last paper shows that the RCs typically used patients' need for treatment to justify the need for CTOs. Nevertheless, in some cases (more frequently for patients with concurrent substance abuse), the RCs described the use of CTOs in combination with ACT as a long-term safety measure to contain dangerousness and to prevent harm. There was substantial variation in the RCs' interpretation of the dangerousness criteria, and RCs who were not part of the treatment team expressed more doubts about accurate predication of risk.

This thesis concludes that for patients on CTOs, the ACT approach provides a window of opportunity to adequately address patients' complex needs, and also to monitor non-adherence and relapse at an earlier stage and promote more voluntary solutions than traditional services.

List of papers

Paper 1

Stuen, H.K., Rugkåsa, J., Landheim, A. & Wynn, R. (2015). Increased influence and collaboration: a qualitative study of patients' experiences of community treatment orders within an ACT community treatment setting. *BMC Health Services Research*, 15:409

Paper 2

Stuen, H.K., Landheim, A., Rugkåsa, J. & Wynn, R. (2018). Responsibilities with conflicting priorities: a qualitative study of ACT providers' experiences of community treatment orders. *BMC Health Services Research*, 18:290

Paper 3

Stuen, H.K., Rugkåsa, J., Landheim, A. & Wynn, R. (2018). How do clinicians make decisions about CTOs in ACT: a qualitative study. *International Journal of Mental Health Systems*, 12:51

Abbreviations

ACT Assertive community treatment

CMO Compulsory medication order

CMHC Community mental health centre

CTO Community treatment orders

GT Grounded theory [research method]

MHCA Mental Health Care Act

RC Responsible clinician

TMACT Tool for Measurement of Assertive Community Treatment

UK United Kingdom

US United States

WHO World Health Organization

1. Introduction

This thesis examines the experiences of patients, providers and responsible clinicians (RCs) with community treatment orders (CTOs) in the context of relatively newly established assertive community treatment (ACT) teams. Despite a lack of solid evidence of improved patient outcomes (Kisely, Campbell, & O'Reilly, 2017), more than 75 jurisdictions worldwide have implemented legal mechanisms to compel patients with severe mental illness (SMI) to adhere to treatment in the community, and to reduce relapse rates and repeated hospital admissions (Rugkåsa, 2016). There has been surprisingly little discussion about CTOs in Norway although they have been widely used since the implementation of the Mental Health Care Act (MHCA) in 1961 (Psykisk helsevernloven [The Mental Health Care Act], 1961).

ACT, which is a well-established intensive mental health service delivery model to support individuals diagnosed with severe mental illness in the community, was piloted from 2009 in Norway. ACT is a model of multidisciplinary community-based teams that provides a full range of medical, psychosocial and rehabilitation services. Controlled studies have shown that ACT is an effective model for reducing hospital use and to improve social functioning, housing stability and increase retention in treatment (Dieterich et al., 2017).

Although some studies on the views and experiences of patients and health personnel with CTOs have been published in the last few years, few studies have explicitly investigated the use of CTOs within an ACT setting. Therefore, the aim of this thesis was to obtain more knowledge of patient and staff experiences with CTOs and CTO decision-making practices within relatively newly established ACT teams. Please see an overview of the specific research questions in Section 3.6.

1.1 Community treatment orders

CTOs are a legal mechanism that authorize clinicians to supervise patients with SMI in the community, and are mainly used to ensure patients' adherence to prescribed outpatient treatment and to prevent relapse and repeated hospital readmissions. Patients subjected to CTOs have to make themselves available for assessments, and most CTO regimes allow for swift recall to hospital when the patients are not compliant (Rugkåsa, 2011).

In the era of de-institutionalization, when the primary locus of treatment of SMI shifted from hospitals to the community, various forms of community-based mental health services were gradually developed (Myklebust, Sørgaard, & Wynn, 2017; Thornicroft & Bebbington, 1989). After the closure of the asylums, the downsizing of large psychiatric institutions started in the 1970s. From 1975 to 2007, the number of psychiatric beds in Norway decreased from 16 000 to 4750 in 2007 (NOU 2011:9, 2011). The introduction of antipsychotic medications in the mid-1950s was an important factor in increased discharge rates and maintenance in the community. The aim of de-institutionalization was both to increase cost-effectiveness and to achieve an ideal of increased freedom and active social involvement for people with SMI. Some universal catchwords of the de-institutionalization process have been ‘decentralized’, ‘community-based’ and ‘person-centred care’ (Pedersen & Kolstad, 2009).

More than 75 jurisdictions worldwide have introduced legislation to allow mandated community treatment, to help patients with SMI achieve stability, to control risk and to provide less restrictive solutions than involuntary hospital admission (Churchill, Owen, Singh, & Hotopf, 2007). Several reviews of disengagement from mental health services estimate that approximately 30-50% of patients disengage from or discontinue recommended mental health services (Kreyenbuhl, Nossel, & Dixon, 2009; O’Brien, Fahmy, & Singh, 2009). Up to 50% of patients with schizophrenia prescribed antipsychotic medication discontinue or are only partially adherent (Lacro, Dunn, Dolder, Leckband, & Jeste, 2002), thus greatly increasing the risk of frequent relapse and revolving door service utilization (Leucht et al., 2012). Legally mandated community treatment is typically seen as preferable to involuntary inpatient hospital admissions from an ethical and personal liberty perspective, and is also a way of controlling risk to the patient and society (Rugkåsa & Dawson, 2013).

The legal criteria for subjecting patients to CTOs vary between jurisdictions, but generally they concern the need for treatment and/or danger to the patient or others (Churchill et al., 2007). In a review of the CTO literature from 1966 to 2005, Churchill et al. (2007) distinguish between three different legal frameworks, presenting CTOs as the ‘least restrictive solution’, in contrast to so-called ‘preventive’ statutes, and CTO schemes which combine ‘preventive’ and ‘least restrictive’ features. Some jurisdictions only authorize CTOs after prior involuntary admissions with the same legal criteria, which often are referred to as the ‘least restrictive’ solution compared to involuntary admissions.

However, in some jurisdictions, for instance in many US states, CTOs can be established in the community without prior hospital admission (often referred to as ‘preventive’ CTO schemes), and with a lower threshold than for involuntary hospitalization. Preventive CTO statutes often recognize the right to intervene before there is a clear deterioration in patients’ mental condition, mainly to prevent readmissions, but also to protect the public from potentially dangerous patients that have been diagnosed with severe mental disorders and that are considered a risk for others.

Preventive regimes are more common in the USA, where CTO decisions are based on court verdicts. In many European countries, on the other hand, CTO decisions rely on authorized clinicians’ judgements. While some critics question and cast doubt over the usefulness and ethics of CTOs (Rugkåsa et al., 2015; Szmukler, 2015), others perceive mandated community treatment as a necessary tool, to be carefully implemented to ensure the right to safe and effective treatment (O’Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006).

Many jurisdictions in North America and Australasia introduced CTOs in the late 1980s and 1990s (also referred to as ‘outpatient commitment’, ‘mandatory outpatient care’ and ‘assisted outpatient treatment’), and they have also been introduced in many European countries since then. In the UK, CTOs were first introduced in Scotland in 2005, followed by England and Wales in 2008. In the Scandinavian countries, CTOs were introduced in 2008 in Sweden and in 2010 in Denmark, while CTOs have been part of the Norwegian MHCA since 1961. In the preparatory documents to the Norwegian Mental Health Care Act, which will be described in Section 2.1, CTOs were presented as a less restrictive alternative to involuntary hospitalization, as a compromise between mentally ill people’s right to liberty and their need of care and supervision.

Compared to some US states and England and Wales, where the focus is on ‘negative rights’, such as the right not to have one’s liberty restricted, the Scandinavian CTO statutes have a more explicit rehabilitation focus, and are framed within an ideology of community integration and securing ‘positive rights’ to patients, such as access to health services and housing (Sjöström, Zetterberg, & Markström, 2011). Despite substantial differences in the CTO rates across countries and also within regions, the characteristics of patients subject to CTOs are reasonably consistent. Around two-thirds of patients are male, the same proportion is diagnosed with schizophrenia, and the mean age is around

40. Patients typically have several prior hospitalizations and many patients subjected to CTOs have problems with substance abuse and/or criminal records. Most live alone in rented accommodation, they are typically single and very few are in regular employment (Churchill et al., 2007; Rugkåsa et al., 2019). Together with some states in Australia, Norway has reported high levels of CTOs, with 61 persons per 100 000 (Bremnes et al., 2016), compared to three of 100 000 adults in some US states and 10 among 100 000 of the adult population in England (Ridgely, Borum, & Petrila, 2001; Trevithick, Carlile, Nodiyal, & Keown, 2018). In many US jurisdictions, patients on assisted outpatient treatment (equivalent to CTOs) are prioritized for intensive case management or assertive community treatment (Robbins et al., 2010). This differs from many European countries, where accessibility and quality of care do not depend on whether or not the patient is under mandated community treatment. Further, disability benefits and subsidized housing are entitlements in many European countries, whereas in the USA, treatment adherence and substance abstinence seem to be more frequently used as a lever to social benefits and subsidized housing (Burns et al., 2011; Monahan et al., 2005; Robbins, Petrila, LeMelle, & Monahan, 2006; Wong, Lee, & Solomon, 2010).

1.2 Compulsion and coercion in community mental health care

Coercion is a complex and multifaceted concept that covers both formal or statutory coercion through mental health legislation and informal coercion, i.e. the range of treatment pressures clinicians (and others, such as the police and family members) may exert to increase patients' adherence to treatment. In some situations care providers may also utilize an explicit condition (treatment adherence or substance abstinence) as a lever to housing, financial benefits and avoidance of criminal sanctions. Since the focus here is on mandated community treatment, I will use the term 'compulsion' to indicate formal or statutory coercion through mental health legislation. 'Informal coercion' will be used to cover the range of techniques or pressures mental health professionals and others may exert over patients to promote adherence (Appelbaum & Le Melle, 2008; Molodynski, Rugkasa, & Burns, 2010; Szmukler & Appelbaum, 2008), while the term 'perceived coercion' will be used to indicate patients' experiences and perceptions of inpatient and community coercion.

Several studies show that perceived coercion is not defined by patients' legal status (Iversen, Høyer, Sexton, & Grønli, 2002; Katsakou et al., 2010). Patients' experiences of

being met with respect and being included in treatment decisions, often referred to as ‘procedural justice’, influence their perception of coercion. The MacArthur study, conducted in the USA in the 1990s, made the important finding that patients who reported that they had a voice in the admission process experienced less coercion than patients who did not have the same experience of respect during the proceedings (Lidz et al., 1995).

Szmukler and Appelbaum (2008) describe the use of coercion within mental health care as ‘a spectrum of pressures... exerted to gain the patient’s cooperation with treatment’, ranging from persuasion, interpersonal leverage, inducements (offers) and threats all the way to invoking legal authority under the law (Rugkåsa, Canvin, Sinclair, Sulman, & Burns, 2014; Szmukler & Appelbaum, 2008). Studies indicate that mental health professionals seem to underestimate informal coercion (Elmer et al., 2018). A focus group study of mental health professionals from ten countries showed that clinicians felt uncomfortable and affronted when the term (informal) coercion was used, even when the interventions were part of regular practice (Valenti et al., 2015). Valenti et al. (2015) argue that this dissonance reflects an underlying tension of paternalism and responsibility vs. autonomy as core values in psychiatry.

Thus, at one end of the spectrum are situations where clinicians provide nuanced information about the pros and cons to find an acceptable solution based on the patient’s specific needs and preferences, while at the other end lie decisions to authorize a legal order to compel or force reluctant patients to take prescribed medication. The practical significance of the spectrum is that the greater the pressure to be applied to a person to accept treatment, the stronger the justification should be. This is in line with Alan Wertheimer’s argument that threats in relation to mental health issues ‘coerce’, but offers (or inducements) generally do not:

“The crux of the distinction between threats and offers is that A makes a threat when B will be worse off than in some relevant baseline position if B does not accept A’s proposal, but that A makes an offer when B will be no worse off than in some relevant baseline position if B does not accept A’s proposal.” (Wertheimer, 1993)

Wertheimer claims that no simple definition can be offered for the term ‘coercion’. The question, then, is what determines ‘moral baseline’, where a threat thus anticipates

making the recipient of the proposition worse off according to an accepted ‘moral baseline’, while an ‘offer’ even if declined, does not. Other scholars have introduced patients’ ‘legal baseline’ (Monahan et al., 2005) and ‘professional duties of care’ owed to patients (Dunn et al., 2012) as alternative and more concrete approaches.

While proponents argue that CTOs combined with enhanced services can improve engagement and patient outcomes over and above the provision of care (Cripps & Swartz, 2018), opponents claim that coercion itself does nothing to reduce readmissions (Burns, 2014). One ongoing discussion is whether or not mandated community treatment would be unnecessary if intensive mental health services, such as ACT teams, were readily available in the community.

1.3 Assertive community treatment

In 2009 the Norwegian Directorate of Health decided to fund the implementation of ACT to provide more comprehensive services to persons with SMI. The background for the implementation of ACT was a report from 2008 (Huus, Storm-Olsen, & Herheim, 2008). This report (IS-1554) showed that although the national mental health programme (1998-2008) had been successful and most people with mental health problems were receiving effective care and treatment, approximately 4000 people with severe and persistent mental illness were not receiving the help they needed. The decision to choose ACT to provide accessible support and coordinated follow-up services for this patient group was in part based on international recommendations and in part on experiences from piloting ACT in one Norwegian region.

ACT is a service delivery model that was developed at the Mendota State Hospital in Madison, Wisconsin, USA in the late 1960s to support the integration of persons with SMI into the community (Stein & Test, 1980). ACT targets patients with severe and persistent mental illnesses (schizophrenia, severe bipolar disorders, or other psychotic disorders), centring around the idea that a community-based team should provide a full range of medical, psychosocial and rehabilitation services. Based on initial findings of ACT in the USA, Stein and Test (1980) concluded that providing support and services to individuals seven days a week and 24 hours a day following hospital admissions, as well as providing time-unlimited support, were essential elements in preventing relapse and hospital admissions. Stein and Test called their approach training in community living

and thought of it as a specific and complex form of psycho-education (Stein & Test, 1980).

ACT focuses on patients with SMI with concurrent substance abuse and poor social functioning, who are often difficult to engage in treatment. The team is intended to have shared responsibility for a small caseload (maximum ten patients for every provider), to have a psychiatrist in the team and to provide multidisciplinary, flexible and intensive home-based support. Another critical ingredient of the ACT model is a holistic approach, facilitated through frequent team meetings to review and tailor treatment plans and services to the needs and goals of each patient. Controlled studies from the USA show that ACT reduces hospitalization and improves social functioning, retention in treatment, and patient satisfaction (Bond, Drake, Mueser, & Latimer, 2001; Essock, Frisman, & Kontos, 1998; Stein & Test, 1980). However, UK studies that investigated ACT found no clinical advantage compared to traditional services (Burns et al., 1999; Glover, Arts, & Babu, 2006; Killaspy et al., 2006).

Possible explanations as to why trials of ACT in the USA showed more positive outcomes than comparable UK studies include different psychiatric hospital use at baseline, poor ACT model fidelity, and the development of better quality of standard community mental health services in the UK (Burns et al., 2002; Dieterich et al., 2017; Latimer, 1999). Community mental health teams (CMHTs), which are the standard care teams in the UK, seem more similar to ACT teams in providing coordinated and more in vivo visits than standard care comparison teams in the USA (Burns et al., 2002).

1.4 Active engagement strategies versus treatment pressure and coercion in ACT

Active engagement strategies are key ingredients of ACT services, and the team is intended to use an array of techniques to engage and retain users in treatment (McGrew, Pescosolido, & Wright, 2003; McGrew, Wilson, & Bond, 2002; Phillips et al., 2001). Much of the literature has defined treatment engagement as involvement or use of services, typically conceptualized as ‘attendance’, ‘adherence’, or ‘retention’. The term ‘disengagement’, meaning dropping out of treatment or poor treatment adherence, is often considered a negative outcome because of its association with relapse, repeated

hospitalizations, homelessness, or incarceration (Dixon, Holoshitz, & Nossel, 2016; Fischer et al., 2008; Kreyenbuhl et al., 2009; Wynn, 1998, 2005; Wynn & Wynn, 2006).

The ACT model specifically emphasizes the importance of assertive outreach, in vivo treatment and support, and an individualized approach based upon the strength of the relationship between the individual user and the treatment team (Bond & Drake, 2015; Phillips et al., 2001). Therapeutic relationships often involve a positive, emotional bond between a service user and provider through mutual trust, acceptance and collaboration on mutually agreed goals (Bordin, 1979; Gillespie, Smith, Meaden, Jones, & Wane, 2004; Pettersen, Ruud, Ravndal, Havnes, & Landheim, 2014; Wynn, 1998, 2005; Wynn & Wynn, 2006).

According to fidelity standards, which define the key characteristics of the model, assertive outreach typically uses assertive engagement approaches and motivational interventions to build intrinsic motivation for receiving services from the team (Bond & Drake, 2015; Manthey, Blajeski, & Monroe-DeVita, 2012; McGrew et al., 2003; Monroe-DeVita, Teague, & Moser, 2011). Fidelity scales measure to what extent the elements are implemented as intended, and may be used to assist teams in improving performance over time (Monroe-DeVita, Morse, & Bond, 2012). In newer model revisions, based on the Tool for Measurement of Assertive Community Treatment (TMACT), there is an increased focus on promoting self-determination and independence, engaging patients in person-centred planning and individualized intervention plans (Monroe-DeVita et al., 2011).

Besides providing long-term integrated care, ACT teams help patients with illness management, vocational rehabilitation, housing assistance, finances, while also providing linkage to GPs and other medical services (Phillips et al., 2001). However, developing supportive and effective therapeutic relationships with reluctant patients often takes time, and according to the ACT fidelity tool (TMACT), patients should not be discharged before 12 months despite active refusal (Monroe-DeVita et al., 2011). Consequently, the distinction between non-directive discussions and compulsion seems more blurred (Szmukler & Appelbaum, 2008).

Medication administration is a cornerstone in ACT, and for this reason the ACT model has been criticized for being too paternalistic and coercive (Gomory, 2002). However, studies have found that patients are more satisfied with ACT than with traditional

community mental health services (Dieterich et al., 2017; Killaspy et al., 2006; Leiphart & Barnes, 2005). Several studies show that ACT teams use less restrictive interventions than traditional community mental health services (Davidson & Campbell, 2007). The low caseload and teams' shared responsibility lead to more time for assertive outreach workers, which in turn entails more opportunities to monitor medication use, frequent meetings for team problem solving and more active involvement of patients in treatment planning decisions (Appelbaum & Le Melle, 2008; Davidson & Campbell, 2007; Killaspy et al., 2009).

Although the founders of ACT stated that coercion was not part of the model (Stein & Test, 1980), newer model revisions acknowledge that use of therapeutic limit-setting strategies (e.g. intensive medication monitoring and outpatient commitment) may be used to create extrinsic motivation for receiving services deemed necessary to prevent harm to patient or others. TMACT specifies that when therapeutic limit setting is used, there should be a focus on promoting patient autonomy, and the team should regularly revise their engagement approach (Manthey et al., 2012).

A number of studies show that treatment pressure and compulsion do not necessarily have a negative effect on patient satisfaction with treatment (Katsakou et al., 2010; Lofthus et al., 2016; Mfoafo-M'Carthy, Grosset, Stalker, Dullaart, & McColl, 2018; Stanhope, Marcus, & Solomon, 2009; Wynn, Myklebust, & Bratlid, 2006). Pettersen et al. (2014) studied the process of engagement among recovering clients with concurrent substance use in Norwegian ACT teams. This research found that clients greatly appreciated the service providers' persistent efforts to establish contact, even though a majority was reluctant at first. In a recent Norwegian study, Lofthus et al. (2016) found that patients subject to CTOs were more satisfied with ACT than voluntarily enrolled patients and also that patients on CTOs reported higher rates of recovery (Lofthus et al., 2018).

Despite fidelity standards guiding practice, there is significant variation across ACT teams in the use of therapeutic limit setting (intensive medication monitoring, representative payeehip; if the person is not fully capable of managing his/her finances, or use of CTOs) (Mfoafo-M'Carthy et al., 2018; Moser & Bond, 2009; O'Reilly, Corring, Richard, Plyley, & Pallaveshi, 2016). Moser and Bond (2009) show that the CTO rate ranged from 0-65% across 23 ACT teams in Indiana, and that the variation in the use of coercive interventions including CTOs was not associated with the teams' fidelity scores.

Patient characteristics, more severe symptoms and hospitalization history, the presence of a representative payee, recent alcohol or drug use and a higher number of arrests were the strongest predictors of CTO/therapeutic limit setting (Moser & Bond, 2009; Neale & Rosenheck, 2000). In a survey of 239 ACT providers from 34 ACT teams in New York, Manuel et al. (2013) show that perceptions of a demoralized organizational climate and stigmatized beliefs about mental illness were correlated with the use of more intrusive intervention strategies.

2. Norwegian mental health care services and the use of CTOs

The Norwegian health care system is undergoing significant reforms, including an increasing focus on quality and integrated care. Although service user influence and involvement are stipulated in the Act on Patient and Service User Rights (Pasient- og brukerrettighetsloven [The Patient and Service User Rights Act], 1999), one may question whether policy discourses and professional statements on service user participation, choice, collaborative decision making and autonomy have led to a significant alteration of practice (Aasland, Husum, Førde, & Pedersen, 2018; Borg, Karlsson, & Kim, 2009; Hansen, Hatling, Lidal, & Ruud, 2004).

2.1 The Norwegian Mental Health Care Act

The treatment and assessment of patients in somatic and mental health care are based on informed consent. The Norwegian Patient and Service User Rights Act promotes patients' self-determination and autonomy (Pasient- og brukerrettighetsloven [The Patient and Service User Rights Act], 1999). Coercion is in conflict with these principles, and the use of coercive measures in mental health care is regulated by the MHCA (Psykisk helsevernloven [The Mental Health Care Act], 1999). The proposal for the 1999 MHCA specified that the possibility to restrict the liberty of individuals with SMI formed an exception to the cultural and legal traditions of voluntariness and the protection of individuals' right to autonomy. Such an exception may be made in cases where it is deemed necessary in order to provide care and protection (Ot.prp. nr. 11 [Parliamentary Proposition No.11] (1998-99)). Further, the proposal emphasized society's moral obligation to take care of people who cannot care for themselves, especially if they are considered as having a severe mental illness, and therefore deemed unable to make rational decisions.

Decisions on compulsory interventions in general adult psychiatry are made by approved clinicians (psychiatrists or clinical psychologists), who consider whether or not the patient has a severe mental illness and whether the additional MHCA criteria are met. In practice, the legal concept of 'severe mental disorder' is equivalent to psychosis. The purpose of establishing involuntary observation or treatment, in either inpatient or community care, is to support individuals in restoring their ability to make valid treatment decisions.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) has led to a rethinking of traditional mental health legislation around the world. This convention endeavors to prevent discrimination on the basis of disabilities. In Norway, the CRPD was ratified in 2013 (Strand, 2014). As in many Western other countries, there seems to be general agreement that mandated community treatment is justifiable in situations where a person lacks decision-making capacity or is thought to present a risk to him/herself or others (Høyer, 2000). Despite discussions and critical concerns, the treatment criteria remained unchanged until the capacity criterion was implemented in 2017. The data collection in the present study was conducted before the capacity criterion was implemented. I will therefore present the MHCA as it was before the September 2017 amendments.

The Norwegian MHCA allows for involuntary observation and admission, in either inpatient or community care, and the legal criteria for involuntary hospitalization and CTOs are the same. Involuntary observation may be used to assess a patient's condition for up to 10 days, in accordance with Section 3-2 of the MHCA. To establish compulsory mental health care in accordance with Section 3-3, all the following conditions have to be met (Psykisk helsevernloven [The Mental Health Care Act], 1999 §3-3, <https://app.uio.no/ub/ujur/oversatte-lover/data/lov-19990702-063-eng.pdf>):

1. *Voluntary mental health care has been tried, to no avail, or it is obviously pointless to try this.*
2. *The patient has been examined by two physicians, one of whom shall be independent of the responsible institution, cf. Section 3-1.*
3. *The patient is suffering from a serious mental disorder and application of compulsory mental health care is necessary to prevent the person concerned from either*
 - a. *having the prospect of his or her health being restored or significantly improved considerably reduced, or it is highly probable that the condition of the person concerned will significantly deteriorate in the very near future, or*
 - b. *constituting an obvious and serious risk to his or her own life and health or those of others**on account of his or her mental disorder*

4. *The institution is professionally and materially capable of offering the patient satisfactory treatment and care and is approved in accordance with Section 3-5.*
5. *The patient has been given the opportunity to state his or her opinion, cf. Section 3-9.*
6. *Even though the conditions of the Act are otherwise satisfied, compulsory mental health care may only be applied when, after an overall assessment, this clearly appears to be the best solution for the person concerned, unless he or she constitutes an obvious risk to the life or health of others. When making the assessment, special emphasis shall be placed on how great strain the compulsory intervention will entail for the person concerned.*

Although the Norwegian CTO statutes are not a guarantee of comprehensive community support, patients who are placed on CTOs are entitled to have a permanent place to live, an individual care plan and free medical treatment. While decisions and complaints about compulsory medication orders are supervised by the County Governor, the patient may direct complaints regarding commitment decisions to the Control Commission. In supervising the various local health authorities, 55 local Control Commissions conduct documentary controls every third month, as a means to protect patients' legal rights. In cases where the RC requests involuntary commitment for more than 12 months, the Control Commission makes an independent review. Patients or close relatives have the right to appeal decisions from the Control Commissions to the civil courts.

Following the Paulsrud Commission's [Paulsrudutvalget] (NOU 2011:9, 2011) suggestion, a capacity based criterion was introduced in the Norwegian MHCA in September 2017, to strengthen patients' legal security and to promote patients' autonomy. This means that involuntary admissions and CTOs can only be used if a patient lacks capacity to make informed decisions. Exemptions to this rule may only be made when the patient is deemed a risk to the health of others or his/her own life. The amendment also involves a narrowing of the dangerousness criterion, which no longer includes the risk of harm to the persons' own health.

2.2 The Norwegian mental health care system

In Norway, a land of approximately 5.3 million inhabitants and 422 municipalities, the predominantly tax-financed health care system may be divided into two health care

levels: primary and long-term care on the one hand, and specialist services and facilities for acute physical and mental conditions on the other. There are few large cities and vast rural areas with a low population density. Half of the municipalities house fewer than 5000 inhabitants, and local government in Norway has strong traditions. Together with the state-run Norwegian Labour and Welfare Administration (NAV), municipalities are responsible for general practitioners and a wide range of universal and rights-based welfare services. These include primary care, regular follow-up services and home care, temporary accommodation and housing, social security benefits, pensions, sick leave benefits, employment schemes and municipal mental health services.

Four Regional Health Authorities manage 21 Health Trusts, which are responsible for organizing a complete set of specialist health services to the population in their catchment area. Psychiatric hospitals (or psychiatric wards in general hospitals) and decentralized mental health care services at community mental health centres (CMHCs), known as district psychiatric centres in Norway, provide diagnostic assessments and treatment on the specialist level.

All citizens have the right to a GP, and GPs have a key role in the health care system as gatekeepers for patients in the provision of health care. Most persons with mild to moderate mental health problems, such as depression and anxiety disorders, are treated by their GP. GPs and local care providers are often responsible for regular follow-up services including medication administration, also for patients on CTOs. Consequently, there is great deal of interchange of patients and tasks between hospitals, the CMHCs, GPs, community mental health nurses and local mental health teams.

In 1998, the Norwegian Parliament introduced its “Escalation Plan for Mental Health” (St.prp. nr. 63 [White Paper No. 63] (1997-98)), calling for a major increase in funding of mental health services, as well as an expansion and major reorganization (Pedersen & Kolstad, 2009). The Escalation Plan also strengthened patient rights by referring to an overarching goal for local primary health care and specialist mental health services to support the ability of service users to cope with and regain control over their lives. During the period of the Escalation Plan (1998-2006), 75 CMHCs were established, with local inpatient wards (which are usually not certified for involuntary treatment), outpatient clinics, and ambulatory services. Treatment at the outpatient clinic typically involves regular meetings with a health professional (psychologist, psychiatrist, mental health

nurse or social worker), usually in their office. However, there are substantial differences in services provided by CMHCs, such as the availability of beds, discharge rates, ambulatory services, and whether they provide outreach services (Myklebust, Sørgaard, & Wynn, 2015).

One of the main goals of the Coordination Reform (St.meld. nr. 47 [White Paper No. 47] (2008-2009)), implemented in 2012, was that municipalities should take more responsibility for patients reported to be ready for discharge and to develop more cohesive and better coordinated health and care services. Contrary to the intention of the White Paper, the reduction in psychiatric beds and hospital stays has not been compensated with sufficient resources and competencies in municipal health and social services, and service fragmentation and siloed systems are a well-known problem (Romøren, Torjesen, & Landmark, 2011).

2.3 The policy context of mental health service user involvement and recovery

The emphasis on service users' involvement and empowerment and the endorsement in the last decade of patient-centred services and recovery as central principles in policy documents and treatment guidelines place new demands on health professionals. Mental health workers are encouraged to support the recovery of people with SMI, providing them with opportunities and resources to live meaningful and productive lives.

An example of this is the “National Guideline for Assessment, Treatment and Social Rehabilitation of Persons with Concurrent Substance use and Mental Health Disorders”, which describes recovery as a social and personal process (Helsedirektoratet [Norwegian Directorate of Health], 2013). Article 37 specifies that care providers' main role is “*to support the patient's own resources throughout treatment in a way that leads to improved self-esteem and quality of life*”. ‘Improving Mental Health’, another policy document (Helse- og omsorgsdepartementet [Ministry of health and care services], 2017), is in tune with the life course approach of the WHO mental health plan. Patient-centredness, shared decision making and social support to enhance participation in normative activities, such as employment, education, and community life are presented as core dimensions of improving health care quality in practice and of empowering patients. Assertive community treatment has been recommended in several treatment guidelines and policy

documents to provide more comprehensive services to persons with SMI and to reduce the use of coercion.

2.4 Piloting assertive community treatment teams in Norway

The first 12 ACT teams, established from December 2009 to February 2011, were included in the research-based evaluation of the implementation of ACT in Norway. During the ACT teams' first year of operation, 338 patients included in the 12 teams were invited to participate in the evaluation. Among the 202 patients (60%) who consented, cross-sectional sociodemographic and clinical data from 142 patients of ACT teams upon enrolment and longitudinal hospital data in the two years before and the two years after were collected. Among the 142 patients included, 59% had concurrent substance abuse and 32% were subject to CTOs (Landheim et al., 2014).

Although the Norwegian ACT evaluation did not show a reduction in the overall number of admissions, there was a 50% reduction in both involuntary admissions and bed days. Among the patients with the most bed days (more than 100) two years before enrolment in ACT, 50% of whom were subject to CTOs, there was a 70% reduction in involuntary bed days at two years' follow-up (Clausen et al., 2016a).

Although the Norwegian ACT teams have made some adjustments to the original model, and are not available 24 hours a day, the teams are intended to provide assertive outreach and to retain contact with 95% of the clients for at least 12 months (Monroe-DeVita et al., 2011). ACT comprises a multidisciplinary team of professionals, which should include a psychiatrist, a psychologist, mental health nurses and other therapists and specialists in the field of substance abuse counselling, employment and peer support. The Norwegian ACT teams were organized as mutually collaborative models, involving financial support and personnel from municipalities and the specialist service level. These principles differentiate ACT from standard (office-based) community mental health services. Currently eight ACT teams and approximately 30 flexible ACT teams, based on the Dutch hybrid service model (Nugter, Engelsbel, Bähler, Keet, & van Veldhuizen, 2016) have been established in Norway.

2.5 Use of CTOs in Norway

The regulation of patients' rights to participate in treatment decisions and increased focus on empowerment and recovery offer a potential for a positive change in mental health service delivery. However, paternalism has strong traditions and high involuntary admission rates have been a long-term concern (Wynn, 2018).

Although two national action plans and legal amendments to reduce the use of coercion have been implemented in Norway since 2006, the rates of involuntary admissions and CTOs are relatively high compared to other Western countries (Bremnes et al., 2016). The first action plan, intended to reduce the use of coercion in mental health care by enhancing knowledge and improving documentation, was launched in 2006. CTOs were first mentioned in the second action plan (2012-2015), which specified concrete interventions to reduce coercion (Helse- og omsorgsdepartementet [Norwegian Ministry of Health and Care Services], 2012). In 2014, 17% of all admissions and 32% of all bed days were involuntary, which amounts to 198 involuntary admissions per 100 000 adult inhabitants (Bremnes et al., 2016).

Some studies indicate that admitting doctors, often working at out-of-hours clinics and with little prior knowledge of the patients they are assessing, find it difficult to specify the medico-legal criteria: whether the dangerousness and/or treatment criteria are met (Røtvold & Wynn, 2015a, 2015b). While there was an estimated 50% increase in the use of CTOs in Norway between 2002 and 2007 (Hatling, 2013), national figures show that among 23 124 patients referred to outpatient treatment at CMHCs, the CTO rate increased from 2.6% in 2008 to 3.3% in 2013 (Ose, Ådnanes, & Pettersen, 2014).

Despite the lack of reliable knowledge about the extent and content of CTOs and geographical variation between different local health authorities (Løvsletten, Haug, Granerud, Nordby, & Smaaberg, 2016; Riley, Straume, & Høyer, 2017; Rugkåsa et al., 2019), Norwegian figures from 2014 suggest that one in three involuntarily admitted patients were placed on CTOs at discharge and that a total of 2400 patients were subject to CTOs (Bremnes et al., 2016). Since 2001, as part of an amendment in the Norwegian MHCA, CTOs can also be initiated at an outpatient basis, without a prior hospital admission. However, community initiated CTOs are not part of regular practice, and we lack knowledge of their use in Norway.

In a recent retrospective Norwegian multicentre study, Rugkåsa et al. (2019) found that 1441 patients were subject to CTOs in six large regional hospitals in 2008-2012. Although 98% of the patients were prescribed psychotropic medication, fewer than 50% of the sample had a compulsory medication order. The median time on CTO was 425.5 days. One-third (33.8%) had been on CTOs for more than two years, and 181 patients (12.8%) had been on the current CTO for five years or more. In a subsample of 274 patients on their first CTO in 2008-09, all patients were placed on CTO on discharge from hospital. While most patients were diagnosed with schizophrenia (76.9%), a considerable substance use problem was recorded in a quarter of the sample (24.5%). The treatment criterion was used in all cases where a criterion was recorded. The treatment criterion was the sole criterion for 213 patients (78.6%), while the dangerousness criterion was used in addition to the treatment criterion in 49 cases (18.1%). The dangerousness criterion was not used for any patient. In term of patient characteristics, the diagnosis of schizophrenia, considerable substance abuse problems, together with perceived dangerousness (application of the dangerousness criterion) were associated with longer CTO duration (Rugkåsa et al., 2019).

3. Status of knowledge of CTOs

While ACT is an evidence-based approach to supporting individuals with SMI in the community, the evidence regarding CTOs' effectiveness on clinical and social outcomes has been conflicting. In this section I will present the status of current scientific literature on CTOs. I will first present the literature search, and then in Section 3.2 I will provide an overview of three randomized controlled trials and meta-analyses, and also describe non-randomized studies investigating the use and effects of CTOs. Thereafter, in Section 3.3 and 3.4 I will describe qualitative research regarding patients' and clinicians' views and experiences with CTOs and clinicians' CTO decision making practice. I will specifically present the qualitative research on experiences with CTOs within an ACT setting.

3.1 Literature search

An initial literature search was conducted in 2013, using the following databases: PsycINFO, Medline, Cinahl, SweMed and Embase, which were considered the most relevant. The review procedure was not systematic as defined by the PRISMA criteria (Liberati et al., 2009). Nevertheless, a large body of literature was searched and reviewed. The following search terms were used combined with Boolean operators AND/OR: 'involuntary outpatient commitment', 'community treatment orders', 'assisted outpatient commitment' and 'patient experiences'. First, relevant articles from 1985–2013 were identified by reviewing abstracts and the article itself if deemed relevant, combined with citation searches to identify other relevant literature. A new literature search was conducted in October 2018, specifically to find studies dealing with ACT providers' views and experiences of CTOs and clinicians' CTO decision-making practices. After reading through 200 abstracts, 120 were found relevant. The literature search revealed mostly studies on the initiation of CTOs, and few studies concentrating on the continuation or termination of CTOs. The search revealed few articles on the experiences of patients, providers and RCs of CTO decision making within an ACT setting.

3.2 Quantitative outcome studies

In the academic literature, the discussion has focused on the ethics of depriving adults of the right to make decisions about their own health care as well as on methodological shortcomings (Szmukler, 2015; Wynn, 2006). Churchill et al. (2007) reviewed the

literature published from 1966 to 2005, included 72 international studies and concluded on the basis of current evidence that there was no firm evidence that CTOs resulted in any beneficial health services or patient level outcomes. Maughan et al. (2014), who conducted the same literature search as Churchill for the period from 2006 to 2013, included 18 articles from 11 studies or registers and concluded: “*There is now robust evidence in the literature that CTOs have no significant effects on hospitalisation and other service use outcomes. Non-randomised studies continue to report conflicting results*” (Maughan, Molodynski, Rugkåsa, & Burns, 2014).

A recent Cochrane review which included data from three RCTs, two from the USA and one conducted in the UK, with a total of 749 participants, concluded that the use of mandated community treatment provides no clinical or social benefits, with the exception that patients are less likely than controls to be victimized (Kisely et al., 2017). Subsequently, some scholars have called for a reconsideration of the use of CTOs, pointing to the absence of evidence from RCTs on their effectiveness (Rugkåsa, 2016; Szmukler, 2015).

Other scholars claim that the three RCTs have biased samples (Segal, 2017; Swanson & Swartz, 2014). A further limitation concerns the measurement and reporting of social outcomes, and also that the trials have been relatively short (11-12 months). Also, in both the North Carolina trial (N=264) and the New York trial (N=142), patients with a history of violence were excluded (Steadman et al., 2001; Swartz et al., 1999), while the comparison condition in the OCTET trial (N=336) has been questioned, and some scholars argue that the positive evidence from large population-based case-controlled studies is good enough (Swanson & Swartz, 2014).

Nevertheless, RCTs, systematic reviews, and meta-analyses have the capacity to reduce the sources of bias, and findings from naturalistic effect studies such as mirror-image and case control studies are more prone to bias. One specific methodological concern is that of regression to the mean, meaning that patients’ condition will often stabilize and improve with or without the CTO (Rugkåsa, 2016). Although the three RCTs have been subject to just criticism, the fact that they all reach the same finding on their primary outcome, i.e. that placing patients on CTOs did not make a significant difference in service utilization or patient outcomes, strengthens the results (Kisely et al., 2017).

Burns et al. (2015) found a high rate of sustained clinical engagement among a cohort from the OCTET trial, independent of the CTO, after 36 months, and also found that over the three years, clinicians managed to maintain a median of nearly three contacts a month. Only eight patients (2%) were discharged by their clinical team during these 36 months, and few disengaged from services (Burns et al., 2015). These levels of disengagement are lower than reported elsewhere (O'Brien et al., 2009). As previously mentioned, community mental health teams, which are standard care for persons with SMI in the UK, share many similarities with ACT teams, providing multidisciplinary and coordinated services. Subsequently, some scholars have called for a reconsideration of the use of CTOs, pointing to the absence of evidence from RCTs on their effectiveness (Rugkåsa, 2016; Szmukler, 2015).

Several explorative subgroup or regression analyses from the North Carolina trial and many naturalistic studies that follow patients before and after implementation of a CTO conclude that CTOs combined with intensive services can improve outcomes if sustained over time (for more than six months), often at the expense of increased experience of coercion (Swartz, Wagner, Swanson, Hiday, & Burns, 2002). Studies show that greater symptom severity, problems related to substance abuse and lack of illness insight (Elbogen, Swanson, & Swartz, 2003; McKenna, Simpson, & Coverdale, 2006; Swartz et al., 2001; Swartz et al., 2002), in addition to past history of involuntary hospitalization, were associated with higher perceived coercion (Link, Castille, & Stuber, 2008). Several studies show that prolonged use of CTOs combined with enhanced services is associated with decreased need for admissions (Swartz et al., 2010), reduced violence (Swanson et al., 2000), lower odds of arrest (Swartz et al., 2001), increased contact with services (S. Kisely et al., 2013), medication use (Van Dorn et al., 2010), reduced mortality risk (Steve Kisely et al., 2013) and even increased subjective quality of life (Phelan, Sinkewicz, Castille, Huz, & Link, 2010; Rawala & Gupta, 2014). Some studies also show that use of CTOs combined with ACT is more effective than intensive case management alone (Swartz et al., 2010). In many US states enhanced services such as ACT are often reserved for persons placed on assisted outpatient treatment by the court, and it might therefore be ACT rather than CTO that is most effective, which has not been controlled for in these studies. Another major concern is that the introduction of CTO statutes leads to an increase in the overall level of compulsion (Kjellin & Pelto-Piri, 2014; Rugkåsa & Burns, 2017). There is also the question of whether the mental health care system is

sufficiently concerned with appropriately resourcing non-coercive efforts to engage patients in treatment, and to what extent mental health services rely on unnecessary coercion (Light et al., 2017; Morrissey, 2015). Consequently, there is an ongoing discussion as to whether improved patient outcomes are related to enhanced services or to the mandatory element in the CTO (Burns, 2014; Cripps & Swartz, 2018; Geller, 2012; Kisely et al., 2017; O'Reilly et al., 2016).

3.3 Patients' views of CTOs

Several quantitative and qualitative studies have shown that views of CTOs vary among patients (Pridham et al., 2016). Although many patients are negative towards CTOs, and the need to adhere to treatment, many patients consider CTOs as a less restrictive intervention than involuntary hospital admissions (Canvin, Bartlett, & Pinfold, 2002; Gibbs, Dawson, Ansley, & Mullen, 2005; O'Reilly et al., 2006; Riley, Høyer, & Lorem, 2014; Sjöström, 2012). Previous research shows that patients' responses to CTOs range from passive acceptance to active resistance (Canvin, et al. 2002; Jobling, 2014).

In a recent review of qualitative studies of patient experiences of CTOs, three themes were particularly highlighted: feelings of coercion and control, medication seen as the main reason for a CTO and the perception of CTOs as a safety net (Corring, O'Reilly, & Sommerdyk, 2017). In a review of quantitative and qualitative research of patient experiences of CTOs from seven countries, Pridham et al. (2016) show that the individual experience of a CTO is contextualized by the interventions that follow in addition to the CTO, and by previous experiences with involuntary hospitalization and involvement with the criminal justice system.

Many patients associate mandated community treatment with the threat of hospitalization (Canvin, Rugkåsa, Sinclair, & Burns, 2014; Riley et al., 2014), reprimands from their doctor (Canvin et al., 2002) and other sanctions such as losing custody of their child (Canvin, Rugkåsa, Sinclair, & Burns, 2013), having their driving licence suspended (Schwartz et al., 2010), or police involvement (Brophy & Ring, 2004). For other patients, the obligation to attend appointments and receive medication and care requires planning of everyday activities. Some patients report that such restrictions can make it difficult to find or maintain employment (Newton-Howes & Banks, 2013), or may constrain their participation in social activities (Stensrud, Høyer, Granerud, & Landheim, 2015). In their

study of patient views and experiences, Newton-Howes and Banks (2013) found no difference in social functioning, satisfaction with care, or perceived coercion among 103 patients that were currently subject to CTOs or had previously been subject to CTOs in New Zealand. However, more educated and employed patients seemed more likely to perceive coercion/negative pressure. Although currently detained patients more frequently reported: 'I only take my meds because of the CTO', nearly half of the patients on CTOs stated that they were better off on a CTO rather than off it (Newton-Howes & Banks, 2013). However, several qualitative studies indicate that patients on CTOs feel stuck in a patient role, and that the one-dimensional focus on medication is felt to impede recovery and transition to a more normal life (Mancini, Hardiman, & Lawson, 2005; Stensrud et al., 2015).

Several studies have shown that patients have varying knowledge about the enforceability of the discretionary CTO conditions, such as medication adherence and attending clinical appointments, and the criteria for recall (Canvin et al., 2014; Stensrud et al., 2015) and also that patients have little knowledge about their care plan (Ridley & Hunter, 2013). Different concepts, such as '*legal clout*' (Canvin et al., 2014) and '*tokenistic behaviour*' (Stomski & Morrison, 2017) have been used to describe clinicians' practice not to address patients' uncertainty for the purpose of enhancing treatment adherence.

Although many patients have negative feelings about the CTO, some patients still report that the use of CTOs provide structure, improved access to services and support. Some patients attribute increased safety and opportunity to live a fulfilling life to CTOs (Brophy & Ring, 2004; Canvin et al., 2002; Gibbs et al., 2005). It has also been reported that patients subject to CTOs value the benefits of improved access to a range of mental health and related social welfare services, such as housing provision, improved medication and more responsive care (Brophy & Ring, 2004; Corring, O'Reilly, & Sommerdyk, 2017; Lofthus et al., 2016; Mfoafo-M'Carthy et al., 2018). Schwartz et al. (2010) show that patients recruited from one ACT team in Ontario, Canada were concerned about the stigma associated with mental illness and loss of dignity while being on a CTO. In a recent study, also from an ACT team in Ontario, Mfoafo-M'Carthy et al. (2018), show that although many patients had negative feelings of CTOs at first, most of the patients acknowledged that their lives had improved. Describing CTOs as a double-edged sword, Gault et al. (2013) refer to service users' and caregivers' real concerns about the benefits and negative effects of medication, and the key role of health professionals' behaviour in

patients' recovery processes.

3.4 Clinicians' views of CTOs

Both Norwegian and international studies show that clinicians seem more positive to coercion in general (Wynn, 2004, 2006, 2018; Wynn, Myklebust, & Bratlid, 2007), and to CTOs in particular, than patients are, and that many clinicians value the CTO scheme for providing security and structure following discharge from involuntary hospital admissions (Canvin et al., 2014; Coyle et al., 2013; O'Reilly et al., 2006; Riley, Lorem, & Høyer, 2018; Stensrud, Høyer, Beston, Granerud, & Landheim, 2016)

In a survey of the use of CTOs among 288 mental health professionals and consultant psychiatrists in two health trusts in the UK, Coyle et al. (2013) found that decision making regarding CTOs was overwhelmingly clinically oriented for all professional groups concerned. Two reviews of qualitative and quantitative studies present reasons for patients being placed on CTOs, from the providers' point of view (Corring, O'Reilly, Sommerdyk, & Russell, 2018; Dawson, Lawn, Simpson, & Muir-Cochrane, 2016). Risk to self and/or others, poor insight of the patient, lack of compliance with treatment, ensuring treatment and contact with the care team, facilitating discharge from inpatient care and preventing hospital admissions are all factors that have remained consistent over the past decade (Dawson et al., 2016; Goulet, Pariseau-Legault, Côté, Klein & Crocker, 2019).

Some studies have shown that providers vary in their perceptions of risk (Lawn, Delany, Pulvirenti, Smith, & McMillan, 2016; Mullen, Dawson, & Gibbs, 2006). Light et al. (2015) found that clients and providers have diverging perceptions of risk. While patients and family members were concerned about distress stemming from mental illness and social and interpersonal difficulties, many providers focused on actual harm and potential risk.

Although the use of CTOs can impede the therapeutic relationship, health professionals have to weigh benefits and disadvantages when considering the use of a CTO to facilitate stable medication and follow-up care (Dawson & Mullen, 2008; Stensrud et al., 2016). In a recent review of qualitative studies of clinicians' views and experiences with CTOs, Corring et al. (2018) noted that although clinicians see benefits for service users, many struggle with the dissonance caused by supporting an imposed treatment regimen while

attempting to adhere to the principles of recovery and person-centred care. In a recent study from an ACT team in Ontario, Canada, Mfoafo-M'Carthy et al. (2018) showed that although many patients had negative feelings towards CTOs at first, many also acknowledged that their lives had improved. The authors also conducted one focus group interview with seven clinicians and two key informant interviews (team psychiatrist and the program coordinator), who agreed that combining CTOs and ACT resulted in regular access to mental health support, fewer hospitalizations and overall improvements in quality of life for patients.

According to Dawson et al. (2016), clinicians report varying levels of client involvement in the CTO process, and there seems to be substantial variation in how the powers of the legislation are interpreted. Stensrud et al. (2016) show how RCs in Norwegian services worry about relapse, and are therefore reluctant to make adjustments. Both Norwegian and international studies show great variance in how RCs consider clinical and functional improvement, and the duration of CTOs seems to depend heavily on RCs' attitudes and opinions (DeRidder, Molodynski, Manning, McCusker, & Rugkåsa, 2016; Riley et al., 2018).

3.5 Summary of the status of knowledge

There are substantial differences in legislation, models of health service and CTO rates between different jurisdictions, and to better understand patient experiences and perceptions of CTOs we need to take into consideration the context within which they occur. Few qualitative studies have explicitly investigated patients' and clinicians' experiences of CTOs in combination with ACT (Mfoafo-M'Carthy et al., 2018; Schwartz et al., 2010). Schwartz et al. (2010) show that patients were concerned about the stigma associated with mental illness and loss of dignity while being on a CTO. Jobling (2014) who conducted an ethnographic study, followed 18 CTO cases in two assertive outreach teams (UK) for eight months, found substantial variation in how different stakeholders (patients, providers and key informants such as clinical leads/managers), perceived CTO outcomes. In a recent study, Mfoafo-M'Carthy et al. (2018) show that although many patients had negative feelings of CTOs at first, many patients acknowledged that they felt better off on, rather than off it. Despite concerns regarding coercion, lack of autonomy and possible incongruence with a recovery approach, the clinicians agreed that combining CTOs and ACT resulted in an overall improvement in the quality of life for patients

(Mfoafo-M'Carthy et al., 2018). Few qualitative studies of clinicians' experiences with CTOs within an ACT setting exist. We therefore believe that our study of patients', ACT providers' and RCs' experiences with CTOs and CTO decision-making in the context of relatively newly established ACT teams can fill a gap in the literature.

3.6 Aim and research questions

The aim of this thesis was to obtain more knowledge of patient and staff experiences with CTOs and CTO decision-making practices in an ACT setting. Although more studies of patients' and care providers' experiences with CTOs have been published since I started to design this PhD project in 2013, the lack of knowledge of such experiences within an ACT context persists. Most qualitative studies of clinicians' views of CTO shed light on the initiation and justification of CTOs, while few studies of recall decisions and CTO termination exist. The ACT model has a clear focus on patient-centred treatment planning and recovery, and little is known about how the tension between patients' autonomy and the clinicians' duty to act in the patients' and society's best interest are resolved in practice. We posed the following three research questions:

- How do patients experience CTOs within an ACT setting? (Paper 1).
- How do ACT providers and RCs experience CTO decision-making within an ACT setting? (Paper 2). In Paper 2, the main focus was on clinicians' experiences with following up patients subject to CTOs within an ACT setting.
- How do clinicians reason and make decisions about the continued use of CTOs, recall to hospital and discontinuation of CTOs within an ACT setting? (Paper 3). In Paper 3, the main focus was on the RCs' reasoning and decision making practice.

4. Methods

Questions of an ontological and epistemological nature constitute the basis for the researcher's selection of research methodology and design (Thornquist, 2003). This means that general assumptions about the world determine what kinds of research questions we pose, and that general assumptions about how knowledge can be obtained determine how the study will be designed and carried out. In this chapter I will first present an overview of the research questions and the data collection sequences, before moving on to describe the beginning of the project: how data were generated and constructed, some key ethical aspects, and how the data were analysed.

4.1 Design

This thesis consists of two qualitative sub-studies and the broad research aims were to investigate patients' experiences with CTOs and providers' and RCs' experiences with CTOs and CTO decision making within an ACT context. Modified grounded theory (GT) was chosen as an appropriate approach, as it is well suited for the study of social phenomena where little knowledge exists. GT focuses upon relationships and social interactions in order to explore, understand or explain what people do and the meanings they make of their actions and the situation in which they are involved. GT provides a flexible methodological framework to develop analytical categories or theory grounded in the participants' accounts (Charmaz, 2014). In contrast to other qualitative research methods, data in GT are collected and analysed simultaneously, and these processes are not divided into two subsequent stages. GT methods based on a constructivist position (e.g. Charmaz, 2014) were used to explore and analyse data.

Patients', ACT providers' and RCs' experiences with CTOs and the CTO decision-making process studied in this thesis involve several issues, including legal regulations, decision making, health policies and clinical practice. Fifteen in-depth interviews with patients, eight semi-structured interviews with RCs and four focus group interviews with ACT providers were conducted. Participants were purposively recruited from four ACT teams that varied in size and in their use of CTOs and ways of organizing the responsibility for CTOs (see table 1, section 4.4), in order to broaden the range of included experiences (Patton, 1990). In addition, case file reviews and observations were used to become familiar with everyday clinical practice and the RCs' decision making.

Sub-study 1. The aim in this study was to explore patients' experiences with CTOs within an ACT setting: individual interviews were carried out.

- In-depth interviews with 15 patients (September 2013 to June 2014)

All the 15 participants from the patient study (Sub-study 1) consented that I could read their case file and the legal documents, attend treatment planning meetings and that I could talk to the ACT providers and the RCs about the use of CTOs in their case (Sub-study 2).

Sub-study 2. The aim in this study was to explore ACT providers' and RCs' experiences with CTOs and CTO decision making within an ACT setting, the following data sources were collected (from June 2014 to November 2015).

Phase I

- Case file reviews (September 2014 to November 2015)
- Semi-structured interviews with 8 RCs (September 2014 to November 2015)

Phase II

- Case file reviews (May to November 2015)
- Four focus group interviews with 20 ACT providers (May to August 2015)
- Observation of four selected treatment planning meetings (May to November 2015)

The first case file review was used as background information, to gain an overview of the clinical and legal documentation. The case files were first reviewed before the individual interviews with the RCs. Nearly one year later, the case file review was repeated, before the focus group interview in each team, and served as a reference point for discussing the RCs and the ACT providers' perspectives and experiences with CTO decision making within an ACT setting.

4.2 Methodological approach

The study of human experience in order to describe, interpret and explain social phenomena and actors' meaning making implies a qualitative and hermeneutic approach. Qualitative research methods provide systematic approaches to investigate phenomena from the perspectives of people who have lived experience of them (Malterud, 2001). Contrary to quantitative research methods, the nature of qualitative inquiry is interpretative and the purpose of the inquiry is to understand a particular phenomenon within a specific context, rather than to generalize to a wider population. Qualitative research methodology is underpinned by interpretivist epistemology and constructivist ontology, and in contrast to a positivistic paradigm, we assume that reality is subjective, multiple and socially constructed by people in their interaction with each other and with wider social systems (Creswell, 2013; Guba & Lincoln, 1994).

During the last 30 years, GT has evolved and to some extent also changed, since its originators, Barney G. Glaser and Anselm L. Strauss presented their original (classical) statements of the logic of grounded theory in 1967 (Charmaz, 2014; Glaser & Strauss, 1967). The early grounded theory writings had mixed epistemological roots in positivist epistemology, pragmatism and social interactionism. By developing this method, Glaser and Strauss aimed to provide a clear basis for systematic qualitative research and to offer a method with a solid core of data analysis and theory construction (Charmaz, 2014; Glaser & Strauss, 1967). Later modified versions of GT have departed from portraying GT as a pure inductive method that allows categories to emerge from the data through rigorous constant comparative analysis, independent of the scientific observer's interpretations (Charmaz, 2014).

In this thesis I have used the guidelines for a constructivist version of GT put forth by Kathy Charmaz (Charmaz, 2014). Subscribing to an interpretative and constructivist research paradigm provides premises and concepts for viewing social realities. In practice, this means that data and theories are co-constructed by the researcher and the participants, and that the researchers' positions, perspectives, priorities and interactions must be acknowledged by the researchers themselves and shared with their readers (Charmaz, 2014).

Although GT is primarily inductive in its approach, when the researchers begin to collect data, they move back and forth between data and analysis, and the researchers will

incorporate ideas, ‘sensitizing concepts’ and theoretical perspectives as tentative (analytical) tools to develop and refine their constructed categories. When employing theoretical coding researchers investigate how categories and codes constructed from data relate to each other as hypotheses to be integrated into a coherent story (Charmaz, 2014).

Symbolic interactionism, which is the major theoretical perspective associated with grounded theory, views interpretation and action as reciprocal processes, and understands meaning as derived through interaction (Blumer, 1969). Symbolic interactionism emphasizes agentic actors and action, leads researchers to attend to process rather than structure, and can be used to raise theoretical questions about the data (Charmaz, 2014). Social interactionists do not deny the existence of social structures but assume that people act in response to how they view the situation, and that people constitute society and collective life through interaction with others. Although Blumer (1969) argues that social structure is resistant and hard to change, the symbolic interactionist perspective treats interaction as indeterminate and open-ended because it consists of interactional processes. This implies that values and fact are linked and that realities are multiple and mutually constructed under specific conditions (Charmaz, 2014; Guba & Lincoln, 1994).

There are different perspectives on how existing literature should be used. Classical GT suggests a delayed literature review, to avoid forcing preconceived theoretical frameworks on the analysis of data. I have followed Thornberg’s advice to conduct a purposive preliminary review of the literature, to assist me in the early stages, followed later by a more concept- specific literature review to enhance my theoretical sensitivity thorough the research process (Thornberg, 2012). Entering the research field with an open mind should not mean shedding all preconceptions to enter the research domain as a tabula rasa. Initial engagement with the literature and reflexivity are important in writing about data and classifying them to assign meaning.

4.3 Starting point and preunderstanding

This thesis is part of the research-based evaluation of the first 12 Norwegian ACT teams. From 2009 to 2014, I was a member of a research team consisting of three sociologists, including myself, from Innlandet Hospital Trust and three clinicians from Akershus University Hospital. The Norwegian teams’ fidelity to the ACT model was assessed after 12 and 30 months, based on TMACT (Monroe-DeVita et al., 2011). During the fidelity

assessments, we specifically asked about organization, the team's use of collaborative approaches to engage service users and more restrictive interventions, and the team's evaluation routines. Nevertheless, we did not have sufficient time to address the team members' experiences with CTOs or the clinical and legal judgments in depth.

The Norwegian team's fidelity score at 12 months ranged from 2.7 to 3.7, indicating low to moderate fidelity (the range was 1-5, indicating no implementation to full implementation). The teams' mean scores after 30 months ranged from 3.1 to 4.1, indicating moderate to high fidelity. Although the scores on the different items showed large variation between teams, the teams had exemplary fidelity (4.4-5) after 30 months on several items (15 of 47) (Clausen et al., 2016a). Few teams had recruited a peer specialist, and although some had recruited a vocational specialist and a substance abuse specialist, they had not implemented the core principles as intended. The teams' case load size influenced many of the items, and the lack of availability of the teams 24/7 meant they were not fully responsible for crisis interventions outside their working hours.

The fact that the substantial differences in the teams' CTO rates did not seem to be reflected in the fidelity scores sparked my (sociological) curiosity. The only two teams with high fidelity scores after 30 months (3.8 and 4.1) were the two teams with the highest (52%) and the lowest CTO rate (6%) (see Table 1, Section 4.4). Although the ACT model has a clear focus on recovery and person-centred care, ACT has been criticized for being an inherently coercive approach. I was struck by the varying CTO rates and I was also curious about the different organization of administrative CTO responsibility among the Norwegian teams. While inpatient ward clinicians make decisions on whether or not to initiate CTOs following involuntary inpatient admissions, in most ACT teams the team psychiatrist or (clinical) psychologist was responsible for all administrative CTO follow-up decisions, including continuation of CTO, recall to hospital and discontinuation of CTO. In a few teams, all the administrative CTO responsibility was deferred to external clinicians at the outpatient clinic, who were not part of the treatment team. This was the origin of my motivation to explore assertive engagement strategies and varying CTO rates, and it is reasonable to assume that my insider position influenced my choice of research questions, methods, recruitment strategies, analysis, interpretation and conclusions. After finishing the first fidelity assessments among the 12 teams, I started to search for literature about formal and informal coercion. When I started to design this thesis in 2013, no studies with

Norwegian data existed, and the conflicting interpretations of the CTO evidence was a motivation to learn more. I also believe that my background as a sociologist and previous work experience from a regional substance abuse centre might have influenced the research process.

4.4 Recruitment of teams

We recruited participants from the two teams with the highest (52%) and lowest CTO rates (6%), and also teams that organized the administrative CTO responsibility differently, to broaden the range of included experiences (Patton, 1990). The decision to select teams with varied organization of the administrative CTO responsibility had important implications for the subsequent data collection, and was carefully considered and discussed with all three co-authors (supervisors). Organization varied within the teams and there was also one team that had deferred the administrative follow-up responsibility to clinicians at the CMHC that were not part of the treatment team.

Table 1: Recruited teams: included patients, CTO rates and responsibility for CTOs and CMOs (Stuen, Landheim, Rugkåsa, & Wynn, 2018)

	Caseload	CTO rate (%)	Responsibility for CTOs	Responsibility for CMOs (compulsory medication orders)
Team 1	76	40 (52)	ACT psychiatrists	ACT psychiatrists
Team 2	67	4 (6)	ACT psychiatrist/psychologist	ACT psychiatrist
Team 3	68	23(33)	External psychologists (CMCC)	ACT psychiatrist
Team 4	38	13 (34)	External psychologists (CMHC)	External psychiatrist (CMHC)

4.5 Recruitment and sample, Sub-study 1

When the inclusion of patients started in April 2013, all the teams had been established for more than 30 months. The recruitment period lasted until November 2015. After the team leaders had confirmed that the teams were willing to participate in the study, a letter to the patients was forwarded through their case manager or the team psychiatrist, depending on whom the patient knew best, to invite eligible patients to participate in the study.

4.5.1 Recruitment and participants, Sub-study 1

We specified in the information letter to the team leaders that we wanted to recruit both male and females who had been enrolled in ACT and subject to a CTO for at least six months, with and without co-occurring substance use, and also that we wanted to recruit patients who were under a CMO. The only exclusion criteria we developed were that the patient had to be enrolled in ACT and subject to a CTO for at least six months. Another criterion was that (the team considered whether or not) the participant had capacity to give informed consent to participate in the study.

We had initially decided to recruit patients, ACT providers and RCs from three teams. However, because we did not manage to recruit more than one participant from one of the teams (Team 3, see Table 1), we decided to include a new team to recruit more participants.

Across the four teams, the team leaders recruited 17 patients among 80 patients subject to a CTO, and 15 of them, nine men and six women, gave their written consent to participate. One participant did not come to our initial appointment. The ACT providers (Team 3) tried initially to reschedule the appointment, but later considered that the participant was not currently capable to provide informed consent to participate in the study. Another participant (Team 1) refused to sign the written consent to participate in the study and was therefore not included. Fifteen participants (nine men and six women), with an age range from 27 to 54 years, gave their written consent to participate in the study.

Fifteen in-depth interviews with patients subject to CTOs were conducted from September 2013 to June 2014; eight participants from Team 1, four from Team 2, one from Team 3 and two from Team 4 were interviewed. The interviews lasted from 35 to 120 minutes. Two participants (from Team 1 and Team 2) refused to be audio recorded, and in these interviews careful notes were taken instead of audio recordings.

Table 2: Characteristics of sample (Stuen, Rugkåsa, Landheim, & Wynn, 2015)

Participants	N
Male	9
Female	6
Diagnosis	
Psychotic disorders, including schizophrenia	10

Schizoaffective disorder	5
Housing	
Independent accommodation	9
Lives alone in staffed sheltered housing	6
History of homelessness after enrolment to ACT	2
Duration of current CTO	
More than one year	11
Less than one year	4
Active substance abuse	
Yes	9
No	6
CMO	
Yes	4
No	11
Antipsychotics	
Depot	12
Oral	2
None	1

4.5.2 Data collection, Sub-study 1

Although qualitative interviewing has many similarities to everyday conversations, it is understood as a situated dialogue with the aim of mutually generating data. In the interviews with patients, it was important to find out how they viewed their worlds, and to understand their actions as they saw them. However, the interview conversation is based on the researchers' agenda and interpretations, which implies a power asymmetry, and the researcher has to take ongoing decisions to navigate and complete the interview. Before the data collection, I developed a thematic interview guide jointly with my co-authors, focusing on the patients' experiences of CTOs. Based on an assessment of the literature, the interview guide was built around the following themes: why and how the CTO was established, how the CTO influenced their lives, and their contact with the ACT team. They were then asked to what extent and how they were involved in the decision-making process. A pilot interview with a person with previous experience of CTOs was also conducted, to frame and refine the questions. The pilot interview was not included in the study.

It was up to the participants to decide where they wanted to meet me. Some participants wanted to meet me at other locations (CMHC, ACT team's facilities, etc.), but most

wanted me to come to their flat. To ring their door bell, to put my shoes next to theirs, and to sit down in their living room and be served coffee was a very different setting from sitting in a clinical office to talk about their daily lives. When I asked about their life situation, some participants showed family pictures and started immediately to talk about their first illness episode and their initial contact with mental health care services.

Because some participants were not included in the national evaluation, and were more uncertain about whether or not to participate in the study, I spent more time with these to introduce the ACT evaluation and to describe the present study. In three interviews, team members and one team psychiatrist came with me to introduce me as an interviewer, to ensure that the patient would feel safe and comfortable with participating in the interview. In one interview the ACT provider stayed for 10 minutes before asking the participant if he was happy to continue the interview without his presence. The interview lasted for 90 minutes, and the participant continued to talk in depth about his experiences and viewpoints about CTOs and the long-term use of compulsory medication, and I do not believe that the ACT provider's initial presence influenced the participant's account. In the other two interviews the ACT providers left before the interview started.

Due to long travelling distances, I conducted the first four interviews in one team during three days. All the interviews started with open questions about their everyday lives, the content of the CTO and whom they had to rely on if they needed someone to talk to or to help them solve problems. After each interview I wrote down reflections to describe the interview context and the flow of the conversation and I also listened through each interview to write down initial thoughts. Since I did not have time to transcribe the first interviews successively, I listened through the first two interviews to reflect upon my own style of interviewing, identify poor questions and missed opportunities to follow up and explore the participants' meanings. The first four interviews were transcribed and then coded successively. Qualitative analysis was performed using methods from GT.

4.5.3 Data analysis, Sub-study 1

The study was guided by a constructivist grounded theory approach, and data were coded in three phases: initial, focused and theoretical (Charmaz, 2014). These phases are not to be viewed as a linear analytical process, rather, the researcher moves between them, back and forth between data collection and comparative analysis.

In the first phase (initial coding), segments of data from the first four interviews were named and thematically coded, sentence for sentence. During the initial coding, I tried to remain open to generate as many ideas as possible inductively. Through initial coding the researcher opens up the data, to define what is happening in the data and ask analytical questions, such as what is happening here, which processes are the participants talking about, and how do they understand them (Charmaz, 2014). The codes captured participants' words as representative of a broader concept of the data, such as "*control*", "*threats*", "*voluntary coercion*", "*they take me as I am*", "*I am willing to collaborate*", "*safety net*" and "*protection*". Keywords and phrases were noted on different coloured Post-it notes and stuck on to a blank A2 chart sheet. The Post-it notes were arranged in a logical order on the paper, and as more interviews were coded, the Post-it notes were compared and sorted, like a brainstorm map that was filled out, and combined with memos, to keep track of thoughts and ideas on the data. Although I performed the coding, all co-authors read two of the first interview transcripts, and were involved in discussions about the most significant codes and concepts.

One emergent theme was the participants' equivocal perceptions of CTOs and the ACT team's enactment of the order and the association between perceived coercion and motivation, which I followed up in more in more depth in the following interviews. Some of the immediate reflections and first memos were important through the data collection process, to focus more directly on the patients' different views and experiences of CTOs. The other interviews were transcribed and successively coded by me.

At the end of this coding exercise, two A2 sheets were covered with Post-it notes containing tentative categories and codes. I also kept a simple table in Microsoft Word to sort all the codes, properties and dimensions, as well as some comments and quotations. This system of creating codes, combined with analytical reflection, was maintained for all interviews. The list of codes was revised continuously as more interviews were coded, and the tentative categories were modified and verified by being applied to further interview transcripts.

During the second phase, focused coding, the most significant and frequent codes from the initial coding were clustered in theoretically linked themes, resulting in a more focused and conceptual analytical approach. These focused codes guided the analysis and were raised into tentative categories by further constant comparison and clustering of

codes and by the construction of working definitions. In this phase it was important to examine how the codes related to each other, and whether the participants had described a typical process.

Three main categories that reflected a tension between the perceived restrictions of CTOs on the one hand and receiving care, treatment and coordinated services from the ACT team on the other were identified (Table 3). While some considered the CTO as a social control mechanism and as a violation of their autonomy, many participants emphasized that there had been an overall reduction in coercive crisis interventions, and that the benefits of receiving support and coordinated services from the ACT team outweighed the disadvantages. We paused the coding process after the first four interviews, and also after interviews eight and thirteen, to conduct more in-depth reviews of the data, following the constant comparative method.

Focused coding was performed manually (Post-it notes and code list), and thereafter the transcripts were imported into NVivo software (Version 10) to gain a better overview of the data. Throughout the study, in order to make constant comparisons between data, codes and categories, I wrote extensive case-based and conceptual memos to develop and refine the properties of each category.

In the third phase, theoretical coding, possible relationships between categories were examined and specified. Theoretical codes were used to form an analytical story of the data (Charmaz, 2014). In accordance with a constructivist approach, pre-existing theories and concepts were also used as a starting point as well as sensitive concepts; this provided inspiration and analytical tools during the analysis (Thornberg, 2012). For instance, in line with Sjöström’s ethnographic study (2006), several participants claimed they would have to follow prescribed treatment whether or not the CTO expired (‘coercion context’). To illustrate the process, Table 3 shows the sub-categories and categories derived from two quotes

Table 3. Main categories and sub-categories

Quotes	Sub-category	Main category
<i>“If I had been transferred to a voluntary status I would have to use medication anyway. If you accept taking medications, the legal compulsion will be discontinued, but if you refuse, if you</i>	Control and protection Lack of influence on medication Coercion context	Experiences with involuntary treatment

<p><i>don't want to take medication, you will be put back on a CTO."</i></p> <p><i>"I'm still taking Cisordinol, which I guess I have accepted. I have some inner peace, ...so it might work. I have accepted that I can live with that medication... Now we have agreed that she (referring to the dialogue with the ACT psychiatrist,) will support me to regain my driving license... and also, practically, they (the ACT team) helped me to clean up my apartment."</i></p>	<p>Building trust</p> <p>A frame for interaction</p> <p>Negotiations about treatment</p> <p>Reflecting the need for treatment and care</p> <p>Security net</p>	<p>The importance of trusting relationships</p> <p>Collaboration as strategy</p>
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Constant comparison and coding were conducted until no new concepts and no significant new insights about the categories emerged. After we had conducted thirteen interviews, and scheduled another two interviews in Team 4, we discussed whether to recruit more participants, but considered after the next two interviews that no new observations or information was revealed (Charmaz, 2014). We discussed meaning saturation as a goal rather than as a reality, as the development of concepts and substantive theory is an open process and modifications of categories are always possible (Malterud, Siersma, & Guassora, 2016).

4.6 Recruitment and sample, Sub-study 2

4.6.1 Recruitment and participants, Sub-study 2

Because we knew that some teams had struggled to recruit psychiatrists, the only inclusion criterion for the individual interviews was that the clinicians had been responsible for the CTO case for one of the 15 patients interviewed in Sub-study 1. Although the participants were purposively recruited, we also decided to also recruit one ACT psychiatrist, who was not directly involved in administrative CTO decisions (Team 4), to better understand the division of roles and the decision making process. This psychiatrist had prior experience with CTO from inpatient hospital wards and the CMHC. At the end of the study period we also included a newly recruited ACT psychiatrist (Team 2).

Instead of interviewing the ACT providers individually, we chose focus groups, because focus group discussions may enable participants to respond and reflect upon ideas shared

by others (Foley & Timonen, 2015). We chose not to include the RCs (team psychiatrists and the external RCs) in the focus groups. While the ACT psychiatrists participated in daily team meetings, the external RCs (based in the Outpatient Clinic) followed up a few CTO patients each, whom they regularly met face to face to conduct third monthly CTO assessments, but were not involved in ongoing team discussions. The only inclusion criterion for the study of ACT providers' and RCs' experiences with CTOs and decision making was that the focus group participants (ACT providers) had two years' experience from ACT. ACT is a comprehensive service delivery model, and we wanted to recruit focus group participants that were trained and familiar with ACT and who also knew most of the enrolled patients. Although most focus group participants had worked in ACT for two years or more, in one of the focus groups (Team 3) two participants had been in ACT for six months or less. In this focus group, two mental health nurses with long ACT experience talked more than the other participants. Although the descriptions and reflections were similar to the other focus group discussions, we cannot exclude that this may have influenced the results.

Table 4: Participants in individual interviews and focus group interviews (Stuen et al., 2018)

	Individual interviews	FG /Team 1	FG/Team 2	FG/Team 3	FG/T4
Responsible clinicians					
ACT psychiatrists	6	2	2	1	1
CMHC psychologists	2				2
ACT providers					
Psychologists			1	1	1
Mental health nurses		2	2	2	2
Social educators		1	1		
Social workers		2	1		1
Nursing assistants		1			
Peer specialists		1		1	
Total	8	7	5	4	4

4.6.2 Data collection, Sub-study 2

In addition to individual interviews and focus group interviews, case file reviews were used as a reference point for discussing treatment non-adherence and CTO decision making with the RCs and the ACT providers. The case file reviews were conducted from September 2014, before the individual interviews with the RCs, and then repeated, before the focus group interview in May to August 2015.

Case file reviews

When conducting case reviews, I first read the documents related to the patients' first involuntary admission, and then the following CTOs assessments in the two-year period before and after enrolment in ACT for each patient. I also looked through the team's notes on patients for the last four weeks before CTO decisions were made. This procedure was repeated before the focus group interviews, in May to August 2015.

Individual interviews

In the individual interviews, all the RCs were asked to discuss specific CTO decisions, including continued use of CTOs, recall to hospital and discontinuation of CTOs. The interviews were based on a thematic interview guide that I developed jointly with my co-authors, drawing on an assessment of relevant literature, previous patient interviews and associated case files. Although the RCs were asked to describe and provide details of specific cases, many RCs also drew on their general experience with CTOs to provide typical examples of the content of the CTO, their reasoning and the clinical implications.

I started all interviews with open questions about the enactment of CTOs and the organization of the follow-up responsibility. We also asked the RCs about the strategies applied to develop supportive relationships with the patients and about their perceptions of CTO decision-making within an ACT context. After the two first interviews, in accordance with the theoretical sample principles of GT (Charmaz, 2014), the interview guide was expanded in an attempt to incorporate questions that could elicit data that was relevant to further developing the ongoing analytical process. One theme that emerged was the lack of interagency collaboration and bed pressure, which invoked conflicting priorities. The interviews were conducted at the CMHC and at the ACT team's facilities. The individual interviews lasted 55–110 minutes, and were audio recorded and transcribed successively by me.

Focus group interviews

The purpose of having focus group interviews with the ACT providers and individual interviews with the RCs was to compare and contrast the RCs' different roles and legal responsibilities regarding CTO use. In two of the teams (Team 3 and Team 4) the external decision makers were not involved in the team's regular meetings and ongoing treatment discussions. Before the focus group discussions started, I introduced the study, myself and the co-moderator, an experienced mental health nurse who also was familiar with the ACT model. Her role was to take careful notes, help me to involve all the participants in the discussion and to summarize important viewpoints. I also asked if they had all read the request I had sent to the team leader by email to specify that the interview was scheduled for 120 minutes, and also to emphasise that participation was voluntary.

Since I had previously met some participants while conducting fidelity assessments (in Teams 1 and 2), it was important to specify that the focus group discussions had a different purpose. I pointed out that the ACT teams' CTO rates varied and that the CTO responsibility was organized differently across the teams, and that I wanted them to describe, reflect upon and discuss their views and experiences with CTOs. In all the focus group interviews the participants were asked to introduce themselves, briefly describe their previous experience with the patient group and with following up patients on CTOs, and when they started in ACT. I started all interviews with a very general and open question, asking them to comment on the ACT model's focus on collaborative interventions and rapport building on the one hand and describe their experiences with following up patients mandated to accept treatment on the other.

The following extract in Table 5 shows that the different ACT providers' responsibilities regarding medication administration and their functioning in their team seems to influence their perceptions of CTOs. The quote also illustrates how focus group discussions have the potential to elaborate and expand the participants' perspectives. It was the group and the interaction that emerged during the conversation that was the informative source and not primarily the individual staff member's perspectives.

Table 5. Focus group interaction

Team 2

Me: We can start with you (name/social worker)

Participant 1: I don't think there's such a big difference. Some of those who are subject to coercion, who arrive like that, are still cooperating with us regardless of whether there's coercion or not. That's the impression I've got. Once we've established contact, coercion doesn't play such a huge part, except when it comes to situations where we... where they show that they don't want to cooperate. But I think, from a social therapy point of view, it's like a dialogue regardless of coercion.

Participant 2: Can we join this conversation?

Me: Yes.

Participant 2: I disagree a bit. I think for some patients we have who are under coercion, it can be difficult to get a good relationship with them. Like with (X) who we often go and see, it's difficult to get good cooperation and get him to trust us. (...) There's a lot of focus on coercion. There's a lot of coercion in relation to medicines, er... there's a lot of focus on what's negative for him when we're with him. We do get along well sometimes, when we talk about other more pleasant things, but I think ... it seems harder for him to relate to us because he's under coercion.

Later in the interview Participant 1 referred to her initial statement, saying that:

I retract the first thing I said, that it didn't matter so much. The people on coercion who come here, well they arrive with a different position.

This extract also shows that the conversation often switched back and forth, and because the quotes were often loaded with important insights and conceptual leads, the focus group discussions were more challenging to navigate than the individual interviews. I was sometimes uncertain whether or not to ask the participants to specify a particular situation or viewpoint or to allow the focus group discussion to continue.

One strategy I used was to specify that I would ask the participants to discuss a specific episode or viewpoint in greater depth later in the interview, and ask the participants to continue their reflections and give a sign to the co-moderator to make notes and to help me remember. When I wanted to change the topic I often summed up and asked the co-moderator if she had something to add or specific questions she would like to ask. After each focus group interview she transcribed her notes and we met to discuss and consolidate our impressions. All the focus group interviews were audio recorded and successively transcribed and coded by me.

Non-participant observation

After I had transcribed and coded the individual interviews and the focus group interviews, I also attended four theoretically sampled treatment planning meetings, one in each team. The treatment planning meetings were specifically selected to capture treatment discussions and how CTOs were justified and described in the legal documents and as presented by the ACT providers and the RCs. In one case the CTO was removed, another patient had recently been involuntarily admitted some months after the CTO was removed, in two cases the RC clearly stated that the CTO was to be continued and in one of these cases the team discussed the need for long-term compulsory inpatient substance abuse treatment.

During the treatment planning meetings, I listened to the team discussion, mainly to explore the teams' treatment planning practice and reflections on the use of CTOs. Although the ACT psychiatrist participated in the treatment planning meetings, external decision makers, who were not part of the team, were not involved in the treatment planning process and multidisciplinary input and discussions were not part of the CTO assessment.

Only one team (Team 2) had systematically included patients in treatment planning meetings. In this team, all patients were invited to come to the ACT team's facilities, and most patients attended a so-called annual review. First, the patient had a scheduled appointment with the psychiatrist, who conducted a physical and psychiatric assessment. All patients were asked to describe their situation, perceived medication side-effects and if they had any current medical concerns. Thereafter, each patient sat down with one of the team members to talk about and update the patients' treatment goals, where the ACT provider documented the patients' viewpoints and wishes. The patient did not want me to

record the meeting but agreed that I took notes. In some cases, the case manager had documented the patients' wishes and also conflicting perspectives if the team had different treatment goals in the case file. While some ACT providers in the other teams regularly sat down with the patients to highlight the patients' treatment goals and preferences, it was not an established practice in all teams. Some of the teams lacked procedures for systematically updating the treatment plans.

4.6.3 Data analysis, Sub-study 2

Concurrent data collection and comparative analysis, to develop initial and more focused codes, and to continue to collect data to test conceptual leads and hypotheses, is fundamental in a grounded theory research design. Coding generates ideas to explore and to expand, and occurs in stages.

In this sub-study I started by reading specific case files in each team, to gain an overview of the clinical and legal documentation in each case. This information was used as a reference point to ask more specific questions about the RCs' reasoning and decision-making practice. After the initial coding of the first two interviews, I used the same procedure with Post-it notes combined with a separate matrix with codes and tentative categories. In the following interviews I combined open-ended questions with more focused questions and hypotheses about abstract concepts and tentative categories, to specify their properties and define relationships between them.

I successively coded the first five individual interviews with the RCs, before conducting new case file reviews. I then conducted the focus group interview in each team, which I transcribed and coded. The last two individual interviews with RCs were at the same time as the focus group interviews. To enhance the coding approach, the focus group interview and RC interview transcripts (from the same team) were analysed alongside each other. Through these iterative stages of analysis, the codes, concepts and categories within and between transcripts and different data sources were compared to look for similarities and differences. Memos, which is a core element in GT, were used to compare data, explore ideas about codes, and to direct further data gathering to increase the level of abstraction.

Although the treatment planning meetings were transcribed and analysed, they were mainly used to validate the categories, and not used a primary data sources. Agreement was reached between me and the co-authors through ongoing discussions about categories that emerged and theoretical saturation. The initial and focused coding was performed

manually, after which the data was moved into the NVivo software to achieve a better overview of the data. The process of constant comparison was continued with the help of the software. Subsequently, in theoretical coding, possible conceptual connections between categories were examined by comparing, sorting and combining the memos, in order to integrate them into a coherent story (Charmaz, 2012).

4.7 Ethical considerations

The study was part of the national research-based evaluation of the 12 Norwegian ACT teams, and before recruitment of participants, relevant approvals were obtained. The initial plan was to recruit patients enrolled in ACT who had consented to participate in the national evaluation, with the ethical approval for the national evaluation granted by the Research Ethics Committee (2010/1196), which also applied to this study. In addition, we obtained a separate approval for this study, since we also wanted to recruit participants who had not consented to participate in the national ACT evaluation. The ethical approval granted by the Research Ethics Committee also applied to the focus group interviews with ACT providers and individual interviews with responsible clinicians, and also, to conduct case file reviews and observation of treatment planning meetings. Approval of the study was also granted by the PhD programme at the Faculty of Health Sciences of UiT The Arctic University of Norway, following the preparation of a detailed dissertation proposal.

In the interview setting, before the interview started, I first informed the participants about the study. I also spent time to explain that we have little knowledge about the content and the duration of CTOs, and that our aim was to conduct a study of providers' and RCs' experiences with CTO decision making within an ACT setting. I therefore asked for their permission to discuss their CTO case with ACT providers and the RCs, and also requested permission to read their case file, which those included in the national evaluation had consented to in writing. Five participants who were not included in the evaluation consented to participate in the study in writing.

One main concern is that participants may have felt pressure to participate, and another concern was that the interview could arouse painful emotions. I had made an agreement with the team leader to inform all participants that they could contact the ACT team if they needed someone to talk to. All informants were informed that their participation was

voluntary and that they could withdraw their consent at any time. I also explained that they could call me or send me an email if they had questions about the study or if they wanted to reformulate something they had said. I also asked the participants about how they had experienced the interview. While some just nodded and said it was OK, others said that they appreciated the opportunity to describe their experiences with CTOs and ACT, and that they hoped that their viewpoints could be used to describe current practice and help other people.

5. Results

In this chapter I will summarize the results of the three papers included in this thesis.

5.1 Summary of Paper 1

“Increased influence and collaboration: a qualitative study of community treatment orders within an assertive community treatment setting”

Background: The first 12 Norwegian Assertive Community Treatment (ACT) teams were piloted from 2009-2011. Among the 338 enrolled patients during the teams’ first year of enrolment, 38% were subject to community treatment orders. The purpose of this study was to explore patients’ views of CTOs within an ACT context.

Methods: We conducted in-depth interviews with 15 patients that were followed up by ACT and currently subject to CTOs. The data were analysed using a modified grounded theory approach.

Results: Although most participants described CTOs as a less restrictive intervention than involuntary inpatient admission, they had different views of CTOs. While some participants presented CTOs as a control mechanism and as a serious violation of their autonomy, others perceived CTOs as a safety net and as an important factor to stay well. Many participants considered the length of CTOs as a main concern. The three main categories in this study, experiences with involuntary treatment, the importance of trusting relationships and collaboration as a strategy, indicate that the perception of coercion is context dependent and that the ACT team’s comprehensive and integrated services provided a different mental health setting from what they had known before, with a different frame of interaction. The ACT team’s availability, the flexible combination of interventions, continued care, support and possibility to make choices were considered as important improvements to traditional (office-based) community mental health services. Many participants valued the ACT team’s focus on addressing unmet needs such as finding housing, getting assistance with their finances, and reducing isolation. Participants with active substance abuse emphasized that there had been an overall reduction in coercive crisis interventions, and that the benefits of receiving practical support and coordinated services from the ACT team outweighed the disadvantages.

Several of the participants described a gradual transition toward increased influence, collaboration and shared responsibility.

Conclusion: The relationship between care providers and patients is of importance to how patients interpret the providers' behaviour and use of restrictive interventions. While some remained clearly negative to the CTO, many participants stated that they had come to accept the CTO, provided that they received other services they found beneficial.

5.2 Summary of Paper 2

“Responsibility with conflicting priorities: a qualitative study of ACT providers’ experiences with CTOs”

Background: Few studies have explicitly investigated the use of community treatment orders within an ACT context. The aim in this study was to explore ACT providers’ and responsible clinicians’ experience with CTO decision-making within an ACT setting, and how the tension between patients’ autonomy and clinicians’ responsibility to act in patients’ best interest is resolved in practice.

Methods: Four focus group interviews with 20 ACT providers and eight semi-structured interviews with RCs involved in CTO decision making in ACT were conducted, combined with case file reviews for 15 patients. The data were analysed using a modified grounded theory approach.

Results: The analysis of ACT providers’ and RCs’ accounts and experiences of CTOs within an ACT setting shows that the CTO follow-up responsibility involves challenges and dilemmas. Many patients enrolled in ACT have concurrent substance abuse and low social functioning, and a main finding was that the ACT providers and RCs believed the CTOs were sometimes necessary in order to provide continued treatment. The team approach and a high proportion of in vivo contact were considered to be particularly important, in that it afforded comprehensive and patient-centred support and opportunities to build rapport. However, balancing effective care and patient autonomy was difficult. Three categories leading to the main theme of ‘responsibility with conflicting priorities’ were identified; ‘conflicting priorities: treatment and autonomy’, ‘ACT and providing practical support and comprehensive services’ and ‘ACT and building rapport’. Engaging reluctant patients was described as laborious work, and as many participants in our study

indicated, lack of time and available treatment resources could lead to an overly defensive CTO practice. Shared caseload responsibility and daily team meetings were presented as windows of opportunity to a more responsive treatment approach. Many participants referred to CTOs as a safety net to facilitate medication reduction, especially those with a history of rapid relapse or serious illness episodes. It was important to try to establish a common understanding about the need for medications and patients' possible choices and opportunities, especially if it was uncertain whether the medication was effective.

Conclusion: Many participants emphasized that for patients placed on CTOs, the ACT approach could address non-adherence and relapse at an earlier stage than traditional services and more easily offer patients choices and negotiate treatment in crises.

5.3 Summary of Paper 3

“How clinicians make decisions about CTOs in ACT: a qualitative study”

Background: Few studies have explicitly investigated the use of CTOs within an ACT setting. The aim of this study was to explore how RCs reason and make decisions about continued use of CTOs, recall to hospital and discontinuation of CTOs within an ACT setting.

Methods: The study was based on eight semi-structured interviews, case file reviews and observation of selected treatment planning meetings. The data were analysed using a modified grounded theory approach.

Results: The participants emphasized that CTOs were mainly founded on patients' clinical needs, and also that establishing stability and safety for patients enrolled in ACT is often a lengthy process. Many patients subject to CTOs were referred from hospitals and high security facilities, and the RCs emphasized that CTO decision making typically involved multiple and interacting risk factors. In the analysis, we identified three categories leading to the main theme of 'feeling more confident and secure through shared responsibility', illustrating that being part of a multidisciplinary team with shared caseload that provided intensive services allowed for more nuanced assessments and reduced coercion. However, there was substantial variation in the RCs' interpretation of the dangerousness criterion. The external clinicians who were not part of the treatment team expressed more doubts about the accurate prediction of risk. Many participants

referred to the functional split between inpatient and outpatient care, and the lack of communication and uncoordinated changes to treatment plans as typical concerns. Further major concerns were bed pressure and lack of inter-agency collaboration on a small subgroup of patients with co-occurring substance abuse with higher risk of victimization and violence during acute phases of illness.

Conclusion Patients' need for treatment was typically used to justify the need for CTOs. In some cases the RCs described the use of CTOs combined with ACT as a long-term safety measure to contain dangerousness and to prevent harm. Our study participants emphasized the context in which psychiatric assessments were made, and that a multidisciplinary team approach and close monitoring allowed for more focused preventive efforts.

6. Discussion

This chapter discusses how the two sub-studies, combining empirical data with theory and previous research, address the research questions: how patients and ACT providers experience CTOs and RCs' decision making within an ACT setting. In Section 6.4 I will discuss the methodological strengths and limitations. In section 6.2.5, before the Conclusion, I will discuss some clinical implications and possible avenues for further research.

6.1 Discussion of the main findings

Our first study highlights a variety of experiences related to CTOs, mainly understood as the need to accept treatment and to have regular contact with the ACT team. Many patients described a gradual transition toward regarding the CTO in combination with ACT as an acceptable solution, provided that they received other services they found beneficial. The analysis of the ACT providers' and the RCs' accounts showed that CTOs were mainly founded on patients' clinical needs, in order to provide continued treatment. The providers and the RCs underscored that the ACT model's team approach, comprehensive service provision and frequent patient contact allowed for increased flexibility and more voluntary solutions on CTOs. In some cases, and more frequently for patients with co-occurring substance abuse, the RCs considered CTOs as a long-term measure to reduce or contain dangerousness and to prevent harm.

6.1.1 Patients' gradual transition toward regarding the CTO as an acceptable solution

As has been suggested in some previous studies, the participants had different views of CTOs (Corring et al., 2017; Gibbs et al., 2005; Pridham et al., 2016). While some participants perceived the use of CTOs as a security net and as an important factor to stay well, others considered CTOs as a control mechanism and as a serious violation of their autonomy (Nyttingnes, Ruud, & Rugkåsa, 2016). Although many patients were negative towards CTOs, and stated that they wanted the CTO to be discontinued, and to get off antipsychotic medication, most participants described ACT as a different mental health setting than they had known before, with a different frame of interaction. The ACT team's flexible range of interventions and practical assistance to solve practical everyday problems, such as secure housing and finances, was presented as important improvements

on traditional (office-based) mental health services. Three main categories were identified: ‘Experiences with involuntary treatment’, ‘The importance of trusting relationships’ and ‘Collaboration as a strategy’.

Some patients described a change process involving acknowledging the need for treatment, and presented the CTO in combination with ACT as a negotiated agreement, and as an important factor to stay well. This finding concurs with previous studies that show that some patients consider the CTO as a helpful step toward community stability (Gibbs et al., 2005). In order to obtain help and to stay safe, a few patients wanted the CTO to be continued to assure the team’s obligation to intervene if their condition worsened, and they were not capable of making sound treatment decisions.

Nevertheless, many patients in our study had difficult experiences from mental health care, and were struggling with personal losses, distress and lack of engagement. Subsequently, many participants described a challenging process of developing a trusting therapeutic relationship with the ACT team. As other studies have shown, many patients highlighted the ACT providers’ and the team psychiatrist’s willingness to listen to their experiences, and to have a say in treatment decisions as an important starting point for building supportive therapeutic relationships and shared treatment goals (Appelbaum & Le Melle, 2008; Priebe, Watts, Chase, & Matanov, 2005). Interaction with empathetic and engaged clinicians and increased influence in treatment decisions were seen as particularly important to promote patients’ sense of hope and self-agency, the belief in the possibility of a better future and the power of their ability to influence their own life (Bjornestad et al., 2017; Veseth, Binder, & Stige, 2017). The results suggested that how patients viewed care providers’ attitudes and their ability to provide tailored help and communicate respectfully seemed to influence patients’ recovery processes and satisfaction with treatment.

Some previous studies have shown that many patients seem to value the access to services and the sense of security obtained (Riley et al., 2014), and that some patients attribute improvements in their health and social functioning to treatment under the order (Gibbs et al., 2005). In a Norwegian study, Lofthus et al. (2016) showed that patients subject to CTOs were more satisfied with ACT than voluntarily enrolled patients and also that patients subject to CTOs reported the highest recovery rates (Lofthus et al., 2018). Based upon many patients’ past experiences of mental health care and coercion, and modestly

improved life conditions after enrolment to ACT, some authors have concluded that it is not coercion per se that is the key ingredient but the service context that accompanies it (Lofthus et al., 2016; Phelan et al., 2010).

6.1.2 Patients' emphasis on the importance of a trusting relationship and collaboration

Several studies have argued that patients subject to CTOs experience a paternalistic and one-dimensional focus on medication compliance, which seems to impede their recovery processes (Mancini et al., 2005; Stensrud et al., 2015). In a recent Norwegian study, Stensrud et al. (2015) show that many patients subject to CTOs felt that they that they were being locked in a passive patient role and that their life was on hold. Stensrud et al. (2015) show that most patients contrasted the CTO with living an ordinary life in the community, and that many patients felt that the CTO hindered them from activating their own strengths and resources (Stensrud et al., 2015). These findings indicate that the power dynamics and interactional context of coercion (Sjöström, 2006) have a huge existential impact because they may alter the identity of patients (Gault, 2009; Norvoll & Pedersen, 2016).

Recovery is often described as a unique personal process, which can be distinguished from a clinical response or symptom amelioration in that its fundamental emphasis is on hope, empowerment, self-management and opportunities for participation and social integration (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007). Several studies have shown that change processes and achievements that are normally seen as deeply personal, such as positive changes in self-perception and identity, are predominantly interpersonal. An important aspect of these studies (Borg & Kristiansen, 2004; Schön, Denhov, & Topor, 2009; Topor, Borg, Di Girolamo, & Davidson, 2011; Topor & Denhov, 2015) is that recovery is seen as a interpersonal and social process, and that individuals are able to redefine themselves as a person (as opposed to a patient), with problems but also with strengths and abilities, through social relationships (Schön et al., 2009). In a grounded theory study of 58 Swedish participants who either considered themselves recovered from SMI or in a process of recovery, the helpful relationships with professionals were characterized by cooperation and reciprocity (Schön et al., 2009).

Many people with SMI consider recovery as a journey of small steps, characterized by a growing sense of agency and an installation of hope (Drake & Whitley, 2014). ACT targets patients with co-occurring substance use problems and low social functioning, who often lack social networks and support. The patients in our study emphasized that having someone to call who encouraged them to participate in everyday activities, and also that control over symptoms and the overall reduction of coercive crisis interventions, and shorter inpatient stays were important building blocks to gain increased control over their lives. Thus, Weingarten's notion of "reasonable hope", seems relevant: this is relational and concrete and directs our attention to what is within reach more than what may be desired but unattainable (Weingarten, 2010).

Consistent with previous research (Borg & Kristiansen, 2004; Dixon et al., 2016), our study shows that building trusting therapeutic relationships takes a long time. Many patients emphasized that "small things", such as being offered a cup of coffee and practical help to arrange furniture or everyday activities, in addition to conversations that are not primarily interventions to improve the person's adherence to treatment, can have major importance in improving service users' condition and well-being. What is here referred to as "small things", such as having someone to talk to, and also joke with, who does not give up on them (Deegan, 1988), along with the experience of being listened to and having one's experiences and knowledge respected, has been reported as pivotal in many studies (Ness, Kvello, Borg, Semb, & Davidson, 2017; Schön et al., 2009; Ware, Tugenberg, & Dickey, 2004). Herrestad and Biong's (2011) phrase "as opening something locked", used to describe the understanding of hope of members of crises resolution teams and home treatment teams, seems relevant (Biong & Herrestad, 2011).

Several studies have showed that these "small extra" things (such as buying food or giving cigarettes) which sometimes imply that health personnel provide services or favours that extend beyond their professional duties, have major "symbolic value" that make the individual feel valued and cared for (Ljungberg, Denhov, & Topor, 2015; Skatvedt, 2017; Topor, Bøe, & Larsen, 2018). According to Øye (2010), who studied interactions on an inpatient ward, the exchange of gifts (material or symbolic) ties people together. If reciprocal expectations among staff and patients are established, patients will often be more positive about participating in activities offered. Forming relationships that create reciprocal obligations that can be seen as manipulative or rewarding seems to be an inherent element in all social relationships. Thus, reciprocal relationships seem to

constitute a productive and central aspect of society's normative foundation (Rugkåsa et al., 2014; Øye, 2010)

6.1.3 Addressing adherence through assertiveness and concrete problem solving

Three categories leading to the main theme of 'Responsibility with conflicting priorities' were identified in Paper 2: 'Conflicting priorities: Treatment and autonomy', 'ACT and providing practical support and comprehensive services' and 'ACT and building rapport'. Our data show that the ACT providers and the RCs believed that CTOs were sometimes necessary in order to ensure medication adherence and monitoring. Many patients were referred to the ACT team from hospitals and high security wards, and the clinicians were typically concerned about the risk for disengagement, especially after discharge.

Although the ACT providers and the RCs underpinned that conflicts regarding medication were unavoidable and that coercion could impede the therapeutic alliance, a main finding was that the ACT approach was considered helpful in that it afforded comprehensive and patient-centred support and increased opportunities to build rapport. The ACT model's structured approach, the daily team meetings and sharing ideas about clinical problems allowed for more flexibility and more voluntary solutions while on CTOs.

Recent studies suggest that clinicians' CTO practice in Norwegian services varies (Riley et al., 2018; Stensrud et al., 2016). Riley et al. (2018) show that the organization of local health care seems to influence the decision makers' role and the implementation of CTOs. Riley et al. (2018) show that due to long distances, some RCs only met patients face to face at yearly reviews, just before applying to the supervisory commission for a CTO extension, and had little insight into the patients' daily lives (Riley et al., 2018). In focus group interviews with eight RCs and 14 local care providers, Stensrud et al. (2016) found that local care providers that followed up the CTO decision (mostly general and mental health nurses) tried to downplay the coercive framework while assisting patients in their everyday lives. Stensrud (2016) argued that many RCs' one-sided focus on patients' lack of insight led to a paternalistic approach, and, as many of the participants in our study emphasized, time constraints and lack of regular contact with patients seemed to maintain a conservative CTO decision-making practice.

The participants presented the ACT model's focus on long-term and comprehensive service provision and shared caseload responsibility as a major improvement from traditional (office-based) mental health services. Further, to have a psychiatrist in the team and in clinical work where contact takes place in the community was seen as an important quality improvement. In those teams where the ACT psychiatrist (or clinical psychologist) was responsible for the enactment of CTOs, the clinicians emphasized that they often knew the patients well and that ongoing team discussions, including efforts to negotiate and agree on medications and what should be in place to safely remove the CTO, afforded more security and confidence. Input from different team members provided better insight into the everyday lives of patients and as a team they could more easily address non-adherence at an earlier stage and offer patients more choices and negotiate treatment during crises.

Although patient involvement and the rights of patients to make informed decisions are enshrined in law to ensure patient autonomy, mental health care professionals seem to struggle to integrate the practice of person-centred care and shared decision making in practice. Since the implementation of the capacity criterion in the Norwegian MHCA, clinicians are required to incorporate shared decision making and professional discussions about non-adherence as a personal and legitimate choice (Aasland et al., 2018; Roe & Davidson, 2017; Yeisen, Bjørnstad, Joa, Johannessen, & Opjordsmoen, 2019). A recent report shows that although the involuntary admission and CTO rates first decreased right before and after the implementation of the capacity criterion in the Norwegian MHCA in 2017, the involuntary admission rates increased in 2018 to the same high level (Helsedirektoratet [Norwegian Directorate of Health], 2019). This shows that there is an urgent need to put the power inequality between professionals and patients on the agenda, at a more concrete level, with opportunities for training and guidance and systematic reflection (Hem, Gjerberg, Husum, & Pedersen, 2018; Valenti et al., 2015).

6.1.4 Clinicians' emphasis on assertive and tailored interventions as a means to address autonomy

Some scholars have criticized ACT for being too paternalistic and for not encouraging patient empowerment, and some scholars have raised concerns about coercion (Angell, Mahoney, & Martinez, 2006; Gomory, 2002; Szmukler, 1999; Williamson, 2002).

Although some patients report that ACT providers sometimes step over the line,

becoming too authoritative and intrusive (Krupa et al., 2005), patients and their families are generally more satisfied with ACT than with traditional services (Heiervang et al., 2014; Killaspy et al., 2006; Killaspy et al., 2009; McGrew et al., 2002; Weimand, Israel, & Ewertzon, 2018).

In a study of what patients disliked most about ACT among 182 patients recruited from six CMHCs in Indiana (US), few patients considered ACT staff to be coercive and patients were almost as likely to express concerns about the under-availability of the core features of ACT, such as frequency of services and availability of staff (McGrew et al., 2002). McGrew et al. (2002) found that patients of high-fidelity programmes had fewer complaints about the intrusive aspects of ACT. Thus, coercion is a relational and contextual phenomenon. Patients' living conditions and also clinicians' willingness to involve patients in treatment decisions and respectful communication seem to be important aspects of perceived coercion.

During the last 15 years the ACT model has had a clear focus on recovery, integrating individualized and person-centred approaches, and promoting autonomy, client choice, collaborative treatment planning and self-directed care (Cuddeback et al., 2013; Monroe-DeVita et al., 2011). According to Cuddeback et al. (2013), higher TMACT (model) fidelity scores among ten ACT teams in Washington State were associated with reduced hospital stays and reduced days in acute crisis units. In the Norwegian ACT evaluation no such association between TMACT fidelity and reduced admission rates was found (Clausen et al., 2016a).

However, in line with other studies, the Norwegian ACT evaluation showed that patients' lives are modestly improved under ACT in terms of fewer inpatient days, and improved quality of life, reduced substance abuse and psychiatric symptoms, enhanced practical functioning and greater satisfaction and treatment retention (Chinman, Allende, Bailey, Maust, & Davidson, 1999; Dieterich, Irving, Park, & Marshall, 2010; Kortrijk, Kamperman, & Mulder, 2014; Landheim et al., 2014). We still lack knowledge about the association between TMACT fidelity and patient well-being, quality of life, and other important person-centred outcomes.

The ACT providers and the RCs in our study presented antipsychotic treatment as a mainstay in treatment, to prevent serious relapse. Many patients had experienced frequent readmissions, with little social support after discharge. The recovery vision of the ACT

teams was typically presented as providing comprehensive support in order to help people to reconnect to life and gradually take more responsibility for their own lives. Many participants highlighted that the team approach provided better opportunities for close follow-up and more responsive treatment.

The ACT providers underlined that they often knew their patients well, and when they had managed to establish a dialogue about a patient's life situation, possible choices and future goals, they could start to take more therapeutic risks, by allowing increased patient autonomy. For instance, the ACT psychiatrists stated that they sometimes used the CTO as a safety net to try to reduce or discontinue drugs in an attempt to establish a common understanding with patients about the need for medication, in combination with psychoeducation and close follow-up, while considering the risk-benefit ratio, and discontinuing antipsychotics when indicated.

While there is an overall agreement that antipsychotic medication is effective in the acute phases of treatment (Leucht et al., 2012), and also that antipsychotic maintenance treatment substantially reduces relapse risk in most patients with schizophrenia for up to two years follow-up, few large scale, high quality evaluations of long-term antipsychotic treatment exist (Smedslund, Siqueland, Kirkehei, & Steiro, 2018; Sohler et al., 2016), as is the case for long-term high quality evaluations of many other medication types. Some recent studies have shown favourable outcomes for patients who gradually discontinued antipsychotic medication, compared to those who were prescribed antipsychotics for prolonged periods (Harrow, Jobe, & Faull, 2012; Harrow, Jobe, Faull, & Yang, 2017; Wunderink, Nieboer, Wiersma, Sytema, & Nienhuis, 2013). However, the causal relationship is not clear, and it could be that people with less severe illness and better premorbid functioning are more likely to stop taking medication. Nevertheless, this means that not all patients that have received a psychosis-related diagnosis need continuous long-term antipsychotic treatment.

Previous research shows that people with mental health problems want to be more actively involved in treatment decisions (Bjornestad et al., 2019). Involving patients in treatment decisions and joint crisis planning seems important in reducing the use of coercion (de Jong et al., 2016). Previous research has shown that patients' retrospective acceptance of coercion often depends on treatment outcomes and perceived procedural justice, which refers to patients' perceptions of fairness and respect (Katsakou et al.,

2010; Nytingnes et al. 2016; Pridham et al., 2016). Some studies have shown that clinicians tend to persuade patients to follow their advice rather than inviting them to take an active role in treatment decisions (Stensrud et al., 2016). However, other studies indicate that patients do not necessarily want the full responsibility and to take the final treatment decision (De Las Cuevas, Penate, & de Rivera, 2014; Hamann et al., 2007), and that many physicians overestimate the value patients with SMI ascribe to independence or autonomy in relation to other values, such as safe and predictable care (Lepping & Raveesh, 2014; Rise, Westerlund, Bjørgen, & Steinsbekk, 2014). Subsequently, collaborative decision making and patients' informed decision making should depend on patients' illness severity and capacity to make informed decisions. To provide and repeat helpful information and involve patients as much as possible in decision making, also when their cognitive capacity is impaired, seems important to improve patients' attitudes toward treatment, and thus to promote compliance and long-term outcomes (Bjornestad et al., 2019).

6.1.5 Addressing clinical uncertainty through shared responsibility

In Paper 3 we identified three main categories leading to the main theme of 'feeling more confident and secure through shared responsibility', illustrating that the team approach allowed for close monitoring and more focused preventive efforts. The RCs in our study emphasized that CTOs were mainly founded on patients' clinical needs, to ensure medication adherence and monitoring. However, in some cases the RCs described long-term use of CTOs as a tool to contain dangerousness and harm. Many patients were referred from acute wards and high security wards, and the participants pointed out that CTO decisions often involved multiple risk and interacting risk factors. Subsequently the CTO follow-up responsibility involved challenges and conflicting priorities. Another main finding was the variation in the RCs' interpretation of the dangerousness criterion; here, external clinicians who were not part of the treatment team seemed to express more doubts about the accurate prediction of risk. As other studies indicate, symptom severity and current substance abuse, in addition to the perception of danger to the patient or others, were presented as important factors contributing to longer CTO duration (Rugkåsa et al., 2019).

Risk assessments and management to prevent suicide and violent behavior among individuals with SMI has become an important focus in community-based care. Use of

formalized risk assessment tools and procedures to guide clinical decisions is now a standard part of specialist mental health service provision in an effort to prevent harm. However, suicide and violence against others are rare events, and clinicians often end up with many ‘false positives’ (i.e. those predicted to be ‘high risk’ but not committing such acts) (Ryan, Nielssen, Paton, & Large, 2010; Szmukler & Rose, 2013). Szmukler and Rose (2013) argue that reducing uncertainty comes at a cost, and that a serious ethical concern emerges when coercive interventions are applied to cases where a large proportion is false positive. Compulsory treatment has obvious implications for autonomy and liberty and in the case of CTOs, it has been estimated that 142 CTOs would be needed to prevent one readmission (Kisely et al., 2017).

Stensrud et al. (2016) describe infrequent contact and lack of continuity in the contact between the RC and patients subject to CTOs and service fragmentation as major problems in traditional (office-based) mental health services. Although Norway is a rights-based welfare state with a well-funded health system, the mental health services are still fragmented and sometimes poorly coordinated (Romøren et al., 2011). For persons with co-occurring mental health and substance use problems, complex service systems and service fragmentation is recognized as a barrier to recovery in several studies (Ness, Borg & Davidson, 2014).

In contrast to many other countries, community outreach to follow up patients with psychosis is routinely provided in the UK. Burns et al. (2015) found high rates of sustained clinical contact and no significant difference between the CTO and control group on contact frequency, readmissions or disengagement from services in patients with psychosis over 36 months. A highly assertive and coordinated approach was maintained throughout the three years and very few patients (2%) were discharged by the clinical team.

Among the 142 patients that consented to participate in the evaluation of the Norwegian ACT teams, nearly 60% had concurrent problematic substance use. Patients with problematic substance use had more severe psychiatric symptoms, in particular manic symptoms and lower level of functioning, and they were more often subject to CTOs upon enrolment into ACT than participants without problematic substance use (Clausen et al., 2016b).

Psychosis and substance abuse have been linked to poorer outcomes with more hospital days (Crebbin, Mitford, Paxton, & Turkington, 2008), shorter but more frequent admissions (Schmidt, Hesse, & Lykke, 2011), greater violence (Crebbin et al., 2008), more severe psychopathology, and higher relapse and mortality rates (Farrelly et al., 2007; Linszen, Dingemans, & Lenior, 1994).

Although the Norwegian ACT evaluation did not show a reduction in the number of admissions, there was a significant reduction in compulsory admissions and total inpatient days. Being subject to CTOs upon enrollment was significantly associated with a reduction in involuntary bed days after ACT enrollment (Clausen et al., 2016a). Also, patients with co-occurring substance use problems had significantly fewer involuntary inpatient days, despite severe problematic substance use at two years follow-up (Clausen et al., 2016b).

The RCs in our study highlighted that the ACT approach enabled early detection of warning signals, quick responses and stepping up of the intensity of interventions during crises, all of which allowed for more nuanced judgements and more comprehensive understanding of risk. Many RCs in our study highlighted that collaboration with inpatient ward clinicians provided basic safety and security. Although the ACT team was mainly involved in admission and discharge, disagreements between the ACT psychiatrist and the responsible ward clinician and uncoordinated changes to treatment plans were typical concerns. In some teams more than others, bed pressure and lack of inter-agency collaboration were major challenges. Increased professional liability regarding a subgroup of patients with co-occurring substance abuse, with higher risk of victimization and violence during acute phases of illness, put the RCs' professional responsibility to the test. Several of these patients had frequent encounters with the police and were regularly transported to the acute ward, and were often, from the RCs' point of view, prematurely discharged after a few days. Balancing patient autonomy with the right and need for treatment and protection of other people could be a difficult balance to strike.

While the Norwegian Health Minister has demanded amendments in the MHCA to improve patients' autonomy and legal safeguards, the Minister of Justice pulls in the opposite direction to protect other people. Based on an amendment in the Penal Code in 2016, the legal criterion for an insanity defence also includes less serious offences, referred to as harmful or "burdensome" behaviour (Lov om endringer i straffeloven 2005

mv. (strafferettslige særreaksjoner m.m.). This means that more persons previously admitted under the MHCA will potentially be ‘pushed’ toward court-ordered involuntary mental health care. It seems relevant to mention that Norway has not had the same increase in forensic psychiatric beds as in many other countries and that independent forensic hospitals do not exist. After the amendment to the Penal Code, there was a 20% increase in persons receiving court-ordered involuntary mental health care, from 177 persons in 2015 to 200 persons in 2017 (Nasjonal koordineringsenhet for dom til tvungent psykisk helsevern, 2017).

While there has been a substantial reduction in sub-acute beds in recent decades, from 2005 to 2015 there was also a small reduction in high-security beds from 229 in 2005 to 214 beds in 2018 (Rosenqvist et al., 2018). In 2014 four out of ten referrals were rejected for admission (Kompetansesenter for sikkerhets-, fengsels- og rettspsykiatri [Regional centre for research and education in forensic psychiatry and psychology, 2015).

This might imply that the mental health services will be more crises driven, and that people may have to deteriorate to the point where they are deemed to pose an immediate risk to self or others as a necessary requirement for involuntary admission (Appelbaum, 1994; Large, Ryan, Nielsen, & Hayes, 2008). Another concern is that clinicians’ increased focus on the level of risk and on management and documentation will compromise patients’ access to individually tailored treatment and rehabilitation services.

6.2 Methodological considerations

According to Malterud (2001), qualitative methods are founded on an understanding of research as a systematic and reflective process for the development of knowledge that in some way can be contested and shared. In qualitative studies, relevance, rigour, transferability and the credibility of the results and conclusion are judged by the documented methodological steps taken by the researcher(s): how the data were collected and analysed and how the categories were developed. Validation in qualitative research refers to a judgment or agreement among competent others of the “accuracy” of the findings, and concerns the entire research process (Creswell, 2013). Contrary to quantitative research, where the aim is to generalize to a wider population, qualitative research methods involve different types of data and questions to be answered, and it is important to discuss whether the findings are valid in other contexts (transferability).

Compared to quantitative research, a more convincing level of reflection on the qualitative researcher's personal engagement and subjectivity is required (Stige, Malterud, & Midtgarden, 2009).

6.2.1 Preunderstanding and reflexivity

Within qualitative and interpretative methods, it is acknowledged that the researcher's background and preunderstanding influence the choice of research questions, methods, analysis, interpretations and conclusions, and these factors are often discussed in considering the usefulness and the quality of research (Creswell, 2013). While the grounded theory researcher is meant to remain free of "theoretical ballast", I have argued from a social constructionist perspective that every gaze and observation is theoretically informed. Thus, the findings and also the research teams' interpretations may have been influenced by their belief in the importance of a social dimension of mental health care.

Based on my involvement in the ACT evaluation and closeness to the field when I started to design this study, I had an advantageous position, known as positioned insight (Paulgaard, 1997), which enabled and constrained the research process in various ways. For instance, I knew that the ACT teams had varying CTO rates and that some teams used external RCs to follow-up the administrative CTO responsibility. Both ACT and CTOs are complex interventions, and I assume that my knowledge of the ACT model and the Norwegian teams was a major strength. I also believe that my professional background as a sociologist and my experience from a regional substance abuse centre made me more attentive to social and structural factors, such as lack of interagency collaboration and diffusion of responsibility, which is one of the findings in Sub-study 2. Rather than putting forth a claim regarding replication by other researchers, an assessment of credibility depends upon rich descriptions of participants' experiences and of the researcher's role in the research.

6.2.2 Validity and transferability

There is little knowledge of patients' and ACT providers' experiences with CTOs and RCs' decision-making practices in an ACT setting, and grounded theory was selected to explore experiences with CTO in relatively newly established ACT teams (context). We wanted to investigate how CTOs affected social relationships and interaction (process). The quality of grounded theory research should be judged by how well the data have been contextualized and "saturated" for variation in context and meaning (Timonen, Foley, &

Conlon, 2018). Contextualized and “saturated” data means that the data capture the complexity of the phenomenon under study and are therefore likely to be relevant to the practice setting.

The research team considered that the perspectives provided from patients, ACT providers and RCs, that are the three stakeholders directly involved in CTO decisions within an ACT setting, would provide relevant and valuable insights. Thus, triangulation of methods and different data sources, and also the fact that I conducted all the data collection and iterative coding, provided a more comprehensive understanding of the CTO decision-making process.

In this way, triangulation of different data regarding the teams’ clinical and legal CTO practice validates the findings. Further, when collecting data, my knowledge of the ACT model and the teams’ clinical practice enabled me to ask relevant questions and pursue follow-up questions during the interviews and enhanced my sensitivity of how to explore and focus during the observations. However, the risk of ignoring or taking some aspects for granted can be referred to as *home-blindness* (Paulgaard, 1997), and there might have been relevant questions about CTOs that I omitted to ask, or answers or nuances the participants did not elaborate on which they assumed that I had understood. Therefore, to conduct one pilot interview with a person with previous experience with CTOs and to receive her feedback after the interview was valuable. She commented that I should give the participants more time to reflect upon their experiences with CTOs and summarize and check their answers, in order to help people to talk and reflect upon difficult episodes and coercion in mental health care. To check and challenge the participants’ answers may contribute to validation of the interpretation of statements and a collective understanding (Brinkmann & Kvale, 2015).

All qualitative research involves the interpretation of texts, and in line with constructivist grounded theory, I was jointly responsible with my co-authors for data collection and the iterative analysis, in order to build the conceptual understanding from interpretations of the participants’ accounts. It was valuable that all co-authors read some of the interview transcripts in both studies, and participated in discussions about my initial coding, which helped me to prepare and guide the following interviews and fine-tune the analysis. In order to validate the findings we had ongoing discussions throughout the research process about expanding and delineating categories, how to refine the properties of the categories

and decisions about saturation, throughout the research process. Also, presenting preliminary results and drafts of papers in a multidisciplinary PhD group with experienced mental health nurses, physicians, psychologists and sociologists was valuable to discuss the richness and reliability of our analysis and conclusions.

Grounded theory researchers typically start with aspirations of substantive theory building, often referred to as conceptual explanations, models or frameworks, to fully explain social phenomena or provide greater conceptual clarity. There are many practicalities in research, and due to requirements from ethics committees to formulate concrete research questions, to provide a review of the literature and to define the sampling process, several modifications to central GT principles were made. It is acknowledged that limited time and resources in PhD research projects often constrain theoretical sampling, conceptual analysis and saturation (Timonen et al., 2018). None of the three papers presented in this thesis provide a ‘core concept’; they provide thick and nuanced descriptions and greater conceptual clarity and understanding, rather than a fully elaborated theory that covers all aspects, stages, consequences, and likelihood of a process or a phenomenon. However, I still believe that the three papers in this thesis provide valuable insight and greater conceptual clarity.

Transferability depends on considerations about the sample, and to what extent the findings have meaning for others in similar situations. Demographic information about patients enrolled in ACT and the treatment setting seem important for considering the transferability of the results. ACT targets patients that are difficult to engage in treatment, many abuse substances, have had legal problems, have experienced frequent readmissions, and have had high degrees of conflict with their families. Also, many studies show a lower prevalence of concurrent substance abuse among patients subject to CTOs in traditional outpatient settings compared to patients enrolled in ACT (Rugkåsa et al., 2019). Patient characteristics and the service contexts both seem relevant to understand patients’ different views of CTOs. Compared to Nytingnes (2016) and Stensrud (2015), where most participants had strongly negative descriptions of CTOs, most patients in our study considered the ACT team’s comprehensive service provision as a more acceptable care regimen.

6.2.3 Sub-study 1: Strengths and limitations

Because I knew some of the team leaders I believe that I had easier access to the field, even though we spent a long time to recruit eligible patients to participate in the study. Although 15 participants might be considered a small sample size, it is a strength that we managed to recruit participants who differed in age, gender and living conditions, and also in whether they had concurrent substance abuse, and whether or not they had a current medication order. I also believe it was a strength that I reached out to some participants with the greatest problems whom the ACT teams struggled to engage in treatment. Some participants had been subject to involuntary treatment orders for more than 10 years, and could therefore provide nuanced and valuable insights about the service context and how involuntary treatment was delivered, negotiated and explained.

Since I am not a trained clinician, I could take a more ‘naïve’ position in the in-depth interviews with the patients, to explore their experiences and perceptions of CTOs by asking open questions in order to provide richness and depth to the data. This meant that the patients were asked to describe their views and experiences, and to explain and clarify what mattered to them, and how the CTO influenced on their daily life and their relationship with the ACT team. To take an open and explorative approach, and to let people with first-person experience steer the conversation, often produces more interesting and richer data. This might also provide opportunities and alternative angles to the research field. Many patients were positive towards the ACT teams’ comprehensive and coordinated services, which allowed me to probe more specifically about the content of the CTOs, and their involvement and influence in specific treatment decisions. I did not conduct a second interview to verify the analysis or arranged a meeting to elicit the participants’ comments and feedback, largely because of the time frame for the thesis, and the long travelling distances and high costs involved. This is a strategy termed “member check”, where the findings are presented to the research participants for corroboration and criticism. This can be considered as a limitation of our study.

6.2.4 Sub-study 2: Strengths and limitations

To our knowledge, this is the first study to investigate ACT providers’ experiences with CTOs and RCs’ decision making within an ACT context. Although a small number of participants is a limitation in Sub-study 2 as well, the strength of this study is that it draws on a rich dataset and triangulation of different data sources. In this study, interviews

combined with case file reviews and observations were used to become familiar with the team's clinical everyday practice, and also to follow the RCs' decision making over time.

We were concerned with issues of process and context for which GT is particularly well-suited. We started all the interviews with open introductory questions about the participants' views and experiences with CTOs and the ACT team's follow-up services. However, a more detailed examination of the distribution of team practitioner sub-groups' attitudes and views would require more interview data and more extensive observation in order to investigate patterns of similarity and for differences to emerge clearly. For instance, questions on whether psychologists and psychiatrists make different priorities in CTO assessments have been raised (Aasland et al., 2018). Despite modifications and limitations, I consider that both Paper 2 and 3 generate new perspectives and relevant analyses that seem useful for informing policy and practice, especially for the new Flexible ACT (FACT) teams, which are currently being established in many health regions.

6.2.5 Clinical Implications and future directions for research

Qualitative methods to explore patients' and care providers' experiences with CTOs in different service contexts can provide new insights, potentially challenge traditional assumptions and supplement the existing understanding of mental health care and perceived coercion, thus prompting politicians and practitioners to re-evaluate practice.

The participants in our study presented the ACT team's availability and comprehensive service provision as a major improvement from traditional (office-based) community mental health services. ACT targets patients with concurrent substance abuse with low social functioning, who are often difficult to engage in treatment. Several of the participants in our study lacked social networks, and to have someone to call, who helped them to e.g. arrange their furniture and encouraged them to participate in everyday activities, was considered important to promote patients' well-being and quality of life. Unlike office-based mental health services, ACT/FACT teams seem more adequately resourced to provide coordinated and tailored treatment.

Reducing the use of coercion has been a central policy goal, and based on current CTO evidence, it seems reasonable to conclude that extensive use of CTOs can no longer be justified. After the implementation of the capacity criterion in the Norwegian MHCA,

clinicians are now required to conduct more structured and regular assessments of patients' capacity to consent/dissent to treatment in order to guide their clinical decisions. ACT teams and also more recently established FACT teams seem more suitably resourced to follow up and monitor patients' fluctuating illness severity and decision making capacity. We still do not know whether or not the implementation of the capacity criterion and the narrowing of the dangerousness criterion in the Norwegian MHCA will influence RCs' decision-making practices.

However, in teams with many newly enrolled patients who are subject to CTOs at intake, it seems challenging for the team psychiatrist and/or the clinical psychologist to provide more legal documentation and paper work, while continuing to spend as much time with patients to involve them in treatment decisions and work with patients outside the office, which is a critical ingredient in the ACT model. Future research to explore how the legal amendments will influence the RCs' role and responsibilities and the ACT/FACT teams' enactment of CTOs will be needed. Further, whether psychologists and psychiatrists make different priorities in CTO assessments has been questioned (Aasland et al., 2018), and to investigate to what extent professional background will influence the implementation of the capacity criterion seems a relevant next step.

7. Conclusion

One main purpose of this study was to explore patients' experiences with CTOs within relatively newly established ACT teams. The findings and interpretations indicate that patients have mixed views of CTOs. Although most participants considered CTOs as a less restrictive intervention than involuntary admissions, some participants considered the length of CTOs as a major concern. Nevertheless, several of the participants described a gradual transition toward regarding the CTO as an acceptable solution, provided that they received other services they found beneficial. The participants emphasized that establishing trusting relationships takes time, and that the ACT team's availability and the flexible combination of interventions, continued care, support and possibility to make choices were important improvements from traditional office-based mental health services.

ACT targets patients who have experienced frequent readmission and often have received little follow-up and support after discharge. Due to the ACT team's long-term treatment perspective and the ACT providers' ability and willingness to reflect on different alternatives regarding medication, living conditions and everyday activities, some patients felt that they were better off on the CTO. Thus, to address patients' unmet needs and the quality of the patient-provider relationship seem to be important aspects of patients' subjective perceptions of coercion.

Our data showed that the ACT providers and the RCs considered CTOs as a useful tool to ensure that patients remain in treatment and to help patients achieve stability and to remain safe. The findings and interpretations from the study show that the ACT model's team approach and focus on in vivo work, and having a psychiatrist on the team who attended regular team meetings, promoted flexibility and more voluntary options. Patients' symptom severity and current substance abuse, and the perception of danger to the patient or others were presented as important factors contributing to longer CTO duration.

Other main findings were that there was substantial variation in the RCs' interpretation of the dangerousness criterion, and that external clinicians outside the treatment team expressed more doubts about the accurate prediction of risk. Also, in some teams more than others, bed pressure, lack of inter-agency collaboration for the most severely ill patients and increased professional liability were seen as major challenges.

Previous studies have suggested that lack of time and available treatment resources in traditional mental health services and clinicians' one-sided focus on medication adherence seem to impede patients' recovery processes. CTO decisions were described as challenging and complex, and, despite new regulatory changes, clinicians are still faced with the dilemma of balancing coercion and autonomy. Our findings indicate that for patients on CTOs, the ACT model's team approach could appropriately address patients' complex care needs, monitor non-adherence and relapse at an earlier stage and, as most patients and clinicians emphasised, more easily offer patients choices and negotiate treatment in crises.

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APPENDIX 1

Interview guides

Delstudie 1. Tema guide

HVERDAG

- Kan du fortelle hvordan den siste uken har vært for deg?
- Hvis du er bekymret eller du opplever at livssituasjonen din er vanskelig,
- Hvem er dine viktigste støttespillere?
- Hva er viktig for at du skal ha det bra?

KONTAKT MED ACT-TEAMET

- Hvordan har du opplevd å bli møtt av ACT teamet?
- Hvilke tjenester mottar du fra ACT teamet?
- Mottar du tjenester fra kommunen?

BETYDNINGEN AV TUD (LIVSSITUASJON/SELVFORSTÅELSE)

- Hvordan opplever du det å være underlagt tvungent psykisk helsevern?
(Positivt/negativt/ambivalent)
- Hva innebærer TUD for deg i hverdagen? Oppfølging, hjelp, medikamentell behandling
- Det at du er på TUD, har det betydning for ditt forhold til andre?
- Familie, venner, helsepersonell? (Positivt/negativt/ambivalent)
- Har du opplevd mye bruk av tvang i psykisk helsevern før du ble inkludert i ACT-teamet?
- Har du noen gang vært i situasjoner hvor du tenker at tvang har vært nødvendig?

BRUK AV TUD I ACT

- Er det noen i ACT teamet som har snakket med deg om hvordan de vurderer situasjonen din og behovet for tvungent psykisk helsevern fremover? (varighet og innhold)
- Opplever du at ansatte i ACT teamet tar hensyn til dine ønsker og vurderinger når det gjelder behandling og oppfølging?
- Har du vært involvert i utforming av behandlingsplan/kriseplan?
- Hva kan du bestemme når det gjelder bruk av medisiner?
- Får det konsekvenser hvis du ikke følger opp den medikamentelle behandlingen?
- Kan du bestemme hvor ofte teamet skal se deg? Hva skjer hvis du avviser kontakt?
- Bruk av medisiner og bivirkninger, er det noe du pleier å diskutere med ansatte i ACT? (Er dette noe du pleier å snakke om med psykiateren i ACT? Med andre?)
- Har du opplevd at teamet ikke har respektert dine ønsker?
- Hva er viktig for deg fremover?

Intervjuguide. Delstudie 2: Vedtaks ansvarlig

1. Hvordan vil du beskrive ACT sammenlignet med tradisjonell poliklinisk behandling for denne målgruppen?
2. Kan du beskrive din rolle, og ansvaret du har i ACT teamet?
3. Hvordan er det administrative TUD ansvaret organisert i teamet?
4. I hvilken grad, og på hvilken måte er de andre i teamet involvert i TUD avgjørelser?
5. Er det andre som deltar i disse avgjørelsene? (eksterne klinikere eller pårørende)
6. For pasienter som er inkludert i ACT, hva er innholdet i tvang uten døgnopphold?
7. Hva gjør dere når pasienter unndrar seg behandling? (oppfølging og medikamentell behandling)
8. Dersom pasienter nekter å ta medisiner og tilstanden forverres, hva er det som tilsier at overføring til døgnavdeling blir nødvendig?
9. Hva mener du er fordelen ved å ha pasienter på TUD?
10. Hva mener du er den største ulempen ved å ha pasienter på TUD?
11. Tenker du TUD primært som et virkemiddel for å håndtere farlighet/risiko eller som et verktøy for å sikre nødvendig behandling? (forhindre innleggelse versus fremme pasientens livskvalitet/bedring)
12. Bruker du spesifikke kriterier eller sjekkliste knyttet til oppheving av TUD? (behandlingsoppfølging, oppmøte, symptom stabilitet)
13. Hvordan formidles informasjon til pasienten og til pårørende om avgjørelser knyttet til etablering og oppheving av tvang?

Spesifikke TUD avgjørelser

Du har vært involvert i behandlingsplanlegging og/eller vedtaksfetting for (konkret pasient)

- Hva har vært de viktigste vurderingene i hans/hennes sak?
- I hvilken grad er frivillig behandling forsøkt?
- Hva er det du vektlegger i hans/hennes sak? (faktorer/kriterier knyttet til vurdering av tilbakeføring/innleggelse og oppheving av TUD)
- Kan du fortelle om hva som skjedde i forbindelse med hans/hennes siste innleggelse?
- Har dere (ACT teamet) diskutert hva som skal til for at TUD vedtaket kan oppheves?

Intervjuguide. Delstudie 2. Fokus gruppe

1. Hvordan oppfatter dere behandlingstilbudet ACT gir sammenlignet med poliklinisk oppfølging av målgruppen?
2. Hvordan jobber dere med kontaktetablering når nye pasienter tas inn i teamet? Hva med pasienter på tvungent vern? (ulike strategier)
3. Hvordan er TUD ansvaret organisert?
4. I hvilken grad, og på hvilken måte påvirkes kontaktetableringen av at pasienten er underlagt tvungent vern? (relasjonen til pasienten og hvordan dere jobber)
5. Hvilken rolle har dere? (ansatte med og uten ansvar for depot administrering)
6. På hvilken måte er teamet involvert i diskusjoner og avgjørelser knyttet til tvungent vern?
7. Hva innebærer TUD for pasienter som følges opp av ACT?
8. Hva skjer når pasienter underlagt TUD ikke møter opp eller motsetter seg behandling?
9. Hva er teamets hovedfokus og prioriteringer knyttet til pasienter på TUD?
10. Hva er den største fordelen ved å ha pasienter på TUD?
11. Hva er den største ulempen ved å ha pasienter på TUD?
12. Har dere spesifikke kriterier eller sjekklister knyttet til oppheving av TUD? (behandlingsoppfølging, oppmøte, symptom stabilitet)
13. Hvem er det som er ansvarlig for å gi informasjon vedrørende innleggelse og TUD vedtak til pasienter og pårørende?

Konkrete saker

Dere har vært involvert i behandlingsplanlegging og oppfølging av (konkret pasient)

- Hva har vært viktige hensyn og vurderingene i hans/hennes (TUD) sak?
- Hvordan forstår dere kriteriet om at frivillig behandling må være forsøkt?
- Hva er det dere vektlegger i den ukentlige oppfølgingen, og i behandlingen?
- Har dere vært involvert i beslutningstakingen? Hvilke faktorer/kriterier er det som vektlegges i forhold til vurdering av overføring/innleggelse og oppheving av TUD?
- Kan du/dere fortelle om hva som skjedde i forbindelse med hans/hennes siste innleggelse?
- Har dere diskutert hva som skal til for at TUD vedtaket kan oppheves?

APPENDIX 2

Paper 1, 2 and 3

RESEARCH ARTICLE

Open Access



Increased influence and collaboration: a qualitative study of patients' experiences of community treatment orders within an assertive community treatment setting

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Abstract

Background: Since 2009, 14 assertive community treatment (ACT) teams have started up in Norway. Over 30 % of the patients treated by the ACT teams were subject to community treatment orders (CTOs) at intake. CTOs are legal mechanisms to secure treatment adherence for patients with severe mental illness. Little is known about patients' views and experiences of CTOs within an ACT context.

Methods: The study was based on qualitative in depth interviews with 15 patients that were followed up by ACT teams and that were currently subjected to CTOs. The data were analyzed by using a modified grounded theory approach.

Results: While some participants experienced the CTO as a security net and as an important factor for staying well, others described the CTO as a social control mechanism and as a violation of their autonomy. Although experiencing difficulties and tensions, many participants described the ACT team as a different mental health arena from what they had known before, with another frame of interaction. Despite being legally compelled to receive treatment, many participants talked about how the ACT teams focused on addressing unmet needs, the management of future crises, and finding solutions to daily life problems. Assistance with housing and finances, reduced social isolation, and being able to seek help voluntarily were positive outcomes emphasized by many patients.

Discussion: The participants had different views of being on a CTO within an ACT setting. While some remained clearly negative to the CTO, others described a gradual transition toward regarding the CTO as an acceptable solution as they gained experience of ACT. Many of the participants valued the supportive relationship with the ACT team, and communication with the care providers and the care providers' attitudes could make a significant difference. The study shows that the perception of coercion is context dependent, and that the relationship between care providers and patients is of importance to how patients interpret the providers' behavior and the restrictive interventions.

Conclusions: Although some patients focused on loss of autonomy and being compelled to take medications, other patients emphasised the supportive relationships they had with the ACT teams and that they had received help with housing, finances, and other daily life problems. Thus, being on mandated community treatment could be acceptable in the opinion of several of the patients, provided that they received other services that they found beneficial.

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Background

Use of compulsory admissions and community treatment orders (CTOs) are by international standards, high in Norway [1–3]. The use of coercion raises a range of ethical, clinical, and legal questions [4]. Reducing the use of coercion within mental health care settings has been given high priority in government policy, and in 2006 a national action plan was introduced. Even so, there has been little debate about CTOs in Norway, which have been used since the Norwegian Mental Health Act (MHA) [5] was implemented in 1961. CTOs are legal interventions to enhance treatment compliance for persons with severe mental illness that have a history of disengagement from services and frequent re-admissions. Besides mandating patients to attend appointments and adhere to treatment, the CTO regime also relies on the provision for rapid recall to hospital for its enforcement. Since 2001, as part of an amendment of the MHA [5], CTOs can also be established in an outpatient setting.

In the Norwegian legislation, the need for compulsory admission and CTO is regarded as a clinical decision, and it is based upon the responsible psychiatrist's or clinical psychologist's judgment. It does not require a court verdict, but the decision may be appealed to a Supervisory Commission that is headed by a judge. The decisions of the Supervisory Commission may be appealed to the civil court system. The legal criteria for compulsory admissions and treatment are that the patient suffers from a severe mental disorder and that the possibility of cure or considerable improvement will be lost if the patient is not admitted or treated, or that treatment is deemed necessary to prevent harm to self or others [6]. Unlike most other CTO regimes, in Norway, a separate Medication Order is needed to compel patients to take medication. If the patient subjected to a CTO and a medication order refuses medication, the patient may be taken to a psychiatric facility to receive medication involuntarily there [5]. The responsible clinician is obliged to conduct a clinical assessment every third month to uphold the CTO. The Supervisory Commission controls all relevant documents and performs independent reviews to decide whether the legal conditions of the CTO are fulfilled.

While there has been much discussion internationally regarding the effectiveness of CTOs [7–9], it has been estimated that above 30 % of the involuntarily admitted patients in Norway are discharged onto CTOs [10]. Moreover, there was an estimated 50 % increase in the use of CTOs between 2002 and 2007 [11]. CTOs were first explicitly mentioned as an integrated part of government policy in a white paper from 2012, where increased voluntariness and patients' autonomy were presented as guiding principles for mental health care

[12]. In this policy document, ACT was a recommended treatment model for individuals with severe mental illness, a history of treatment refusal, and frequent relapses, with the aim of reducing the need for involuntary hospital admissions [12].

The Norwegian Directorate of Health financially supports the implementation of ACT in Norway and since 2009, 14 ACT teams have started up. This qualitative study formed part of a national evaluation of the implementation of ACT teams in Norway. ACT has been described as a robust model of community-based treatment for patients with severe mental illness with complex needs, who have not benefitted from traditional health services. ACT teams provide continued and comprehensive mental health and social rehabilitation services, and offer support and practical assistance with daily life in the community. A Cochrane review concluded that ACT compared to standard mental health care reduces frequency and length of hospital admissions and improves housing stability, employment, and results in higher patient satisfaction with services [13]. Besides increased medication adherence and improving patients' social functioning, social inclusion and recovery are important aims of ACT [14–16].

ACT teams are typically multi-disciplinary, and usually include a psychiatrist. Team members share responsibility for the patients. The teams have a low caseload and frequent team meetings, in order to be able to follow up patients closely. The low caseload ensures that ACT teams can offer intensive services and respond flexibly and proactively during crises. Teams have a 'no discharge' policy. ACT teams typically use specific engagement techniques, such as assertive outreach and providing practical help and assistance with daily life problems such as housing and patients' finances, in order to comprehensively meet patients' needs [17–20].

There are also some studies that examine CTOs, although most of these have not examined patients in ACT. It has been suggested that CTOs can improve outcomes if sustained over time (for more than six months) and if linked to intensive services. However, there has been much debate about these findings [21–24]. Prior studies that have examined patients' experiences with CTOs have pointed to certain topics as particularly central, such as loss of autonomy and being pressured to take medications, while other studies have emphasised perceived benefits such as increased social functioning [25–28]. The aim of this study is to obtain more knowledge about how patients experience CTOs within an ACT context. The study aims to shed light 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.

Methods

Design

The study draws on a modified grounded theory approach [29], inspired by a constructivistic and interpretative framework, which is a recognized method for investigating phenomena where limited prior knowledge exists. An inductive approach enables depth and richness of data generation, and facilitates the description and development of a conceptual understanding in terms of social actors' motives, actions and accounts. Qualitative interviews [30, 31] were used to examine the patients' experiences. Participants were sampled purposively from four ACT teams that varied in size and in their use of CTOs. An iterative process of data collection and analysis, inspired by Charmaz' flexible guidelines [29], was used to explore the complexity of individual experience and perceptions.

Recruitment and sample

Purposive sampling methods [32] were used to gather rich data, based on a maximum variation sample. Two urban and two rural ACT teams were selected. We first contacted the team-leaders to inform about the study 30 months after the teams started up. At this stage, one of the urban teams had 76 included patients, of which 40 were on a CTO. The other urban team had 68 patients, of which 23 were on a CTO. One of the rural teams had 67 patients, of which 4 were on a CTO. The other rural team had 38 patients, of which 13 were on a CTO. The team leaders were given written information about the study and a separate information letter that was forwarded to the patients. The inclusion criteria in this study were that the participants had been included in the ACT-team, and been subjected to a CTO for at least six months. Patients that the ACT teams deemed to ill to participate were excluded. To secure rich and nuanced accounts, positive as well as negative, we emphasized that we wanted to include males and females, with and without a compulsory medication order and persons with and without co-occurring substance abuse problems. The team leaders decided which staff members that made the first approach to the patients to ask if they were willing to participate in the study. We recruited new participants until data saturation occurred and subsequent interviews did not reveal substantial new information.

Interviews

Data were collected by the first author (HKS) through in depth qualitative interviews in the period from September 2013 to February 2014. In three interviews, a staff-member introduced HKS as an interviewer, and in two of these they left before the interview started. In the third interview, the staff-member stayed for the first ten

minutes and left when the participant was comfortable to continue the interview without his presence. Because this interview lasted for 90 min, we do not believe the staff-member's initial presence affected the participant's responses. A total of 15 interviews were conducted (see Table 1 for an overview of the characteristics of the participants). Nine interviews were conducted in the participants' homes, while six participants preferred to have the interview somewhere else (i.e. at the outpatient clinic, at the ACT-teams' facilities, etc.).

A thematic interview guide was developed jointly by the authors, based on a literature review and a pilot interview with one patient. All the interviews started with open questions about the participants' everyday lives and whom they had to rely on if they needed someone to talk with or help them solve problems. We continued to ask more specific questions about why and how the CTOs were established, about the content of the CTOs and how the CTOs influenced on their daily lives. We followed up with clarifying questions. After the first interviews, one central theme that emerged in the participants' accounts was their equivocal perception of CTOs and the ACT team's enactment of the order, and the association between coercion and motivation, which we followed up and explored in depth in the following interviews. The interviews lasted from 35 to 120 min, and all but two were recorded digitally and transcribed verbatim. These two patients did not want to be recorded, but accepted that detailed notes were taken.

Table 1 Characteristics of sample

Gender	Male	9
	Female	6
Age	<37	5
	37–47	6
	>47	4
Diagnoses	Psychotic disorders, including schizophrenia	10
	Schizoaffective disorder	5
Active substance abuse	Yes	9
	No	6
Accommodation	Independent apartment	9
	Supervised apartment	6
CTO duration (current)	Less than 1 year	4
	More than 1 year	11
Medication order	Yes	4
	No	11
Antipsychotics	Depot	12
	Oral	2
	None	1

Analysis

An iterative process of data collection and analysis was used to develop a conceptual understanding of the participants’ experiences, actions and strategies, based on main categories grounded in the data [29]. The first eight interviews were conducted within a concentrated time period because of long travelling distances. The interviews were first listened through several times, and reflections and thematic codes were written down. Then the first eight interviews were transcribed verbatim, and the initial coding identified meaning units in the transcribed text. After the initial coding, we compared the most frequently used codes by going through larger segments of data, in order to develop more focused codes. Subsequently, we followed the same procedures with the other interviews. After the initial coding, the most central codes were clustered in theoretically linked themes, to develop categories and sub-categories, based on properties and dimensions (focused coding). Subsequently, categories were linked together (theoretical coding). The initial and focused coding was done manually, and thereafter the data was moved into the NVivo software [33]. The process of constant comparative analysis was continued with the help of the software until no additional new observations or information emerged (i.e. when data saturation was reached). Memo writing was used through the process, to increase the level of abstraction and to develop the categories.

Ethical considerations

The study was approved by the Regional Committee for Medical and Health Research Ethics, South-East Region (case file number 1196/2010). All participants were informed that their participation was voluntary and that they could withdraw their consent at any time. Written informed consent was obtained after HKS assured that the participants were informed about the purpose of the study. There was an agreement with the ACT teams that the participants could contact them after the interview if the interview elevated emotional difficulties. Many of the participants experienced not to have a choice regarding medications, and the compulsory nature of treatment was a key theme. Medication monitoring is an important component within ACT, together with a wider psychosocial approach to meet the patients’ complex needs. Use of involuntary treatment and medications is a contentious issue and it is therefore important to clarify that we believe medications may be beneficial for some patients and less beneficial or even unnecessary for other patients. We believe the circumstances of each individual patient must be taken into consideration when considering the matter. However, while we acknowledge that our view might have impacted the interpretation of the data, we aimed to explore the patients’ own views and experiences.

Results

In our analysis, we identified three main categories that reflected a tension between the perceived restrictions of the CTO on the one hand and receiving care, treatment and coordinated services from the ACT team on the other (Table 2). First, we describe the patients’ experiences with involuntary treatment, second the importance of therapeutic relationships with the ACT team, and third, the patients’ understanding and strategies, with regard to collaboration with the ACT team.

Experiences with involuntary treatment

Most participants were under a CTO with prescribed antipsychotic depot medication when they were admitted to the ACT-team. The purpose of the CTO was to ensure continued treatment after discharge from an involuntary hospital admission. Although reporting that they were obliged to have regular contact with the ACT-team, most participants described the coercive elements of the CTO to be that they had to take medications and that the psychiatrist had the authority to impose restrictions.

Control and protection

Most patients explained the CTO by their refusal to take medications:

“I do not want to take antipsychotic medications. That’s why I’m under a CTO.”

Only one participant reported additional conditions attached to the CTO beside medications and appointment attendance. In addition to having a guardian and being followed up by the ACT team under a medication order, she had to live in a supervised residency as part of the CTO. She was not happy with the arrangement:

“I didn’t realize that it would be like this. I feel stigmatized. My whole life has been taken over, controlled by others.”

Table 2 Main categories and sub-categories

Main categories	Sub-categories
Experiences with involuntary treatment	Control and protection
	Lack of influence on medication
	Coercion context
The importance of trusting relationships	Building trust
	A frame for interaction
Collaboration as strategy	Negotiations about treatment
	Reflecting on the need for treatment and care
	Security net

Like some of the other participants, she described the CTO as a legal mechanism to monitor and control her behaviour, and as a violation of her civil rights and autonomy. Some participants described the CTO as part of an integrated sequence of coercive interventions based on persuasion, pressure, threats, and use of force as a means of control. One participant said:

"I'm a bit paranoid, but that's no reason for keeping me under detention for more than ten years. They want to have me in the system to have me under control."

Some of the other participants, who described symptom reduction and improved life conditions, regarded the CTO more as a protective framework, and as a positive component in their recovery. As one participant said:

"It is to hold me, so that I won't use substances early in my recovery process."

Another patient, who recently had been discharged and now was on his first CTO, emphasized:

"The reason why they put me on a CTO was to secure my legal rights and to ascertain that I would adjust."

Like some of the other participants, he regarded the CTO as a legal tool to prevent relapse. He referred to the simplified admission routines, which enhanced sustained follow-up, free medications, and free dental treatment – all components of the patient's CTO.

Lack of influence on medication

The participants' views and experiences of the CTO was often influenced by previous negative experiences from the mental health services. They not only addressed the legal authority of clinicians and coercive practices, but also how they encountered a strict medical understanding where their opinions, judgements and wishes were ignored. A perceived overemphasis on medications, a lack of clarity and predictability and a lack of involvement and respect were the most prominent points the patients made. Many of the participants had been under different coercive regimes for many years. They had been mandated to use medications they often did not believe that they needed, and which they often felt had more negative side effects than benefits. Some made the point that the medications made them numb, tired and passive, and several stated that medications did not eliminate their auditory hallucinations or delusions. CTOs are often used for sustained periods of time, and the uncertainty about the duration of the CTO was difficult to accept for several of the patients:

"The psychiatrists believe I don't know my own best interest after 42 years. It is just like I am a big idiot. I have tried antipsychotic medications for 15 years, so I should have some idea of what I am talking about. It's like talking to deaf ears."

Several participants wanted to have the CTO discontinued in order to come off medications completely. Other participants questioned the psychiatrists' insistence regarding the continued use of depot antipsychotics:

"To be compelled to use depot medication in an indefinite time period is the worst of it, it takes away all my motivation and hope for the future. I have managed by using little medication, which I have administrated on my own. I have managed fine. I can need an admission in life crises. I am being overmedicated, and that depot makes me unwell."

The control assessments often focused on previous illness episodes, and some of the patients felt they had few opportunities to talk in depth about their daily life and their thoughts about the future. The patients described that previous crises were the most important factor with respect to how their present life situation was understood. Typical statements from the patients were:

"Everything is being documented and is being used against me"

"I am not being heard"

In these cases, giving the patient medication was typically seen as the only solution by the health professionals. The experience of being in a confined position, without influence on treatment decisions was perceived of as disempowering by the patients, as was encountering low expectations about their future prospects.

Coercion context

For many participants, the initial contact with the ACT-team had been established in the hospital ward, where the same ACT-team members had picked them up when they were discharged from the hospital and helped them to get settled in their apartments. Although being compelled to use medications, many participants valued the ACT teams' comprehensive and coordinated services. Many of the participants used phrases like:

"There is not much coercion" and "It is not voluntary, but it is not coercion either."

Most of the participants described the CTO as compelling them to take the prescribed medication and to accept the psychiatrists' authority to impose restrictions. When being asked about the consequences of treatment refusal, many referred to the potential threat of being re-admitted to hospital, and not least, the realistic prospects of a medication order:

"I have to use medicines whether I want to or not, but it will end up with more coercion and it will be more difficult if I am not willing to take the injection."

Another participant said:

"That would have had consequences, and then they would come after me. Then there would be coercion."

One participant claimed that the ACT team had not initially informed him that the CTO that was in effect did not authorize compulsory treatment. When he refused to take antipsychotics, the psychiatrist had initiated a compulsory medication order, which the County Medical Officer then rejected because of a formal mistake. He had recently been informed that a medication order had now been established according to the proper procedures:

"There is a threat behind. There is no point to take it further. I'm not being heard anyway. Both the supervisory commission and the County Medical Officer do as the physician recommends. We have no say. They believe it is important that I use medications. It has a high price. I feel that it is for the safety of the system."

Many participants described treatment pressure as an integrated part of mental health care, and that coercion did not depend on a CTO. The participants' accounts illustrate the blurred distinction between formal and informal coercion by referring to the responsible clinician's discretionary powers:

"If I had been transferred to a voluntary status I would have to use medications anyway. If you accept taking medications, the legal compulsion will be discontinued, but if you refuse, if you don't want to take medications, you will be put back on a CTO. There is coercion regardless whether you have a voluntary or involuntary legal status...You don't have the right to choose how you want to live your life or which medications you want you use, like a normal person...The more they counteract me, the more I counteract them."

While the patient described the consequences of coercion as distrust and reactance, he discussed having been given a new treating psychiatrist as a potential turning point:

"At least I am in a dialogue with her. She recognized that the psychosis could be caused by other things... Then I was more receptive. She has been right in some of the things she has said, she is at least forthcoming, and she tries to understand and to do something about the situation."

The importance of trusting relationships

Many of the participants who had long histories of being under coercion described a gradual transition from resistance to medication toward developing a therapeutic alliance with the ACT-teams, based on an ongoing dialogue about how to address unmet needs and future goals. Although being compelled to use medications, many described the ACT team's availability, practical support and assistance in solving daily life problems. They also emphasised that they were being listened to. The patients described the uniqueness of being treated by an ACT-team, and especially that the frame of interaction differed from other types of mental health treatment.

Building trust

Several emphasized the importance of taking small steps and that building trust takes time:

"There is something special when you have your own apartment. They enter your private area. It has to be someone you know, that you have built a relation to, who you trust...building trust takes time."

In addition to the practical and emotional support they felt they received from the ACT-team, many valued the team's availability. Several mentioned that it was important for them that they had someone they could call for practical help or for social contact. While some spoke of the team as a whole, others referred to specific team-members who "walked that extra mile" to find acceptable solutions. As one participant said, by referring to the helpfulness and kindness of a social worker in one of the teams:

"I don't know what I should have done without X."

One participant who had been in care of the team for six months emphasized:

"I haven't talked to them about personal stuff yet, but she (the psychiatrist) said it would take time to get to

know each other, and that it will not happen at once. They just take me as I am. That's nice. The most important is that they pick up the phone when I call, and to know that they are accessible when I call. They have helped me with lots of things."

Despite having weekly medication delivery appointments she said:

"I contact them. I'm able to wash and make food and stuff. I can be alone most of the time, there is no fuss. I wouldn't have put up with that."

Being able to live their lives in their own apartments and having appointed a guardian to safeguard their finances was described as important life improvements. "At least it's a start" was how one participant who previously had stayed with friends or in shelters, who recently had moved into a supervised residency, described his situation.

A frame for interaction

Many participants had difficult experiences from mental health care, and were struggling with personal losses, distress and lack of engagement. The dreary everyday life and lack of joy were explained as the main reason for their wish to have the CTO discontinued to come off medications. As one participant said:

"I regard myself as part of the community, but I am simultaneously afraid because others are making progress while I have stagnated...Now I am 34 years, I feel full, old and fed up. My experience is that the medications are hindering me. I find it difficult. She (the psychiatrist) is trying to comfort me, simultaneously as her words are forcing me. She wants to collaborate. It is uncertain if I can trust her...I am willing to collaborate with the ACT-team. I realize that they want to help. I am trying to accept that I need medications. I see that the choices I make are of importance."

What many of the participants valued most was that staff-members participated in meaningful dialogues, and that they were willing to listen to their experiences and viewpoints. Typical phrases were "the ACT team talks to us" and "the ACT team wants to help." Many participants emphasized the importance of having someone who stood up for them, who also coordinated services and followed them through progress and setbacks without being judgmental. Conversations about previous re-admissions, risk situations, how to handle future crises and to find reasonable solutions was described as a fine balance. And as one participant said:

"It's important that they (the ACT team) have faith in me when I say that I am doing well, that they have confidence in me. They understand the situation, they have the experience."

Negotiations about treatment

Nearly all the participants had weekly contact with the ACT team. While a few participants refused to talk with the psychiatrist other than at the obligatory control assessments, most participants highlighted the importance of being in a dialogue with the psychiatrist about treatment. One participant who recently had discontinued anti-psychotic medication without informing the team said:

"I just felt empty, I just sat there and had nothing to say."

When the team found out, the psychiatrist had talked about the risks of the participant stopping taking the medication and informed him that the team would conduct more frequent home-visits to monitor his mental health condition. A few other participants who had tried medication free periods under the CTO had experienced to be re-admitted to hospital, earlier than necessary from their point of view, to start back on medications because of symptom exacerbation. Although the ACT psychiatrist insisted on the need to use medications, many participants emphasized that the psychiatrist had involved them more than they had experienced before, and asked which type of antipsychotic medication they preferred and which dosage they found appropriate. And not least, the psychiatrist had been willing to make a reduction plan and slowly decrease the dosage.

While highlighting the importance of being in a dialogue about medications, many participants stated that medications alone were not sufficient to change their life. One participant said:

"Individuals who are compulsory detained should receive optimal treatment and follow up, not just sit somewhere not doing anything, that's not treatment."

In addition to basic needs and continued follow-up, increased safety and predictability, were described as important building blocks to have increased control over their life. To have someone to talk with, who followed them though progress and setbacks, was described as an important factor for staying well. As one participant said:

"It is important that I have contact with the ACT-team. It helps to have someone to talk with and to receive help to learn positive thinking, to be among people with healthy thoughts. I have talked with the

psychologist, I talk with X (psychiatrist) once in a while, and I have participated in a group based education session about psychosis. Now I have most contact with two nurses."

Besides medication monitoring and providing emotional and practical support, many participants had gradually been encouraged to participate in ACT-organized activities; in-door soccer training, swimming, field trips, golf or activities in the community, educational courses, and voluntary work. And what many valued most were the benefits of receiving coordinated services and assistance with ordinary daily life activities and everyday problems.

Collaboration as strategy

Many participants were critical of the CTO regime, partly based on previous experiences from mental health services. Being a psychiatric patient was described as a locked position, where they encountered low expectations and pessimistic attitudes. The participants described a process of gradually engaging with the team, weighing various costs and benefits of receiving continued care and treatment under the CTO.

Reflecting on the need for treatment and care

Many of the participants were still living chaotic lives and many acknowledged the need for help and assistance. One participant who recently had been informed by the ACT psychiatrist that the CTO would not be extended as long as he continued to collaborate and engage in treatment, described the implications of the CTO as: "A way to survive or handle life." And as he emphasized: "It is all about medications, whether they are good for me or not." Even if he was ambivalent about medications, he acknowledged that his family reacted to his behaviour when he stopped taking them and he associated previous admissions with medication discontinuation. And as he said: "It's more about functioning in daily life." Moreover, he stated that:

"I have a formative idea that I'll manage without medications even though everyone else says that I don't. Now it has been proved several times, but I am not able to realize it and that's why I am on a CTO. I experience the ACT team as a good place to be and as good people to use."

After his last admission to hospital, he and the psychiatrist had met several times to come to an agreement about medications. And, as he emphasized, he had to collaborate about prescribed treatment, whether the CTO was lifted or not, to get back his driving license. The psychiatrist had agreed to discontinue one of the antipsychotics that had given him bothersome side effects. He stated:

"I'm still taking Cisordinol, which I guess I have accepted. I have some inner peace...so it might work... I have accepted that I can live with that medication... Now we have agreed that she (referring to the dialogue with the ACT psychiatrist), will support me to regain my driving licence ... and also, practically, they (the ACT team) helped med to clean up my appartement."

A few of the participants consistently claimed that they wanted to have the CTO discontinued to come off medications and to avoid contact with mental health providers. Others stated that they had gradually acknowledged that long term follow up from the ACT team and antipsychotic medication was helping them to manage severe and disabling symptoms. They also often emphasised the importance of ongoing efforts to reduce the side effects of the medications, to improve their daily functioning. A typical phrase spoken by this group of service users was: "I want to collaborate with the ACT team." One participant explained his grounds for accepting treatment by saying:

"I have won my civil rights in other matters than the depot injections. That means that I don't have to be here (at the local psychiatric hospital), and that I don't have to be locked up. That's why I have accepted it and collaborate... I chose to collaborate to have increased freedom."

While some participants had regularly scheduled admissions at the District Psychiatric Centre, others asked the ACT team to arrange shorter voluntary admissions, as part of their crises plan. One participant tended to ask for shorter inpatient stays after cycles of extensive substance abuse, poor nutrition, and lack of sleep:

"It is when I have lived too hard."

Others described physical health problems such as injection wounds and HIV. Several explained their use of substances, first of all injecting amphetamine, as a strategy to overcome the negative side effects of the medications:

"It is to regain energy. I become so self-suffering and I stay in bed."

Although describing increased housing stability, security and predictability, several still experienced to be "trapped" in a situation with persistent psychiatric symptoms, intolerable side effects, and ongoing substance abuse. Discontinuing antipsychotic medication was by some described as a necessary condition to reduce their substance use. Nevertheless, many participants described the CTO as the least-worst solution, with a restricted set

of options and uncertainty about how life would be if they had not been mandated to stay in treatment. Like one participant said, by referring to improved nutrition, more routines and structure:

"I handle the medications better, and I assume I wouldn't have made as many life improvements"

Another participant said:

"I think it is time to reduce the Fluanxol dosage. I have a low dosage indeed, and I could fall back into psychosis."

And for them, as for others, the CTO had been important to facilitate appropriate mental health care and social welfare services they otherwise would not have had access to.

Security net

By comparing their current life situation to the past, several of the patients made the point that the benefits of receiving supportive and coordinated services from the ACT team overshadowed the disadvantages. Several emphasized that there had been an overall reduction in coercive crises interventions after they had begun receiving services from the ACT team, and as one patient said:

"The police have often kicked me into the emergency room for a clinical assessment. I don't know how many times I have been restrained and had injections with medication. Fortunately that's a long time ago."

Like some of the other participants, he was in need of shorter inpatient stays, as he had extensive substance abuse and fluctuating illness episodes. The ACT team often intervened before he reached the point of aggressive behaviour or acute illness. Some participants referred to the CTO as a negotiated agreement and as a necessary safety net to prevent relapse. One participant said:

"It (the CTO) is in place because I previously have stopped using medications, and I can't discontinue treatment until I'm well enough to manage at home. It's positive to know that the team can have me admitted when they see symptoms, and that I can't refuse. When I'm in a psychosis I can refuse taking medications and resist inpatient treatment even though I need it."

Soon after her first CTO had expired she had experienced a serious illness episode when she discontinued medications and refused to have contact with the ACT

team. Like other participants she had needed time to accept the need for ongoing medication monitoring and supervision. She needed to have ongoing discussions with the team psychiatrist and the staff-members to figure out the implications of the CTO. The most important difference between the ACT teams and traditional mental health services was the ongoing dialogue about the use of medications:

"Even if she makes the decisions, I can influence the treatment decisions."

Discussion

One main finding in this study is that the participants had different experiences of being subjected to a CTO while in ACT. While some participants had shorter illness durations and were currently discharged on their first CTOs, others had experienced longer involuntary admissions or been under coercive treatment regimes for most of their adult lives. Although some participants that actively refused treatment were under a medication order, most participants had adjusted to the CTO conditions. In line with Sjöström's ethnographic study [34], several of the participants claimed that they would have to follow recommended treatment whether or not the CTO expired. Some participants who told about ongoing conflicts about the use of antipsychotic medication experienced the CTO as more coercive, based on use of pressure and threats of police assistance for depot medication administration. The medication side effects and the uncertainty about the length of CTOs were described by some participants as the most difficult to accept. Nevertheless, the experience of being legally compelled to receive treatment was often blended with the advantages of receiving other types of care and comprehensive follow-up services from the ACT team. The participants expressed different experiences and opinions. While some remained clearly negative to the CTO, other participants in our study described a gradual transition toward regarding the CTO as an acceptable solution as they gained experience of ACT.

While some participants had experienced longer involuntary admissions, others had previously experienced frequent encounters with the police, repeated emergency room visits and involuntary admissions, often with little social support and follow up after discharge. Many of the participants had lived chaotic lives with active substance abuse. Although Norway is a rights-based welfare state with a well funded health system, the mental health services are fragmented and sometimes poorly coordinated between specialist health care services and primary care services provided in the municipalities [35, 36].

While we are not aware of any prior Norwegian studies of CTOs within an ACT context, two recent qualitative studies explore patients' subjective experiences of

CTOs. Riley et al. [26] found that most of the patients had adjusted to the CTO, which the patients regarded as a less restrictive solution than hospitalisation. The other study showed that most of the patients contrasted the CTO to living an ordinary community life, and the patients felt that the CTO hindered them from activating their own strengths and resources [37].

Many of the patients in our study acknowledged that the CTOs provided access to help and assistance, increased safety and security, as pointed out by Riley et al. [26]. However, some of the patients that described the CTO as a social control mechanism felt that they were not being listened to and treated with sufficient respect, and felt there was a too strong emphasis on medications. This may impede some patients' self-efficacy and recovery-processes [37, 38].

Even if many participants in our study did not experience that they had a choice regarding medications, few described the ACT team's enactment of the CTO as disempowering and as a barrier to improvement. Many participants in our study described the ACT team as a different type of mental health service compared to what they had experienced before, with a different frame of interaction. The participants emphasized the teams' willingness to listen to their views and to have time to reflect on different alternatives, regarding medication as well as basic needs and daily life activities, and that the ACT team understood that medications alone were not sufficient to change the patients' lives.

The ACT teams' availability, the flexible combination of interventions, and being offered time, continued care, support and choices were described as the most important improvements compared to traditional services. What many participants valued most was to have someone to call, who acted out of concern for their well being as well as the teams' willingness to participate in meaningful dialogues. Assistance with housing problems, finances and gradually being encouraged to participate in activities and (voluntary) work were described as important life improvements by many. Others emphasised an overall reduction of coercive crises interventions, more voluntary help seeking, and shorter inpatient stays as important building blocks to gain increased control over their lives. Many of the participants in our study described constrained choices, rather than actual compulsion, and even if extrinsically motivated, many had gradually acknowledged the benefits of receiving continued care, treatment, and supervision under the CTO.

The founders of ACT stated that coercion is not part of the model [39]. Even so, newer model revisions acknowledge that therapeutic limit setting and coercive interventions may be used to safeguard extrinsic motivation for receiving services deemed necessary for continued community living [18]. While some opponents describe CTOs

as intrusive and counterproductive to patients' recovery processes, others justify involuntary treatment as a necessary tool, to be carefully imposed to ensure the right to safe and effective care and treatment [40].

From a patient perspective, recovery is often described as a personal journey, to get one's life back on track after the onset of illness. Symptom relief often has a central role in recovery, as well as combined efforts to enable hope, self-determination, personal growth, and responsibility, with the need for creating choices and opportunities for social integration. Although the ACT model has a strong focus on recovery, medication management and monitoring are cornerstones of the model, which has been criticized for being paternalistic and coercive. ACT teams are supposed to continue to engage reluctant persons for up to a year. One question that has been raised by some is whether treatment that cannot be refused is ethically justifiable [41, 42]. While some have claimed that the ACT model is inherently coercive, others disagree [17, 19, 43–46]. Studies have reported that ACT providers sometimes use assertive and controlling techniques. However, supportive relationships and interpersonal influence have been described as the most frequently used mechanisms for promoting treatment goals [43, 47–49]. As some other studies of ACT show, most participants in our study reported that motivational interventions, persuasion, verbal guidance, and education were more frequently used than threats and force [43, 47–49].

Coercion is simultaneously an objective and subjective concept. There may be a blurred distinction between nondirective discussions and coercion. Several of the participants stated that they did not feel coerced despite being subjected to a CTO.

Although being aware of the potential threat of being brought back to hospital or receiving a medication order if they refused treatment, most participants did not describe the ACT team's enactment of the CTO as coercive. While some participants used phrases like "*I do not experience much coercion*" and "*it is not voluntary, but it's not coercion either,*" others described the CTO as a negotiated agreement and that they were being "*voluntarily coerced.*"

Motivation is often presented as a critical factor for treatment participation, retention and success [50]. One argument often used is that coerced treatment is likely to fail because the individual does not have an internal motivation. Within self-determination theory motivation is described as a continuum, with amotivation described as the lack of intention to act on the one side and intrinsic motivation, the doing of an activity for its inherent satisfaction, on the other [51]. It can be argued that for most people, much behaviour in daily life is actually performed for external reasons. Nevertheless, it may be important

whether patients follow recommended treatment just to avoid negative consequences or whether patients believe that treatment may be beneficial and will help them achieve other goals. Even if the motivation was primarily external, many participants in our study emphasized that communication and the care providers' attitudes could make a significant difference [52]. The experience of being listened to and being involved in treatment decisions was described as a pivotal starting point for building supportive therapeutic relationships and shared treatment goals.

Collaboration with the ACT team was described as a strategy to gain increased freedom. Some participants felt the CTO was a safety net, which made it easier to be readmitted if needed. Moreover, in some situations the ACT team was obliged to intervene to prevent deterioration and serious relapse. Other participants had gradually accepted the ACT team's medication monitoring as a buffer or as a necessary reminder to take medication to stay well. Although recognizing that the psychiatrist had the final decision making authority, several of the participants described a gradual transition toward increased influence, collaboration, and shared responsibility.

Studies from the UK and Ireland have shown that assertive outreach teams appear to be more successful than mental health care teams in engaging reluctant patients in treatment [53, 54]. The low case load and the shared responsibility within the teams imply that assertive outreach workers have more time, and more opportunities to monitor medication use and to more actively involve patients in treatment planning decisions [53, 54].

Some studies have shown that when CTOs were combined with intensive services (ACT) for more than six months, there was a substantial decrease in hospital admissions rates, total days hospitalized, and improved rates of psychotropic medication use [22, 55]. Our study is in line with other studies that show that patients' lives seem modestly improved under ACT [56] and that being coerced does not necessarily negatively influence patients satisfaction with treatment [57, 58]. And like Phelan and colleagues [21] find, assisted outpatient treatment works as a "package deal," where coercion is only one of the elements that have effect.

The study's findings are in line with some other studies that show that trusting therapeutic relationships and non-judgmental and stage-wise approaches are of great importance in engaging patients in care [46, 48, 54, 59]. As Gilbert et al. [30] find, trusting therapeutic relationships seem to modify how patients across different treatment contexts interpret care providers' behaviour and also the restrictive interventions.

The quality of the treatment relationship and the patient's ability to influence treatment decisions seem to be factors that influence the experience of coercive practices [28, 38, 60]. In our study, many participants described the

ACT team's enactment of the CTO as a negotiated agreement, where they had strived to find a balance between the need for safety and the patient's autonomy. As other studies show, the perception of coercion is context dependent [61]. Several of the participants in our study described the experience of feeling gradually less coerced and more autonomous, and they illustrated that the perception of coercion may change over time [53]. And as Bonnie claims [62], sometimes it seems more appropriate to reframe leveraged community treatment based upon the patients' negotiated consent as a "contract" rather than as "coercion."

Strengths and limitations

This is one of very few studies that examine patients' perceptions of CTOs within an ACT team setting. The study gives important insights into how patients that previously have avoided or not benefitted from ordinary services experience living with CTOs. It may be difficult to reach this group of patients. Nevertheless, we were able to include 15 patients with varying opinions and perspective about being subjected to CTOs. The sampling was purposive, and while we made an effort to obtain a range of different perspectives, positive and negative, the results are not representative in a statistical sense. As some of the ACT teams had very few patients on CTOs, we were unable to recruit enough patients to analyze possible differences in patients' perceptions between the ACT teams. In recent years, it has become clearer that service users may play an important part in designing and carrying out research on the different types of services. It is a limitation that the present study did not involve service users in designing or carrying out the research.

Conclusions

This study showed that the participants had different perceptions of being subjected to CTOs while in ACT. Some described the CTO as a security net and as an important factor for staying well. However, other participants described the CTO as a social control mechanism and as a violation of their autonomy. Many of the participants described the ACT team as a different mental health arena from what they had known before, with another frame of interaction. Despite being legally compelled to receive treatment, many participants talked about how the ACT teams focused on addressing unmet needs, the management of future crises, and finding solutions to daily life problems. Many of the patients emphasized the help they got from the ACT teams in finding housing, getting assistance with their finances, and in reducing social isolation.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

HKS designed the study, conducted the interviews, analyzed the interviews, and drafted and revised the manuscript. JR designed the study, analyzed the interviews, and revised the manuscript. AL designed the study, analyzed the interviews, and revised the manuscript. RW designed the study, analyzed the interviews, and revised the manuscript. All authors read and approved the final manuscript.

Authors' information

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RESEARCH ARTICLE

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Responsibilities with conflicting priorities: a qualitative study of ACT providers' experiences with community treatment orders

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Abstract

Background: Patients with severe mental illness may be subjected to Community Treatment Orders (CTOs) in order to secure that the patients adhere to treatment. Few studies have investigated the use of CTOs within an Assertive Community Treatment (ACT) setting, and little is known about how the tension between the patients' autonomy and the clinicians' responsibility to act in the patients' best interest are resolved in practice. The aim of this study was to explore the service providers' experiences with CTOs within an ACT setting.

Methods: The study was based on reviews of case files of 15 patients, eight individual qualitative in depth interviews and four focus group interviews with service providers involved in ACT and decisions related to CTOs. A modified grounded theory approach was used to analyze the data.

Results: The main theme 'responsibility with conflicting priorities' emerged from data analysis (case file reviews, individual interviews and focus group interviews). The balance between coercive approaches and the emphasis on promoting patient autonomy was seen as problematic. The participants saw few alternatives to CTOs as long-term measures to secure ongoing treatment for some of the patients. However, participants perceived the ACT model's comprehensive scope as an opportunity to build rapport with patients and thereby better meet their needs. The team approach, the ACT providers' commitment to establish supportive relationships and the frequent meetings with patients in their home environment were highlighted. The ACT approach gave them insight into patients' everyday lives and, in some cases a greater sense of security when considering whether to take patients off CTOs.

Conclusions: Many of the participants viewed CTOs as helpful in securing long-term treatment for patients. CTO decision-making was described as challenging and complex and presented the providers with many dilemmas. The ACT approach was considered as helpful in that it afforded comprehensive, patient-centered support and opportunities to build rapport.

Keywords: Assertive community treatment, Community treatment order, Engagement strategies, Provider experiences, Compulsory medication, Coercion

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Background

Despite a lack of clear evidence of effectiveness, more than 75 jurisdictions worldwide have implemented community treatment orders (CTOs), which is a legal mechanism to secure the treatment adherence of patients with severe mental illness living in the community [1]. Besides mandating patients to adhere to treatment, the CTO regime also allows for a rapid recall to hospital for its enforcement. In Norway, CTOs have been part of the Mental Health Care Act (MHA) [2] since 1961. Despite being debated in many countries, there has been surprisingly little discussion about their use in Norway [3].

In Norway, the involuntary admission rates and the CTO rates are relatively high compared to other western countries and reducing the use of coercion has for many years been a central policy goal [4]. Although two national action plans have been implemented, the involuntary admission rates and the geographical differences in use within Norway have been remarkably stable, while the use of CTOs actually seems to increase [5, 6]. While we lack reliable knowledge about the extent of CTOs, it is estimated that more than one of three patients are placed under CTOs following involuntary hospital admissions [6].

The use of coercion in the Norwegian MHA is based on clinical judgment [7–9]. The legal criteria for involuntary inpatient admissions and CTOs are identical [2]. In addition to severe mental illness (such as psychosis), one of two criteria must be met; the treatment criterion or the danger criterion. The treatment criterion states that ‘...the application of compulsory mental health care must be seen as necessary to prevent the person concerned from having the prospects of his or her health being restored or significantly improved considerably reduced, or it is highly probable that the condition of the person concerned will significantly deteriorate in the very near future’ [2]. The danger criterion states that admission is needed because the patient represents an ‘... obvious and serious risk to his or her own life and health or those of others on account of his or her mental disorder’ [2]. It is also required that voluntary treatment has been tried and the CTO must be considered as the best solution for the patient. Recently (after the current study was carried out), a capacity criterion has been introduced in the Norwegian MHA [2]. Psychiatrists and clinical psychologists (Responsible Clinicians or RCs) in the specialized mental health services are authorised to make CTO decisions, and are required to conduct clinical assessments every third month. Patients on CTOs typically receive primary health care follow-up services in the municipality and are required to attend office-based assessments at the Community Mental Health Centre (CMHC). Local Supervisory Commissions (SCs) are responsible for safeguarding patients’ legal rights to ensure the criteria are still met. To compel patients placed on a CTO to take medication, a separate compulsory medication order (CMO) must be in place.

Studies in Norway and internationally show that psychiatrists and patients’ families typically are more positive to coercive practices in general and CTOs than patients, who often have more mixed views [10–19]. Even if patients describe CTOs as less coercive than hospital admissions, many patients dislike having to take medications and experience that they have little influence on treatment decisions [16–19]. Studies show that health professionals value the CTO scheme for providing security and structure after discharge from hospital [14, 15, 20–23]. Health professionals often describe CTOs as a useful tool to facilitate stable medication and follow-up because of the patients’ lack of insight [23, 24]. Although the CTO scheme has been used for more than fifty years in Norway, only two published studies of health professionals’ experiences with patients on CTOs exists, to our knowledge. Stensrud et al. [23] found that even if the patients were stable over time, the RCs were worried about relapse and therefore reluctant to discontinue the CTOs. Riley et al. [22], from a different geographical region, show that the organization of the local health care seems to influence on the decision-makers’ role and the implementation of the CTO.

Results from three RCTs and meta-analyses on the effectiveness of CTOs show no clear difference in service use, social functioning, mental state or quality of life compared to standard care [1, 25–28]. Some studies show that CTOs, combined with assertive community treatment (ACT) or intensive case management, were associated with positive outcomes such as decreased hospitalization, increased medication possession, reduced violence, and even increased subjective quality of life [29–35]. However, possible selection effects have been pointed out [1].

In a report from 2008, it was estimated that more than 4000 persons with severe mental illness in Norway (approximately 1/1000) did not receive appropriate mental health services [36]. In 2009, the Norwegian health authorities decided to fund the piloting of ACT teams in order to provide effective treatment and rehabilitation to people with severe mental illness who have not engaged with traditional services. In Norway there has been no tradition for using intensive case management. International research suggests that ACT is successful in engaging service users with a history of treatment and service use discontinuity, reducing hospitalization, increasing housing stability, and reducing homelessness [37, 38]. ACT provides in-vivo services, includes a multidisciplinary approach, shared caseload, responsibility for health and social care, time-unlimited treatment, assertive engagement techniques and a high frequency of contacts [37, 39, 40]. Even if the ACT model did not initially describe the use of coercive interventions, later model revisions allow for the time-limited use of restrictive

interventions and formal coercion when necessary to promote safe community living [40].

In the 12 first Norwegian ACT teams that were established in the period between December 2009 and February 2011, a total of 38% of the patients were subjected to CTOs at enrolment into ACT during the teams' first year of operation [41]. Few studies have investigated the use of CTOs within an ACT setting, and little is known about how the tension between the patients' autonomy and the clinicians' responsibility to act in the patients' best interest are resolved in practice. The aim in this qualitative study was to explore the RC's and ACT providers' experiences with making decisions about CTOs within an ACT setting.

Methods

Recruitment and sample

This qualitative study is part of the national evaluation of the 12 first Norwegian ACT teams [42]. There was significant variation across the ACT teams in CTO rates; between 10% and 59% of the patients were subject to CTOs at intake during the teams' first year of operation. While the ACT psychiatrist or clinical psychologist was responsible for conducting regular CTO assessments in most of the teams, some teams had deferred this responsibility to the CMHCs. For the present study we chose teams with different CTO rates and ways of organizing the responsibility for CTOs, to broaden the range of included experiences [43]. All the teams had been in place at least 2,5 years before the study started. An interview study with 15 patients has already been published [44]. An overview of the four included ACT teams' CTO rates and the organization of the CTO responsibility are presented in Table 1.

Participants

The sample consisted of eight RCs (six ACT psychiatrists and two CMHCs clinical psychologists) who participated in individual interviews and 20 ACT providers who participated in focus group interviews. The psychologists at the CMHC and the ACT psychiatrists were all invited to discuss their experiences with CTOs within an ACT setting. In connection with the patient study [44], we asked the participating patients for permission to read their case files and to talk with the ACT providers and the RCs about their case.

We conducted focus group interviews with 20 ACT providers from the four ACT teams one year after the individual interviews with the RCs. The purpose of having separate interviews with the RCs and to conduct focus-group interviews with ACT providers was to compare and contrast the ACT providers' and the RCs' different roles and responsibilities regarding CTO use. For the focus group interviews, recruitment was aimed at ACT providers with at least two years' experience with ACT. Many ACT providers and RCs would have had much longer experience with managing patients in the community on CTOs. Because we knew that some teams had struggled with recruiting psychiatrists, we did not use other selection criteria than that they had been responsible for the CTO case for one of the 15 patients interviewed in Study 1. An overview of the participants can be seen in Table 2.

Data collection

This qualitative study draws on different data sources, including case reviews, focus group interviews, and individual interviews. From November 2013 to August 2015, after the initial patient interviews [44], the first author (HKS) read the patients' case files, once before and nearly one year after interviewing the RCs. One year after the individual interviews, HKS conducted focus-group interviews, assisted by co-moderators with long experience from treatment and research, to explore the RCs' considerations and the ACT providers' experiences with the follow-up of patients enrolled in ACT and subjected to CTOs.

The individual interviews and the focus-group interviews were conducted using a thematic interview guide developed jointly by the authors, based on a literature review (Additional file 1 and Additional file 2). Even if we had data about the 15 patients' views and experiences with the ACT teams' enactment of CTOs, we only referred to the patients' CTO status in the provider interviews. All the interviews started with open questions about their experiences with the CTO follow-up responsibility, and how the CTO responsibility was organized. We also asked the participants to use some of the specific cases to describe the content of the CTO and its clinical implications. We opened up with phrases like, "When we interviewed (X) he was placed under a CTO, which later was removed, but is now back on a CTO.

Table 1 Overview of CTO responsibilities in the four included ACT teams (at 30 months)

Team number	Patients in Team	Patients on CTOs (%)	Responsible for CTOs	Responsible for CMOs
Team 1	76	40 (52)	ACT psychiatrist	ACT psychiatrist
Team 2	67	4 (6)	ACT psychologist	ACT psychiatrist
Team 3	68	23 (33)	CMHC psychologist	ACT psychiatrist
Team 4	38	13 (34)	CMHC psychologist	CMHC psychiatrist

Table 2 Participants in individual interviews and focus group (FG) interviews

	Individual interviews	FG 1 (Team 1)	FG 2 (Team 2)	FG 3 (Team 3)	FG 4 (Team 4)
RCs					
Psychiatrists	6				
CMHC psychologist	2				
ACT providers					
Psychologists			1	1	1
Psychiatric nurses		2	2	2	2
Social educators		1	1		
Social workers		2	1		1
Nursing assistants		1			
Peer specialists		1		1	

Have you had recent team discussions about the length of the CTOs and the CTO follow-up responsibility?" Even if we used case examples, participants also described other CTO cases.

We asked the focus group participants about the strategies applied to develop supportive relationships with the patients and their experiences with CTOs. The topic guide was based on previous patient interviews, case files, and the interviews with the decision makers. All the interviews were conducted within the ACT team's facilities. The individual interviews lasted 55–110 min. The focus-group interviews lasted 120–130 min, where the co-moderator was invited in to ask for more details and to summarize. The interviews were recorded and transcribed verbatim.

Analysis

We utilized a modified grounded theory approach informed by a constructivist and interpretative framework [45]. The approach is a recognized method for investigating phenomena where little prior knowledge exists. An iterative process of data collection was used to develop a conceptual understanding of the ACT providers' and the RCs' experiences with CTOs based on the categories grounded in the data [45]. The interviews were consecutively thematically coded, to identify meaning units in the transcribed text. Subsequently, we used the same procedures for the focus group interviews. After the initial coding, all the interviews and the memos were read through, to compare the most frequently used codes and develop more focused codes. The most central codes were clustered in theoretically linked themes, which allowed us to develop categories and sub-categories that were linked together, based on their properties and dimensions (focused coding). Subsequently, categories were linked together (theoretical coding). Focused coding was done manually, and thereafter

NVivo software [46] was used to get a better overview of the data. The process of constant comparative analysis was continued with the help of the software until no additional new observations emerged. Memo writing was used through the process, to increase the level of abstraction and to aid in the development of the categories.

Ethical considerations

This study was approved by the Regional Committee for Medical and Health Research Ethics (Case number 2010/1196a). The team leaders were given written information about the study before consenting to participate. The team members were informed about the study and that participation was voluntary prior to choosing to participate in the interviews. In connection with the patient study [44], we asked for permission to use case files and to talk with the ACT providers and the RCs about their case. All data were kept confidential and stored in unidentifiable form.

Results

The participants presented the ACT model's structural components as a window of opportunity to approach the patients' needs. According to the participants, CTOs were mainly used to ensure medication adherence and monitoring, but was also presented as a safety net for calculated risk-taking within the context and opportunities for engagement and practical support provided by the ACT model. CTO decision-making was described as a complex procedure, and the ACT providers' commitment to establish supportive relationships was a central topic in their accounts. Three categories leading to the main theme of 'Responsibility with conflicting priorities' were identified: 'Conflicting priorities: Treatment and autonomy', 'ACT and providing practical support and comprehensive services' and 'ACT and building rapport'.

Conflicting priorities: Treatment and autonomy

The successful use of CTOs was presented as resource-demanding and involved conflicting values and considerations. Respecting patients' autonomy while also meeting their clinical duty to provide treatment was often a difficult balance to strike. As one psychiatrist said:

"Having people under coercion goes against the idea of running your own life, being allowed to make your own choices, make mistakes, learn from your mistakes ... it's a difficult balancing act."

Even if the team frequently had to remind some patients about the need to take medications to stay well and sometimes use police assistance to bring the patients to a treatment ward, most patients adjusted to the "rules" and "conditions" of the CTO. As one ACT provider said:

“There is a threat of being readmitted. They know that if they do not collaborate they might be admitted, so in one way we become a necessary evil.”

Many ACT providers described dilemmas and conflicts regarding medications. Both the inherent asymmetrical power balance and the clinicians’ dual role in combining care with compulsion involved ethical and practical difficulties. As one ACT provider said:

“It’s difficult. We talk a lot about it, especially those of us who travel around giving depot injections. We face a lot of resistance to medication, there’s a lot of coercion involved. We talk about it and reflect on it in the mornings, how to do it in the best possible way and what we could do differently, we do try. I have to speak for myself. I must say that I sometimes feel uneasy, because I don’t always think this helps.”

The psychiatrists emphasized the importance of anti-psychotic treatment to prevent psychotic episodes and in some cases, often regarding patients with concurrent substance abuse; long-term use of CTOs was justified as the least restrictive solution. As one psychiatrist said:

“The reason why I don’t dare to remove the CTO is the patients’ rapid symptom exacerbation associated with substance abuse.”

As many psychiatrists claimed, as a multidisciplinary team they could be much more responsive to the patients’ treatment needs and wishes, and in some cases they would use the CTO as a safety net for a limited time period, to reduce or take patients off medications. One psychiatrist said:

“The art is to find the right maintenance dose and eventually, if it is justifiable to let people become psychotic again, I might terminate the CTO, or let people discontinue medications with the legal framework in place.”

It was often seen as helpful to try to establish a common understanding with patients about the need for medications. A focus on patients’ possible choices and possibilities, rather than on the disagreements was also seen as helpful. Even if the team could not compel patients to take medications unless a valid medication order was in place, the ACT providers would often intervene early to try to convince the patients about the need to take medications to stay well. As one ACT provider said:

“Patients on CTOs do not get the opportunity to stop medications for a longer period if that is unadvisable.”

The teams were often concerned about patients’ substance use, previous history of violence associated with treatment discontinuation, and the early discharge from the Emergency Wards of patients suffering from substance induced psychosis. In such cases the ACT providers felt powerless despite the CTO:

“With (X) we experience powerlessness about what we believe is good for the patient and what we can actually do.”

According to many ACT providers, there was a fine line between educating and convincing patients about the need to take medication and what would amount to pressuring them. For example, it was not always clear when reminders about previous illness episodes might be perceived of as threats. The Supervisory Commission had, at the time of data collection, recently given instructions to one of the teams that CTOs did not authorize threats or persuasive communication about hospital admissions. The ACT providers we interviewed acknowledged that the CTO scheme did not allow threats of hospitalization. As long as a CMO was not in place, the patient had the final word about depot injections, even if that might imply adverse outcomes for the patient.

ACT providing practical support and comprehensive services

CTOs were used to secure treatment adherence, sometimes referred to as a ‘platform for other interventions’. A narrow medication perspective was described as inadequate. Supporting the patients to better manage their symptoms, so that they gradually could take more responsibility for their own lives was deemed equally important. ‘To support people to reconnect with life’ was how several ACT providers described the ACT team’s vision, and many said that the ACT model enabled them to take a wide approach in their work with patients. As one ACT provider said:

“I’m thinking about what you’re saying here, helping people take the bus and so on. We get people who’ve been in hospital for a long time, who’ve been institutionalized and then we have to start from scratch with many of them and help them get back to life after being in an institution for a long time.”

A range of factors, everyday skills training, securing access to welfare benefits and safe housing, helping building social networks, participating in activities and developing a crisis plan or initiating regular voluntary inpatient arrangements were important to stabilize the patients’ lives. Some saw a role for CTOs in order to achieve the ACT aims. As a psychiatrist said:

“Generally speaking, I often regard the CTO as a mechanism to ensure the social relationships and to establish necessary structures.”

The same psychiatrist followed up by saying that many patients need comprehensive and integrated services, and the team’s opportunity to provide a range of different interventions was important:

“That we can provide a variety of approaches simultaneously. Everything from providing a guardian, helping with the Economy, Welfare and Labor Administration, medical treatment and soccer training session and dish

washing together. And drug addiction treatment, motivational interviewing and bus training simultaneously, simply invaluable.”

Providing comprehensive support and having frequent contact with patients was perceived as creating opportunities to address the patients’ motivation to engage in treatment. As one psychiatrist said:

“Because we have established a relationship, we can follow up very ill people, also when they are acutely ill, without the need to rely on coercion. Even if psychotic patients don’t always think we have good intentions, with 2-3 encounters every week, also during crises, we have a better opportunity to work with the patients’ motivation, which is difficult if you meet the patient once or twice a month at an outpatient clinic.”

Many participants described a gradual change in the teams’ treatment approaches. For example by adopting the ACT principle of regular critical team reflections. Others pointed out that having a peer specialist in the teams had been important to improve practice:

“Since I started in ACT 5 years ago there has been a change in our mindset. Having a peer specialist broadened our focus, to see that medication is not the only effective ‘medicine’ in a person’s life. We focus more on employment, different activities, not least a place to live, economy, all the factors that bring safety to a person’s life.”

The participants emphasized the many nuances involved in the content and enforcement of CTOs, and that shared problem solving and critical team discussions were essential. The participants experienced that many patients on CTOs gradually acknowledged the advantages of ACT. As one of the peer specialists said:

“Many patients have negative experiences with the support services and that’s probably the main reason why the ACT team was created. To realize that these are people who can also take care of other tasks or areas of life, I think that’s a positive experience for many patients.”

ACT and building rapport

Because many patients had negative prior experiences with mental health services, building rapport with the patients was described as the most important step to promote treatment acceptance. Even if many participants underpinned that coercion potentially could impede the therapeutic alliance, CTOs were often described as a necessary mechanism to create relationships that could promote stability and safe community living. As one of the psychiatrists said:

“We have a number of patients where we can see that the CTO has made them better, that it’s basically meant that we’ve got into a treatment position. Saying that we’re here to stay even if you reject us, where they’ve eventually got a relationship with someone in the team precisely because they’ve been on a CTO. The obligations you have

give you closer contact and you get a better general idea and you can provide a different approach than we could have without the CTO.”

The participants emphasized that being part of a multidisciplinary team with shared responsibility that provided flexible follow-up services represented a major improvement from traditional outpatient services. The teams’ shared agreement to prioritize the initial engagement process and to spend time with patients across different social arenas was crucial in order to build trust and rapport. The ACT providers’ commitment to establish supportive relationships encompassed something akin to a “we do what it takes” approach. Moving beyond their typical professional roles was in many cases described as an important engagement strategy, to provide continued offers acceptable to patients. The participants emphasized that they used the same engagement strategies with patients on CTOs as with patients not on CTOs. They said that listening carefully and responding to the patients’ wishes was crucial. As one of the ACT providers said:

“We use the same approaches as we use with patients not on CTOs. We want them to be involved in treatment planning decisions as far as possible, and we try to facilitate, listen to them if they have wishes, if things should be different. I think we treat all the patients with respect, also when they are subject to CTOs.”

One strategy often mentioned was to let the social worker or the peer specialist, who were not directly involved in medication administration establish the initial contact with the patient, and to gradually introduce other staff members. Phrases like “good cop, bad cop” were used to describe this difference in role functions. Another important strategy was that one team member established contact while the patient was still admitted to the ward, sometimes to create a position as the person the patient ‘hated the least’.

Engaging reluctant patients was described as laborious work; respect and empathy as well as communication skills, patience, and persistence were crucial success factors. Many ACT providers emphasized they often knew their patients well, and when they managed to establish a dialogue about a patient’s wishes and difficulties, they could start to take more ‘risks’ by allowing increased patient autonomy. As one ACT provider said:

“Most important, when that communication is well established, then we can take more risks with our patients”.

Also, the psychiatrists emphasized that the CTO decision responsibility in ACT was quite different from the traditional office-based services at the CMHC. The ACT model’s team approach, the opportunity to provide regular in-vivo assessments and the daily team meetings increased their confidence in working with this patient

group. One psychiatrist explained that without the ACT context the work would have been much more difficult:

“Then I would have come from outside, I would have been unsure about my assessments in a completely different way from how I feel now.”

As well as considering the patients' symptom severity, concurrent substance abuse and previous illness episodes, the patients' illness insight and the patients' collaboration and motivation for treatment were seen as important factors in CTO decisions. Furthermore, as several of the psychiatrists pointed out, few guidelines or decision aids exist in this field, and CTO discontinuations were often presented as tough decisions to make.

The ACT approach includes continuous team discussions about what should be in place to safely terminate a CTO. This allowed for flexibility, calculated risk taking and voluntary solutions. Several psychiatrists reported that they felt the follow-up was safer and better controlled due to the ACT team's comprehensive and assertive strategy. Also, the ACT approach allowed for reduced coercion and increased patient autonomy. As one psychiatrist said:

“The ACT team is a means of reducing the use of coercion because if you see the patient as rarely as it often happens when you're in an outpatient clinic you're more unsure. I think it's more convenient to have them under coercion than to have them in voluntary treatment. There are some key practical things that don't need to be so important in our case. We can juggle more and feel it doesn't matter so much. We're trying voluntary care because we have a good alliance with the patient, and if it doesn't work, we have a framework around us that enables us to cope with that.”

Discussion

A main finding in this study was that the participants believed the CTOs were sometimes necessary in order to provide continued treatment. However, the follow-up of CTO patients in the ACT setting involved conflicting priorities. Patients enrolled in ACT often have low functioning and concurrent substance abuse, and the ACT approach was considered as helpful in that it afforded comprehensive and patient-centered support and opportunities to build rapport. The long-term use of CTOs might not be in line with the ACT model's focus on recovery and person-centered care. However, for some patients, the participants saw few alternatives to CTOs as a long-term safety measure to prevent relapse and possible harm to the patients themselves or other people.

Moving toward patient-centered approaches

Many patients subject to CTOs had a recent history of treatment discontinuation, and as other studies show, CTOs were described as a clinical tool to promote

treatment adherence to stabilize the patients' condition and to prevent hospital re-admission [14, 15, 20–23]. The participants emphasized the importance of communication and of facilitating patient cooperation. Seeing the patients frequently and assisting them with everyday activities was considered pivotal. Patients enrolled in ACT were often hard-to-reach, and compared to other treatment contexts, the boundary between voluntary treatment and coercion seemed more blurred. The engagement process often involved careful balancing between collaborative approaches to establish contact and being intrusive, and as other studies show, building trust and rapport with the patients was described as the most important step to promote treatment acceptance [47–49].

CTO decisions were described as challenging and complex. The inherent power imbalance between clinicians and patients and the clinicians' conflicting priorities were perceived as problematic for the therapeutic relationship. Despite many patients' adjustment to the CTO conditions, conflicts regarding medications were ubiquitous. It was not always clear when reminding patients about previous illness episodes and the risk of not taking medication should be considered as verbal guidance, persuasion, or threats. However, the participants emphasized that when patients were placed on CTOs, the ACT approach could address non-adherence and relapse at an earlier stage than traditional services and more easily offer patients choices and negotiate treatments during crises.

Addressing clinical uncertainty through shared responsibility

The psychiatrists in our study distinguished between an insider and an outsider perspective to describe their dual responsibilities in ACT, where the ACT model's structured approach was described as an important quality improvement. Shared case-load responsibility and daily team meetings increased the psychiatrists' confidence, and as many participants pointed out, the team's comprehensive follow-up services promoted flexibility and more voluntary solutions. Several of the psychiatrists felt more secure in their decisions to reduce the medication dose or remove the CTO when they could discuss these issues in their teams. As other studies have shown [13, 23, 24], clinicians are concerned about factors such as lack of insight and risk of relapse when making decisions about CTOs. Some prior studies have found that the duration of CTOs seems to depend on individual decision maker's judgments [14, 22, 23]. The ACT approach, with frequent patient contact, the building of rapport and trust and team-based decisions, is likely to afford clinicians more security and leeway in their decision-making processes. On the other hand, engaging reluctant patients was described as laborious work, and as many

participants in our study indicated, lack of time and available treatment resources could lead to an overly defensive CTO practice.

Addressing adherence through assertiveness

During the last the last 15 years the ACT model has had a clear focus on integrating the promotion of autonomy, client choice, collaborating treatment planning and self-directed care [40, 50]. The ACT providers and the RCs in our study highlighted that even if many patients disagreed about the need for medication, many patients gradually acknowledged the benefits of ACT, such as help with obtaining safe housing and welfare benefits. Studies have suggested that services that emphasize empowerment and recovery can improve outcomes [50, 51]. Although the ACT model has a strong emphasis on recovery, medication administration and monitoring are cornerstones of the model. Some studies have found that ACT providers often use targeted efforts to encourage adherence to medication [52–54]. Other studies show that some Assertive Outreach Teams have reported using less restrictive practices and more varied and flexible approaches than less intensive Community Mental Health Teams [55–57]. Interestingly, a prior study found that patients subject to CTOs in Norwegian ACT teams were more satisfied than patients without CTOs [58]. Our respondents' overall positive view of ACT stands in contrast to some other studies describing concerns relating to paternalism, rights to privacy and self-determination and human rights [59–61].

Assertiveness as a means to increase autonomy

The participants stated that mandated community treatment was justified when it was seen as necessary in order to protect patients or others from dangerous or threatening behavior. However, balancing effective care and autonomy was difficult [62]. Using overly paternalistic approaches was seen as a pitfall, as was underestimating a patient's vulnerability, impaired decision making and willingness to take part in treatment decisions. Participants' descriptions of patients' self-efficacy and agency resonate with a relational understanding, where autonomy is achieved and exercised in the context of supportive relationships and available opportunities in the community [63–65]. Studies suggest that many patients experience CTOs to be disempowering, usually because the patients experience a one-sided focus on medications and not being sufficiently involved in treatment decisions [14, 16–19]. Focusing on procedural justice, which refers to the patients' perceptions of fairness and being treated with respect, can be important in mitigating experiences of coercion [66]. Our respondents discussed the importance of building trust and involving patients in treatment planning decisions. A long-term

commitment was seen as necessary in order to improve the patients' life conditions and thereby help them to gradually take more control of their own lives [64, 65].

These findings differ somewhat from those in Lawn et al.'s study [16], where providers were drawn into a coercive role as their first response to patients who resisted their views of what was needed. Lawn et al. [16] found that providers did not engage these patients in a meaningful dialogue about their personal experiences of CTOs, and that their practice was predominantly focused on risk management and compliance. Many participants in our study referred to CTOs as a safety net to facilitate medication reduction, especially with patients with a history of rapid relapse or serious illness episodes. It was important to try to establish a common understanding about the need for medications and the patients' possible choices and opportunities, especially if it was uncertain whether the medication was effective [67]. Some ACT providers described a reorientation in the ACT team's medication approach as a learning process, from a deficit-oriented focus (i.e. on symptoms and medication) to a more person-centered and recovery-oriented approach. Furthermore, to sit down as a team to critically reflect on ethical dilemmas and the course of action, also to 'keep each other in check', was in line with what other studies have found to be important to improve practice [48, 49].

ACT and levels of coercion

Swartz and colleagues emphasized that a court order might have an effect on both patients and the service system [28]. In some contexts, patients on CTOs may be given priority to ACT treatment. Our participants emphasized that they used the same approach for patients on or off CTOs. It was not required that patients were on CTOs in order to receive ACT or any other services. The participants in our study highlighted that the impact of CTOs depended on how they were implemented and the services that were provided [68]. From September 2017, a capacity criterion has been introduced in an amendment to the Norwegian MHA so that patients with decision-making capacity no longer can be treated involuntarily unless they or their surroundings are in acute danger. It is unclear how the recent changes will impact clinicians' decision-making processes regarding CTOs. The intention is to reduce coercion. However, some have pointed out that this has not consistently been the case in other countries where legal changes have been made in an effort to reduce coercion [69–73]. Some prior research has suggested that CTOs do not improve patient outcomes [1]. Moreover, it is unclear if any improved outcomes may be attributable to enhanced community services rather than to their compulsory nature. Increasing resources and improving the quality of services might lead to reduced coercion [74].

Nevertheless, with changes in the Norwegian MHA, some commonly accepted benchmarks for what constitutes good practice and acceptable risk seems required.

Limitations

This study has several limitations. The greatest limitation is the small number of teams included. The sample consisted of four ACT teams, so the results may not be widely generalizable. The teams were sampled purposively in order to include teams with different CTO rates and that also organized the CTO responsibility differently. In this way, we hoped to capture variations in the ACT providers' and the RCs' experiences with CTOs. Most ACT providers had participated in ACT training and workshops, supported by a Norwegian ACT handbook [75] and fidelity assessments after 12 and 30 months. To avoid a one-sided initial enthusiasm for the ACT models' flexible and integrated care approach, we specified that the selected focus-group participants should have at least two years' experience. However, not all of the 20 staff members were as experienced as we had hoped.

Conclusions

The results from this study highlight the challenges and complexities involved in CTO decisions in an ACT context. Although long term use of CTOs may conflict with the ACT model's focus on recovery and person-centered care, for some of the patients, the participants saw few alternatives to CTOs as a long-term safety measure to prevent relapse and possible harm to self or others. The participants highlighted the team approach, and the importance of frequently meeting the patients on different social arenas. This gave them insight into the everyday lives of the patients and a greater sense of security when taking patients off CTOs. Despite new regulatory changes clinicians are still faced with the dilemma of balancing coercion and autonomy. Future research should examine ACT providers and clients' perspectives of CTOs over time.

Additional files

Additional file 1: Interview/discussion guide for focus groups. (DOCX 81 kb)

Additional file 2: Interview/discussion guide for Responsible Clinicians. (DOCX 16 kb)

Abbreviations

ACT: Assertive community treatment; CMHC: Community Mental Health Centre; CMO: Compulsory medication order; CTO: Community treatment order; MHA: Mental Health Care Act; RC: Responsible Clinician; SC: Supervisory Commission

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Availability of data and materials

In order to protect the anonymity of the participants, the data on which this manuscript is based (data from medical case files and interview transcripts) are not made generally available, with the exception of the data that has been carefully selected for presentation in the manuscript.

Authors' contributions

HKS designed the study, reviewed the case files, conducted the interviews, analysed the interviews, drafted and revised the manuscript, and approved the final manuscript. AL designed the study, analysed the interviews, revised the manuscript, and approved the final manuscript. JR designed the study, analysed the interviews, revised the manuscript, and approved the final manuscript. RW designed the study, analysed the interviews, revised the manuscript, and approved the final manuscript.

Ethics approval and consent to participate

This study was approved by the Regional Committee for Medical and Health Research Ethics Sør-Øst (Case number 2010/1196a). The involved patients gave written informed consent to participate in the study. The involved providers were given information about the study and that participation was voluntary and chose to participate in the interviews.

Competing interests

The authors declare that they have no competing interests.

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How clinicians make decisions about CTOs in ACT: a qualitative study

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Abstract

Background: The first 12 Norwegian assertive community treatment (ACT) teams were piloted from 2009 to 2011. Of the 338 patients included during the teams' first year of operation, 38% were subject to community treatment orders (CTOs). In Norway as in many other Western countries, the use of CTOs is relatively high despite lack of robust evidence for their effectiveness. The purpose of the present study was to explore how responsible clinicians reason and make decisions about the continued use of CTOs, recall to hospital and the discontinuation of CTOs within an ACT setting.

Methods: Semi-structured interviews with eight responsible clinicians combined with patient case files and observations of treatment planning meetings. The data were analysed using a modified grounded theory approach.

Results: The participants emphasized that being part of a multidisciplinary team with shared caseload responsibility that provides intensive services over long periods of time allowed for more nuanced assessments and more flexible treatment solutions on CTOs. The treatment criterion was typically used to justify the need for CTO. There was substantial variation in the responsible clinicians' legal interpretation of dangerousness, and some clinicians applied the dangerousness criterion more than others.

Conclusions: According to the clinicians, many patients subject to CTOs were referred from hospitals and high security facilities, and decisions regarding the continuation of CTOs typically involved multiple and interacting risk factors. While patients' need for treatment was most often applied to justify the need for CTOs, in some cases the use of CTOs was described as a tool to contain dangerousness and prevent harm.

Keywords: Assertive community treatment, Coercion, Community treatment orders, Psychosis, Compulsory medication

Background

In Norway, as in many other Western countries, there has been a substantial reduction in the number of inpatient beds and a move towards community-based services, referred to as a 'deinstitutionalization' of psychiatric care [1, 2]. As part of this process of deinstitutionalization, the primary locus of treatment of severe mental illness (SMI) shifted from hospitals to the community. Different legal mechanisms, such as community treatment orders (CTOs), have been used to compel treatment adherence in more than 75 jurisdictions worldwide [3]. Besides

mandating patients with SMI to adhere to treatment, the CTO regime also allows for a rapid recall to hospital for its enforcement. In Norway, CTOs have been widely used since the implementation of the Mental Health Care Act (MHA) in 1961 [4]. Despite lack of robust evidence of effectiveness [5], Norwegian figures suggest that more than a third of all patients discharged from involuntary admissions in 2014 were placed on CTOs [6]. Although two national action plans to reduce the use of coercion have been launched, the involuntary admission and CTO rates in Norway have remained relatively high (61/100,000) compared to other Western countries since recording of data started in 2007 [7].

Decisions regarding compulsory interventions in general adult psychiatry are made by psychiatrists and authorized clinical psychologists [Responsible Clinicians

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(RCs)]. The legal criteria for involuntary hospitalization and CTOs, which are identical, are based on the presence of severe mental illness (SMI) [8]. CTOs have been referred to as a less restrictive treatment option than involuntary hospitalization, either to improve or restore patients' health or prevent significant deterioration in the very near future ('treatment criterion') [9]. Commitment may also be used if the person is likely to pose an obvious and serious risk to his/her own life or health or that of others ('dangerousness criterion'). Additionally, voluntary treatment must have been attempted (or obviously futile), and unless the 'dangerousness' criterion is met, compulsory mental health care must clearly appear to be the best option for the patient. RCs are required to conduct assessments every 3 months to consider whether the legal criteria are met. Decisions regarding involuntary hospitalization and CTOs do not include medication, and the responsible psychiatrist can initiate a separate medication order. Commitment decisions may be appealed to an independent Supervisory Commission, which conducts documentary controls every third month. If extended commitment after the initial 12 months is requested, the Supervisory Commission makes an independent review.

There is an ongoing discussion as to whether the mandatory element of the CTO produces greater clinical benefits for patients than offering them the same package of services on a voluntary basis [5, 10, 11]. International and Norwegian studies show that the use of CTOs is often justified on the basis of patients' lack of illness insight [12], and that they are mainly used to provide support and treatment following involuntary hospital admissions [12–14]. Studies show that patients have mixed views of coercion in general and CTOs in particular, while psychiatrists and patients' relatives are more positive [15–17]. Stensrud et al. [18] found that RCs in Norwegian services were worried about relapse, and therefore reluctant to make dynamic adjustments, even when patients were stable over time. Another Norwegian study [19] shows great variance in how RCs consider clinical and functional improvement. The duration of CTOs seems to depend on the RCs' attitudes and opinions [13, 14, 19]. Although most clinicians would probably support a shift towards a more person-centred and collaborative decision-making approach, some studies have shown that many clinicians tend to use a more paternalistic type of argumentation in clinical decision-making situations regarding patients with SMI [18, 20, 21].

In a report from 2008, it was estimated that approximately 4000 people with SMI were not receiving appropriate mental health care [22]. In 2009 the Norwegian health authorities decided to fund the piloting of assertive community treatment (ACT) teams to provide services to this target group. The ACT model involves

multidisciplinary teams with shared caseload responsibility and a low client–staff ratio (1:10), that provided flexible and intensive home-based support. Prior to this pilot, Norway had limited specialist ambulant community treatment outreach services.

Although ACT has been criticized for being paternalistic and coercive [23], studies show that patients generally are more satisfied with ACT than standard community mental health services [24, 25]. ACT targets patients with SMI with co-occurring substance abuse and poor social functioning, who are often difficult to engage in more traditional services. Some RCTs show that ACT improves outcomes, including reduced hospitalization, improved housing stability and treatment retention [26].

The research-based evaluation of the 12 first Norwegian ACT teams assessed clinical outcomes from 142 patients at baseline and after 2 years follow-up. Although there was no change in the overall number of admissions, there was a 50% reduction in both involuntary admissions and bed-days [27]. Among the 142 included patients, 32% were subject to CTOs at intake during the teams' first year of operation.

The ACT model has a strong focus on promoting patients' autonomy and recovery [28, 29], and, as we have shown previously, the enactment of CTOs typically involves competing priorities and role tensions [30]. Some studies show that assertive outreach teams reported using less intrusive approaches than other community mental health services [31, 32]. Studies have found wide variation in the use of CTOs [14, 33, 34], and we need more knowledge about responsible clinicians' judgments and CTO follow-up decisions. The aim of this study was to explore how RCs within an ACT setting reason and make decisions about the continued use of CTOs, recall to hospital and the discontinuation of CTOs.

Methods

Design

Because CTO decisions and clinicians' reasoning is an understudied area, we found a qualitative design, using a modified grounded theory approach, informed by a constructivist and interpretative framework to be appropriate [35]. Data consisted of in-depth interviews with RCs, case file reviews and observations of treatment planning meetings.

Setting, sampling and recruitment

This study is part of the national evaluation of the first 12 Norwegian ACT teams [27]. When the present study started, the ACT teams had been established for 30 months, and they had showed moderate to high fidelity to the ACT model [29]. However, the ACT teams'

CTO rates varied, and after 30 months of operation, 6–52% of the patients were subject to CTOs. Participants were recruited purposively from four ACT teams that varied in size, in their use of CTOs and in how the CTO responsibility was organized, to ensure that we could include a wide range of experiences [35]. While the psychiatrists or clinical psychologists of the ACT teams in general were responsible for decisions about continued use of CTOs, recall to hospital and discontinuation of CTO, a few teams had chosen to leave the administrative CTO responsibility to clinicians at the Community Mental Health Centre (CMHC). When we started to recruit participants, 40 of 76 patients enrolled in Team 1 were on a CTO, and two full-time ACT psychiatrists were responsible for CTO decisions. Because one psychiatrist was responsible for most cases, this psychiatrist was interviewed twice. In Team 2, four of 67 patients were on a CTO, and the team psychiatrist and also a psychologist (on leave) were responsible for CTO decisions. In this team, there was a replacement of psychiatrists during the study period, and we decided to interview both psychiatrists. In Team 3, 23 of 68 patients were on a CTO, the ACT psychiatrist followed up patients with a compulsory medication order, while psychologists at the CMCH were responsible for decisions regarding the continued use of CTOs, recall to hospital and the discontinuation of CTOs.

In Team 4, 13 of 38 patients were under a CTO, and here we interviewed two psychologists from the CMHC, and also the team psychiatrist, who had prior experience with CTO decision making from other treatment settings. In a prior study involving patients from the same four teams [16], patients gave written consent to use their case notes in the present study. Team leaders and RCs who had been involved in administrative decision-making for the 15 participants in the patient study were given written information about the study [16]. All except three RCs took part. One was on maternity leave and two had only been involved for short periods in temporary positions, and were therefore not included. The final sample included eight RCs (two CMHC psychologists and six ACT psychiatrists); these were interviewed individually.

Data collection

As a background for the individual interviews, we conducted case reviews of the files of 15 patients. After the patient interviews were conducted in 2013 [16], we followed the patients' files until May 2015. In the individual interviews, participants were all asked to discuss specific CTO decisions, including the continued use of CTOs, recall to hospital and the discontinuation of CTOs. The interviews were based on a thematic interview guide developed by the authors, drawing on an assessment of

relevant literature, previous patient interviews and associated case files [16]. Although the RCs were asked to describe and provide details of the 15 cases, many RCs also described other cases anonymously to provide typical examples of the content of the CTO, their reasoning and the clinical implications. We started all interviews with open questions about the enactment of CTOs and the organization of the follow-up responsibility. We also asked the RCs about the strategies applied to develop supportive relationships with the patients and about their perceptions of the CTO decision-making responsibility within an ACT context. The interviews were conducted at the CMHC and the ACT teams' facilities. The individual interviews lasted 55–110 min. Approximately 1 year after the interviews, the first author (HKS) reviewed the 15 case files, before attending four theoretically sampled treatment planning meetings, one in each team. These were selected to observe team discussions and capture the clinical implications of different CTO decisions and how the CTO responsibility was organized [35]. The observations and the interviews were audio recorded and transcribed verbatim.

Analysis of data

We used an iterative process of data collection to develop a conceptual understanding of the RCs' reasoning and decision making based on categories grounded in the data [35]. In order to identify meaning units in the transcribed text, the two first interviews (from two different teams) were thematically coded. After reflections and thematic codes were written down, we made small adjustments to the interview guide to elicit richer data about the functional split between in- and outpatient care. Subsequently, we used the same approach for the other interviews. After the first initial coding, all the memos and the interviews were read in detail, to compare the most frequently used codes and to develop more focused codes. The most central codes were collapsed into broader categories by connecting sub-categories through the constant comparison of data, codes, categories and memos, to develop the range of properties and their dimensions (focused coding). Thereafter, we conducted an incident-by-incident coding of the treatment planning meetings, to clarify and extend the analytical categories. Subsequently, the categories were integrated and linked together (theoretical coding). Focused coding was performed manually, and subsequently NVivo software [36] was used to improve our overview of the data. The process of using a constant comparative method within and between categories was continued using the software until no new observations or properties emerged. Memos were written throughout the process, in order to increase the abstraction level and enhance the development of categories. The case

files were used as a backdrop during the data collection. Although treatment planning meetings were important to consider, compare and specify team differences and the RCs' reasoning, it is the interviews that are in the forefront in "Results" section.

Results

In our analysis, we identified three main categories that reflected the overall finding 'feeling more confident and secure through shared responsibility': (1) CTO as a tool for achieving patient stability and safety, (2) CTO as a tool for containing dangerousness and preventing harm, and (3) CTO and ACT allowing for more nuanced judgments and reduced coercion. We discuss each in turn.

CTO as a tool for achieving patient stability and safety

The participants described CTOs as a useful tool to ensure that patients remained in treatment. For patients with delusions or who for other reasons were not capable of making treatment decisions, the opportunity for prolonged use of a legal mechanism was seen as helpful.

"I will continue the CTO as long as I possibly can. So, a certain time under a CTO, then one can try [voluntary treatment]. As long as I consider her to be so delusional, I won't remove the CTO. That will be up to the Supervisory Commission to decide."

Many patients had an extensive history of treatment discontinuation and frequent readmissions. The RCs often wanted patients to remain on medication for 1–2 years to become stabilized. Few guidelines for decision-making existed, so participants relied on their clinical judgment of patients' present and past situation to assess the best way to proceed.

"I usually look at the past year and the so-called deterioration criterion. How likely is it that they'll get so much worse that they can't cope if we remove the CTO? We consider whether they understand that they need medication. So it's a matter of going through what's happened this past year, if things have been stable."

Although the team could not compel patients to take medication unless a valid medication order was in place, the RCs described how they tried to persuade, negotiate or make agreements. For instance, one RC described how she had spent several years on trials and errors with medications with a patient including deferring the medication administration to the hospital for a period after several violent incidents in the patient's flat. Eventually, they succeeded in stabilizing the patient, and this was partly attributed to finding a more effective and tolerable

medication regimen, the team's long-term commitment, and a clear division of responsibilities.

"From being in hospital 90% of the year, she's had two short admissions during the last 2 years. There's been great collaboration around her [residential staff, hospital clinicians and ACT], where she's been able to try things out. But it takes time to succeed. She may not have any more insight into her illness, but at least she's more motivated for treatment."

Patients' insight into their illness was presented as interdependent with the quality of the patient-clinician relationship, which in turn informed clinical judgments.

"It seems unnecessary to continue the CTO in her [another patient's] case from my point of view. With her I manage to collaborate about medication, and use of CTOs is then by definition not justified."

The decision to terminate the CTO was also founded on improved functioning and that the patient gradually had regained capacity to make informed treatment decisions.

"She finds ... that she has her own identity, a self, and she seems more capable of sorting out what she perceives as psychotic symptoms. I think she's managed very well."

The CTO decision-making process must balance clinical needs and control of risk. The RCs emphasized that this made decision making complex, particularly when there was clinical uncertainty.

"I'm often afraid that something will happen because I've reduced the medication. (X) is one example. He's previously been sentenced for violence, he takes drugs and threatens all kinds of stuff. In his case, I've agreed to gradually reduce his medications. There's no sign of active psychosis in his case file for the last years. He has strong side effects, refuses to take his medicine, and the police get involved. He is under a compulsory medication order, and it's one hell of a mess. So now we've started to reduce his Cisordinol dose, and my plan is to continue to reduce his medication until we maybe see signs that he's getting worse. This (medication withdrawal) doesn't agree with the expectations of the specialist wards. He's one example"

CTO as a tool for containing dangerousness and preventing harm

For patients with concurrent substance abuse, fluctuating illness severity and a history of violence, the participants agreed that CTOs combined with ACT could be justified

as a long-term safety measure to prevent harm. They described the decision to use a CTO as founded on an overall consideration of the situation and a responsible prediction of future risk, involving deliberate self-harm, aggressive behavior or violence.

"If it's a matter of patients that have been severely ill, and committed serious violence and previously stopped taking their medicine as soon as the CTO was terminated, and they carry on taking [illicit] drugs, then I might keep the CTO for years if voluntary treatment doesn't seem feasible."

There was substantial variation in how the RCs discussed the legal dangerousness criterion. In some cases the RCs described repeated patterns of neglect and risk to self or others. The participants' accounts showed substantial overlap between their interpretation of the treatment criterion and the dangerousness criterion. While some RCs explained that they mainly used the dangerousness criterion when patients had to be readmitted to hospital, a few RCs used the dangerousness criterion to justify a CTO more than others. However, as the following example shows, most agreed that it should only be used when necessary.

"I think it's pretty ok to have him under coercion, because coercion protects society, but we see that it's really difficult to build a therapeutic relationship with him. He's actually a good example of the difficult considerations involved. Without the CTO, he'd just go to pieces. It would be quite reckless not to use a CTO with him."

However, according to some RCs, it was unclear where the legal threshold for obvious and serious danger was.

"The dangerousness criterion is difficult to apply. With (X) it was a borderline case. You often solve it by writing something about it in the documents about the decision. He had a weapon and we considered there was a certain risk he might use it. You're often asked [by the Supervisory Commission] if you want to apply it [the dangerousness criterion], but as I understand it, there's a high threshold for dangerousness, so you often apply other criteria instead."

For clinicians with authority to make decisions about compulsion who were not regular members of the treatment team, the lack of knowledge of the individual patient was a significant problem in the prediction of risk.

"As for assessing the risk of violence, it's incredibly difficult to say how big the risk is that something will happen. That's very hard to predict. (...) It might be

easier if you were in a treatment position, within a team. But I'm sitting in my office, and I'm supposed to make an assessment of a patient I hardly know."

The participants emphasized the importance of the context in which psychiatric evaluations were made. Even if collaboration with the local treatment facilities and psychiatric hospitals had been established, many RCs considered the functional split between in- and outpatient care as a challenge. Concerns were that the responsible ward clinician might initiate treatment that had previously failed or that the ACT psychiatrist was not involved in CTO discussions prior to discharge. As one ACT psychiatrist said: *"We can make suggestions, but since they're legally responsible [while patients are admitted], they make all the decisions"*. A further concern was that many patients with concurrent substance abuse were prematurely discharged from the ward by the responsible inpatient clinician. In one such case with a man in his early twenties, who was often not at home and difficult to reach, the RC strove to balance care and control.

"I made a transfer because I didn't want to have sole responsibility as long as he has a serious mental illness and makes these choices [substance abuse/crime]. When he was an inpatient, they didn't find anything, so he was discharged on the same principles. He is not at home, has no phone and we run after him, knock on his window, and then we're responsible for him. I think that's difficult. I don't like being responsible for someone I can't get hold of at all."

One team psychiatrist explained that patients with co-occurring substance use disorders were referred to a separate dual diagnosis team, and that she often managed to arrange need-based long-term hospital admissions. Other RCs described a different scenario; lack of beds and inter-agency collaboration for the most severely ill patients was seen as a major challenge.

"Our whole group, or our main group, which has suicidality, violence and substance abuse, has no sub-acute services. We don't often get acute admissions for more than 2 or 3 days."

Some RCs referred to a small subgroup of patients who had frequent encounters with the police, who were regularly transported to the acute ward, where the lack of psychiatric beds and inter-agency collaboration and increased professional liability put the clinicians' professional responsibility on test. As one RC noted: *"You're expected to keep the situation under control, which implies that you maybe ought to have people on CTOs. For me, that's difficult"*.

Use of CTOs and ACT allows for more nuanced judgments and reduced coercion

The RCs underlined that the team approach and the focus of the ACT model on assertive engagement strategies and comprehensive service provision allowed for more nuanced judgments and increased flexibility when working with patients with chaotic lives.

“As a team we have better opportunities to adequately address the patients’ needs and provide close follow-up. I also find that we have more material to help us decide whether or not a patient should be on a CTO, and also that it’s easier to terminate the CTO. (...) Because many of us know the patients, our discussions become more composed, and more nuanced.”

Frequent patient contact and the opportunities for this contact to remain over considerable time were presented as important in reducing coercion. Feeling more confident and secure through shared responsibility was a typical way of summing this up:

“In my view, the most important things to reduce coercion are close contact, continuous follow-up care and to have good relationships”.

“We feel more confident about terminating a CTO in an ACT team.”

However, conflicting attitudes and disagreements in the team, often involving medications, were challenges the team had to manoeuvre. One psychiatrist who had been in ACT since the team was established described a steep learning curve. Critical team reflections and debriefings were considered as important learning arenas.

“People joined the team with strong objections to overmedication. I was really frustrated, and also discouraged and afraid. (...) When people have been around and got some experience of the sickest patients, that kind of ideological attitude disappears. When it comes to individual patients, I’d say we do that [discuss medication]. We have lively discussions about medication, we look critically at the dose, and think about when we should start and how long we should wait.”

While daily team meetings provided an overview of each patient’s condition, in teams where the team psychiatrist or psychologist was responsible for CTO follow-up decisions, the team was also more actively involved in CTO discussions. As one RC said:

“We try to have a discussion. We look at the medical history and sum up about the patient, and then we

ask everyone if they have an opinion for or against. We assess it together.”

Close follow-up care and frequent observations were used to devise a colour scheme on the teams’ blackboard with details of all the patients; different colors indicated each patient’s current situation, legal status and treatment needs. According to participants, the ACT approach afforded flexibility to provide more intensive treatment to patients in periods of extra need, including illness severity and stressful life events. It also allowed for discussions of priorities, such as whether two instead of one ACT provider should conduct home visits.

“How frequently we go and see patients depends on whether they’re in a green, yellow or red phase [on the blackboard]. If they’re actively psychotic and need close monitoring, they’re red”.

To give an example of the team’s discussion of priorities and tailored interventions, the RC described a newly enrolled patient who several ACT providers had visited regularly in a high-security ward. During the first weeks following discharge, the team had daily conversations with both the patient and the residential staff, and this was gradually reduced to 2 days a week. The team psychiatrist had recently been involved to consider further safety measures, and decided to bring the patient back to the high-security facility after serious threats against residential staff. After a few days the patient had called the team to ask for support and assistance at discharge. In this case the RC considered the team’s close follow-up and monitoring as an alternative to long-term inpatient care.

“We referred him back to the security ward on Friday and picked him up on Monday. Now he could be discharged with close follow-up care by the team. Coercion is still being used, but at a lower level than if we hadn’t been there for him.”

Discussion

This study illuminates the RCs’ reasoning surrounding the use of CTOs within an ACT setting, including decisions about their continued use, their termination, and recall to hospital, at a time when ACT represented a relatively new approach. The participants emphasized that CTO decisions involved tensions and challenging professional judgments. Although the use of CTOs was mainly founded on patients’ clinical needs, CTOs were also presented as a tool to contain dangerousness. The participants stressed that being part of a multidisciplinary team with shared caseload, frequent patient contact

and comprehensive service provision allowed for more nuanced judgments and increased flexibility.

CTOs were typically described as a useful tool to ensure that patients remain in treatment, mainly to help patients achieve stability and remain safe, which the participants said often takes a long time. Patients' symptom severity, lack of illness insight, co-occurring substance abuse, frequent readmissions and a history of deliberate self-harm or violence, and the likely consequences of patients' decisions were presented as decisive factors in CTO decisions.

Norwegian and international studies show that CTOs are often founded on patients' lack of insight, to prevent psychotic relapse [12], which often has a disruptive effect on people's quality of life and their capacity for independence. A Norwegian study showed that CTO practices vary [19] and that some RCs only met patients at yearly reviews, knew little about the content of local care services and the impact of CTOs on patients' everyday lives. Some studies suggest that clinicians' narrow understanding of 'lack of insight' and that a one-sided focus on compliance with medication may impede patients' recovery process [18, 37, 38]. Our data show that the ACT providers perceived that the multidisciplinary nature of their work allowed for frequent patient contact, coordinated support, relationship building and more flexible treatment options. As a specific component of clinical care, the ACT model's focus on everyday activities and improving patients' lives was seen as pivotal to improve patients' well-being and to gradually help patients work toward greater independence and self-sufficiency [30]. Further, the ACT team's long-term treatment perspective and the ways in which the teams often managed to gradually involve patients in treatment decisions and joint crisis planning were considered as important in reducing the use of coercion [39].

ACT targets patients with co-occurring substance abuse and low social functioning who have not remained in care. While some studies describe the implementation of CTOs as a complement to involuntary inpatient care [19, 40, 41], the participants in our study presented the use of CTOs combined with ACT as the least restrictive solution. The Norwegian ACT evaluation did not show a reduction in the number of admissions, but there was a significant reduction in compulsory admissions and total inpatient days. Patients with co-occurring substance abuse had significantly fewer involuntary inpatient days, despite severe problematic substance use at 2 years follow-up [42]. Although the ACT model has been criticized for being paternalistic and coercive, studies show that patients are generally more engaged and satisfied with ACT than traditional community-based services [25]. The

Norwegian ACT evaluation also revealed a high user satisfaction; patients subject to CTOs were more satisfied with ACT than voluntarily enrolled patients [43], and they also reported the highest degree of recovery [44].

The participants emphasized that many patients that were referred to them from hospital wards and high-security facilities were already subject to CTOs and that the CTO decision-making in the ACT team typically involved multiple interacting and complex risk factors. Similar to what is reported in other studies, our participants emphasized that a multidisciplinary team approach and close monitoring provided more comprehensive understanding of risk [45]. In addition, the team's position enabled the early detection of warning signs, quick responses and the stepping up of the intensity of interventions during crises all of which allowed for more focused preventative efforts.

The use of CTOs was sometimes presented as a long-term safety measure to prevent harm that could result from patients' symptom severity, co-occurring substance abuse, frequent readmissions and a history of victimization, deliberate self-harm or violence. However, there was substantial variation in interpretation of the dangerousness criterion, and the two RCs that were not part of the treatment team expressed more doubts about the accurate prediction of risk. This "risk as difficult to predict" finding has been reported in other studies. Feiring and Ugstad [20] found that many RCs were reluctant to assess whether a patient was at risk of harming others or societal consequences of untreated mental disorders. Assessing patients' potential dangerousness is also challenging for GPs [9]. In Norway, the MHA has been founded on a strong treatment philosophy [46], and clinicians may find it less stigmatizing to refer to patients' treatment needs than to dangerousness.

Our study participants emphasized the importance of the context in which psychiatric assessments were made. While ACT allowed for comprehensive assessments, reflective team discussions and multiple interventions, the functional split between inpatient and outpatient care was seen as a challenge. Although the ACT teams were mainly involved in admissions and discharge, disagreements between the ACT psychiatrist and the responsible ward clinician and uncoordinated changes to treatment plans were typical concerns. An ongoing debate in other European countries concerns which of the organizational models in mental health care, i.e. continuity of care or a functional split of responsibility between inpatient and outpatient care, is most effective [47–49]. Lindgren et al. [50] found that continuity across treatment settings was associated with better long-term outcomes. Despite lack of solid evidence of whether specialization or continuity

of care is more effective (length of stay) [48], studies show that patients and clinicians prefer continuity across inpatient and outpatient settings [48, 49, 51, 52].

Many RCs described lack of inter-agency collaboration regarding a small subgroup of patients with co-occurring substance abuse with higher risk of victimization and violence during acute phases of illness as a main concern. Bed pressure and lack of treatment resources was seen to place clinicians in a position where they have to balance discretionary standards for civil commitment and ambiguous benchmarks for what constitute good practice and acceptable risks. Based on a recent amendment in the Mental Health Care Act, from September 2017, involuntary admissions and CTOs can only be used if the person lacks decision-making capacity, unless the person is deemed to constitute a risk to his/her own life or the safety of others. The amendment also involves a narrowing of the dangerousness criterion, which no longer includes the risk of harm to the person's own health. Although capacity is a cornerstone in autonomous decision making, it is well known that psychiatric patients' capacity to make informed decisions can fluctuate [53]. Many RCs in our study stated that they often applied the treatment criterion to justify the need for CTOs. The RCs will now be required to use a more structured approach to consider patients' capacity to make treatment decisions, as of yet we have no knowledge of whether the recent amendment influences RCs' decisions within an ACT setting.

Limitations

The strengths of this study is that it draws on a rich dataset, and that we know that participants work in ACT teams with moderate to high fidelity to the model. One limitation is the small number of participants. Although the aim of qualitative studies is not to generalize the results, we cannot exclude the possibility that other RCs would have provided a more nuanced and deeper understanding of the RCs' reasoning and CTO decision making. Since a majority of the participants were psychiatrists, the inclusion of other participants may have enabled a focus on possible variations between professionals in attitudes and decision-making practices. It would have been interesting to complement this research with experiences of CTO decision making in an ACT setting from the perspectives of family members and hospital clinicians.

Conclusions

The RCs found that many of the patients enrolled in ACT are hard to reach and difficult to treat. The ACT model's holistic and long-term treatment perspective was described as a more attuned way of working with

patients with complex needs than traditional outpatient services. The participants emphasized that CTOs were mainly founded on patients' clinical needs, and also that establishing stability and safety for patients enrolled in ACT is often a lengthy process. The main finding, 'feeling more confident and secure through shared responsibility' illustrates that the focus of the ACT model on frequent patient contact, shared case-load and comprehensive service provision was considered as a major improvement on traditional community services in that it could facilitate more nuanced assessments and reduce coercion. However, in some cases the RCs described CTOs combined with ACT as a long-term safety measure to prevent harm. Many RCs described a small subgroup of patients with co-occurring substance abuse who had frequent encounters with the police, where bed pressure and lack of inter-agency collaboration was presented as a main challenge.

Abbreviations

ACT: assertive community treatment; CMHC: Community Mental Health Centre; CTO: community treatment order; MHA: Mental Health Care Act; RC: responsible clinician; SC: Supervisory Commission; SMI: serious mental illness.

Authors' contributions

HKS, RW and AL conceptualized the specific research questions and analytical approach for this manuscript. HKS conducted all the interviews and observed treatment planning meetings. The initial coding and analyses were conducted by HKS and discussed with RW, JR and AL. HKS wrote the first draft of the manuscript; all authors edited and revised the manuscript. All authors read and approved the final manuscript.

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Competing interests

The authors declare that they have no competing interests.

Availability of data and materials

In order to protect the anonymity of the participants, the data on which this manuscript is based, have not been made generally available, other than the parts of the raw data that have been reflected in the quotations.

Ethics approval and consent to participate

The Regional Committee for Medical and Health Research Ethics approved the study (Case number 2010/1196a). Before consenting to participate, the team leaders were given written information about the study. The RCs and team members were informed about the study and told that their participation was voluntary before they chose to participate in the treatment planning meetings and the interviews. In connection with the prior study of patients [44], we obtained permission to use case files and to discuss their case with the ACT providers and the RCs. The study data were stored in unidentifiable form and kept confidential.

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