SHOULDERING THE ROLE OF KEY HEALTH PROFESSIONAL FOR INDIVIDUALS DETAINED ON A COMMUNITY TREATMENT ORDER IN MALTA: MENTAL HEALTH NURSES' EXPERIENCE

By

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ABSTRACT

Background: Community Treatment Orders (CTOs) were introduced locally when the Mental Health Act was revised in 2012 and are being increasingly used in practice. Nurses are usually the appointed Key Health Professionals (KHPs) for individuals detained on CTOs. Although nurses are important stakeholders within this scheme no actual exploration of how they are coping with challenges incurred from the responsibilities of the role of KHP for individuals on a CTO has been done.

Aim: This study aimed to explore the meaning that Mental Health nurses (MHNs) attribute to the experience of caring for individuals detained on a CTO. The objectives of this study were to explore the views of MHNs on CTO's framework, identify the challenges faced by MHNs whilst caring for individuals on CTO, explore how these challenges influenced care provision, explore how they coped with emerging challenges, and identify ways to support them in their role as KHPs.

Design & Method: A qualitative approach was utilised following the Interpretative Phenomenological Analysis (IPA) principles. A purposive sample of seven Mental Health Nurses acting as KPHs for individuals on a CTO were recruited. Semi-structured interviews were conducted and transcribed verbatim. Data was analysed using IPA methodology.

Results: Three superordinate themes emerged namely: "Paving through Responsibilities", "Targeting the Challenges", and "Attempts at Maintaining Balance".

The first super-ordinate theme "Paving through Responsibilities" produced two sub-themes, "Juggling between Care and Control" and "Therapeutic Relationship is Key". The participants imparted how they regarded the CTO as a measure to support, protect and ensure treatment compliance for patients with severe mental illness. However, participants described that combining care with coercion led to ethical dilemmas, especially when enforcing treatment. To cope with these difficulties and safeguard the therapeutic relationship, participants tried to direct any conflicts regarding treatment to the administrator of the CTO. They also empathized with and guided patients to focus on their recovery process. Furthermore, unease about possible litigation and blame was evident and to safeguard themselves, the participants tended to focus more on their legal responsibilities than their caring role.

The second super-ordinate theme “Targeting the Challenges” produced three sub-themes mainly “Involvement in Care Decisions”, “Resources” and “Validation and Understanding”. The participants shared their views on how the existing clinical practices are affecting care provision, the service users, and themselves as KHPs. The difficulties experienced by MHNs resulted from the complexity of their role, patient-related aspects, procedural issues, and system insufficiencies, which left the participants feeling unsupported and burdened with all the caring and legal responsibilities. Moreover, findings hinted that care planning within the local care context is focused on risk and is gripped by a blaming culture leading the participants to experience persistent emotional distress and exposing them to higher burnout risks.

The final superordinate theme “Attempts at Maintaining Balance” produced two sub-ordinate themes, “Support Systems” and “Hear Us Out”. Effective dynamics and cultures within the team and reflective practice were regarded as major support structures and helped participants to cope with difficulties. Moreover, participants regarded relatives as partners in care and viewed their contribution as essential for both themselves as KHPs and for patients’ recovery process.

Conclusion: MHNs described that caring for patients within CTO’s framework is indeed a complex and challenging endeavour. Participants described how the coercive aspect and legal obligations challenged their caring role and the therapeutic relationship. Furthermore, the study’s results showed that work approaches and systems’ culture could influence the provision of care and professionals’ psychological well-being. Recommendations from these findings point to a need for change in the present modus operandi and the availability of more support for MHNs to deal with challenges within the CTO framework, which will ultimately result in improved patient care outcomes.

Keywords: Community Treatment Order, Mental Health Nurses, Key Health Professional, Lived Experiences, Patients, and Service users.

DEDICATION

To

My mother Maria Dolores

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The completion of this dissertation would not have been possible without the encouragement and assistance of various people. First of all, my deepest appreciation goes to all the participants of this study. The completion of this work was only possible through their valuable contribution.

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LIST OF ABBREVIATIONS

ACT	Assertive Community Treatment Team
CMHC	Community Mental Health Clinic
CMHT	Community Mental Health Team
CN	Charge Nurse
CO	Conveyance Order
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CTO	Community Treatment Order
FREC	Faculty Research Ethics Committee
IPA	Interpretative Phenomenological Analysis
ITO	Involuntary Treatment Order
KHP	Key Health Professional
MCH	Mount Carmel Hospital
MHA	Mental Health Act
MHN	Mental Health Nurse
MHRT	Mental Health Review Tribunal
OC	Outpatients Commitment Orders
OT	Occupational Therapist
PAP	Participatory Action Research
PCNF	Person-Centred Nursing Framework
PICO	Population, Intervention, Comparison, and Outcome
PIO	Population, Intervention, and Outcome
PN	Psychiatric Nurse
PRISMA	Preferred Reporting Items for Systematic Review and Meta-Analysis
RMO	Registered Medical Officer
SW	Social Worker
UoM	University of Malta
UREC	University Research Ethics Committee

CHAPTER 1. INTRODUCTION

1.1 Background of the study

An advancement in mental health illness management and treatment resulted in the widespread deinstitutionalization of mental health services and enabled individuals with severe mental health problems to live in the community (Snow & Austin, 2009). This shift in care focus presided over the amendments to Mental Health Laws in many countries and led to the introduction of Community Treatment Orders (CTOs) (Rugkasa, 2016). CTOs also called "mandated out-patient treatment, out-patient commitment assisted out-patient treatment, and supervised community treatment" were established in North America and Australasia in the 1980s and are presently being used in various countries (Rugkasa & Dawson, 2013). CTOs are legal procedures and are either approved by a court or initiated by a responsible specialist, depending on the laws of each country. CTOs aim to enhance treatment compliance and prevent relapse and readmissions to hospitals for individuals who suffer from severe mental illness and who are prone to disengage from health services.

Individuals placed on a CTO are coerced to abide by psychiatric treatment in a community setting which is a less restrictive option when compared to hospital compulsory care (Rugkasa, 2016). However, outcomes from nonrandomized studies show conflicting results on the benefits gained through CTOs. Certain studies report some benefits whilst others report none. Randomized studies produce similar findings, with the exception that CTOs may reduce the possibility of individuals becoming victims of crime (Rugkasa, 2016). Findings from a systematic review of qualitative studies on the perceptions of persons on a CTO showed that although patients preferred CTOs to hospitalisation, they still considered the CTOs compulsory in nature (Nakhost et al., 2019).

Moreover, research shows that clinicians face various challenges during the different stages of the CTO process. The use of CTO remains arguable, and opposition often stems from the fact that to gain some improvement in patient's quality of life, one must sacrifice the patient's civil liberties (Nagra et al., 2016). Research indicates that ethical dilemmas often stem from the CTO framework's coercive aspect that challenges clinicians' therapeutic relationship and caring role (Francombe et al., 2018; Stensrud et al., 2016;

Lawn et al., 2015; Lessard-Deschenes & Goulet, 2001). Moreover, resource constraints and aspects within the care environment may influence clinical decisions and could lead to the excessive use of CTOs (Light et al., 2017; Nagra et al., 2016). Alternatively, research shows that clinicians consider team discussions and reflection as positive aspects since these practices enable them to cope with the elaborate and complicated CTO framework (Stuen et al., 2018).

To the knowledge of the researcher, this is the first study to be conducted locally on MHNs' experience whilst caring for individuals on a CTO. The present study aims to identify the challenges faced by MHNs and the impact that these challenges may have on the provision of care. Hence, this may assist mental health professionals, stakeholders, and policymakers to formulate and/or change care approaches to target difficult aspects for the benefit of service users and service providers alike.

An overview of the CTO framework and its implementation in the local scene is presented in the next section.

1.2 The Local Scenario

Before the review of the local Mental Health Act (MHA) in 2012, persons with severe mental health problems had no choice but to be admitted to the state-owned psychiatric hospital whenever they experienced a regress in their mental health.

The new act introduced involuntary treatment in community settings therefore care could be provided at a community level limiting admission to the hospital as a last resort.

CTOs are intended for individuals who quickly disengage from health services, which could result in a relapse of mental health conditions leading to repeated hospitalizations. A responsible specialist completes the CTO application through the Seventh Schedule of the MHA and is approved by the Commissioner for Mental Health. CTOs are granted for a period of six months and after reviewing the patient, the responsible specialist decides whether to renew or revoke the CTO (Office of Mental Health Commissioner, 2013).

The CTO framework provides various safeguarding measures to protect patients' and others' safety and ensure patient cooperation and treatment compliance. A responsible carer and a key healthcare professional (KHP) are appointed, and a care plan is compiled as stipulated by the MHA. If the patient does not have or refuses to have a responsible carer or the responsible carer refuses to give consent, a mental welfare officer can endorse the application for the CTO.

The KHP is responsible for managing and ensuring that the patient is following that care plan and for providing feedback to the patient's responsible specialist. If the patient fails to fulfil his obligations, the KHP will assist both the patient and the responsible carer and will continue to encourage the patient to follow the care plan or make the necessary arrangements to have the treatment plan reviewed. However, if the patient continues to refuse assistance, putting himself and others at risk the responsible specialist may decide to issue a conveyance order. Application for a conveyance order is done through the Ninth Schedule of the MHA. The police are involved and would accompany the patient to be reviewed by the responsible specialist. An admission to the hospital may ensue unless the patient agrees to follow the treatment plan.

If the patient remains in the hospital for less than ten days the CTO remains valid otherwise the CTO becomes invalid and an application for an involuntary admission treatment order is made (Office of Mental Health Commissioner, 2013).

Former and new patients may be detained on a CTO before discharge from the hospital to ensure treatment compliance and care provision. Thereafter, MHNs, nurses, or social workers from one of the six Community Mental Health Teams (CMHTs) or the three Outreach Mental Health Teams are appointed to act as KHPs for these patients. Presently, all appointed KHPs are MHNs or nurses except for one who is a social worker.

1.3 Overview of the Literature Review

In chapter two the author will present a critique of the studies reporting on the views and experiences of clinicians caring for patients on a CTO. The researcher identified seven qualitative studies. However, the experience of MHNs was not the main objective of the reviewed studies. The extensive literature tended to explore the experiences of patients, relatives, and other care providers alongside the experience of nurses. All studies included nurses in their participant groups however only two studies included MHNs. Therefore, only clinicians' experience was considered for this study's literature review.

The researcher hopes to contribute to the lacuna of international and local research, as there seems to be a gap in the literature since few studies explored the views and experiences of MHNs caring for individuals on a CTO.

1.4 Significance of the Study

The decision to carry out a qualitative study emerged from the design's properties as these enable the researcher to gain in-depth information and explore the research question set for this study: 'What are the lived experiences of MHNs caring for individuals detained on a CTO?'

The significance of this research area originates from the author's own experience as a Charge Nurse (CN) in one of the local CMHCs. Locally, more patients are placed on CTOs and nurses must fulfil the responsibilities incurred by the increase in demand. The researcher noted that nurses frequently voiced concerns about various challenges whilst caring for these patients. Furthermore, as demonstrated in the extant literature and from personal beliefs, the compulsory powers passed to nurses through the CTO framework could jeopardize the therapeutic relationship and give rise to ethical dilemmas. Thus, the author wanted to identify the challenges faced by MHNs, how they coped with these difficulties, and explore what could be done to support them in their role as KHPs for individuals on a CTO.

1.5 The Dissertation Structure

To assist the readers to gain a better understanding of the presented study a description of its layout and contents will follow. In the first chapter, the researcher introduces the study and explains the rationale for the topic's choice. A critical discussion of retrieved literature is presented in chapter two. Chapter three comprehensively describes the research method utilised in this study. Chapter four hosts the data analysis and the researcher's interpretations. Chapter five incorporates a critical analysis of the study's findings, alongside extant literature considering McCormack and McCance's Person-Centred Nursing Framework, (PCNF) (2016). Chapter Six brings the study to its' conclusion and provides recommendations for education, clinical practice, policy developments, and future research.

The process to retrieve research and a critique of the existing literature is presented in the next chapter.

CHAPTER 2. LITERATURE REVIEW

2.1 Introduction

This chapter outlines the framework and the search strategies that were used to identify and retrieve research focusing on the experience of MHNs caring for individuals detained on a CTO. Moreover, the inclusion and exclusion criteria utilised to guide the search process will be presented in more detail.

This will be followed by a critique of the existing literature that explores the different views and challenges experienced by clinicians whilst caring for individuals on a CTO. The researcher identified a dearth of evidence since very few studies explored the experience of MHNs. To target this limitation the present study will focus on the experiences of a fairly homogenous sample of MHNs who are appointed as KHPs for individuals on a CTO.

Furthermore, since the revision of the local MHA in 2012, the use of CTOs is noted to be increasing. However, no local studies have been conducted to explore the experience of MHNs when they are appointed as KHPs for individuals on a CTO. Therefore, this study aims to explore the views and challenges local MHNs face and understand how they can be supported in their role as KHPs.

2.2 The Search Process

Polit and Beck (2018) posit that an in-depth strategy needs to be conducted to locate relevant studies on the topic of interest. The search process will be discussed in more detail in the following section.

2.2.1 Generating Keywords

Polit and Beck (2018) advise researchers to utilise the acronyms PIO or PICO to formulate good questions when searching for relevant literature. In the PIO form, the researcher uses keywords that cover three components, “P: population”, “I: intervention” and “O: outcome” to formulate a good question. If the researcher is interested in qualitative information, the question is constructed from two components, the population, and the situation (Polit & Beck, 2018). Hence, the formulated question of this literature review reads; What is the lived experience of MHNs (the population) when they are caring for individuals on a CTO (the situation)?

Relevo (2012) posits that a word's different terminology must be employed to conduct a thorough literature search. Table 2.1 displays the keywords, synonyms, and alternate terms used to retrieve relevant studies.

Table 2.1 Key concepts, synonyms, and alternate terms

Key components of the question	**Key concepts**	**Synonyms and alternate terms**
Population	Mental Health nurses caring for individuals on a CTO	Mental Health nurses; psychiatric nurses; nurses; practitioners; clinicians; service providers
Situation (Central phenomenon)	The experience of Mental Health nurses caring for individuals on a CTO	Experience; views; community treatment order; outpatients commitment orders; compulsory psychiatric community treatment

The search process for relevant articles compatible with research exploring the lived experience of MHNs caring for individuals on a CTO was guided by inclusion and exclusion criteria presented in the next section.

2.2.2 Inclusion and Exclusion Criteria

Inclusion and exclusion criteria define the search protocol and guide the search for relevant articles to answer the research question (Polit & Beck, 2014). Table 2.2 outlines the inclusion and exclusion criteria employed for this literature review.

Table 2.2 Inclusion and exclusion criteria utilised for retrieving relevant literature

Inclusion criteria	Exclusion criteria
• Studies including the experience of Mental Health nurses/ nurses caring for patients on a CTO. • Studies published in the last 10 years (2012-2022). • Peer-reviewed articles. • Studies published in the English Language. • Not restricted to any geographical region.	• Studies not including the experience of Mental Health nurses/ nurses caring for patients on a CTO. • Studies published in a language other than English. • Non-peer-reviewed studies. • Studies published earlier than 10 years ago.

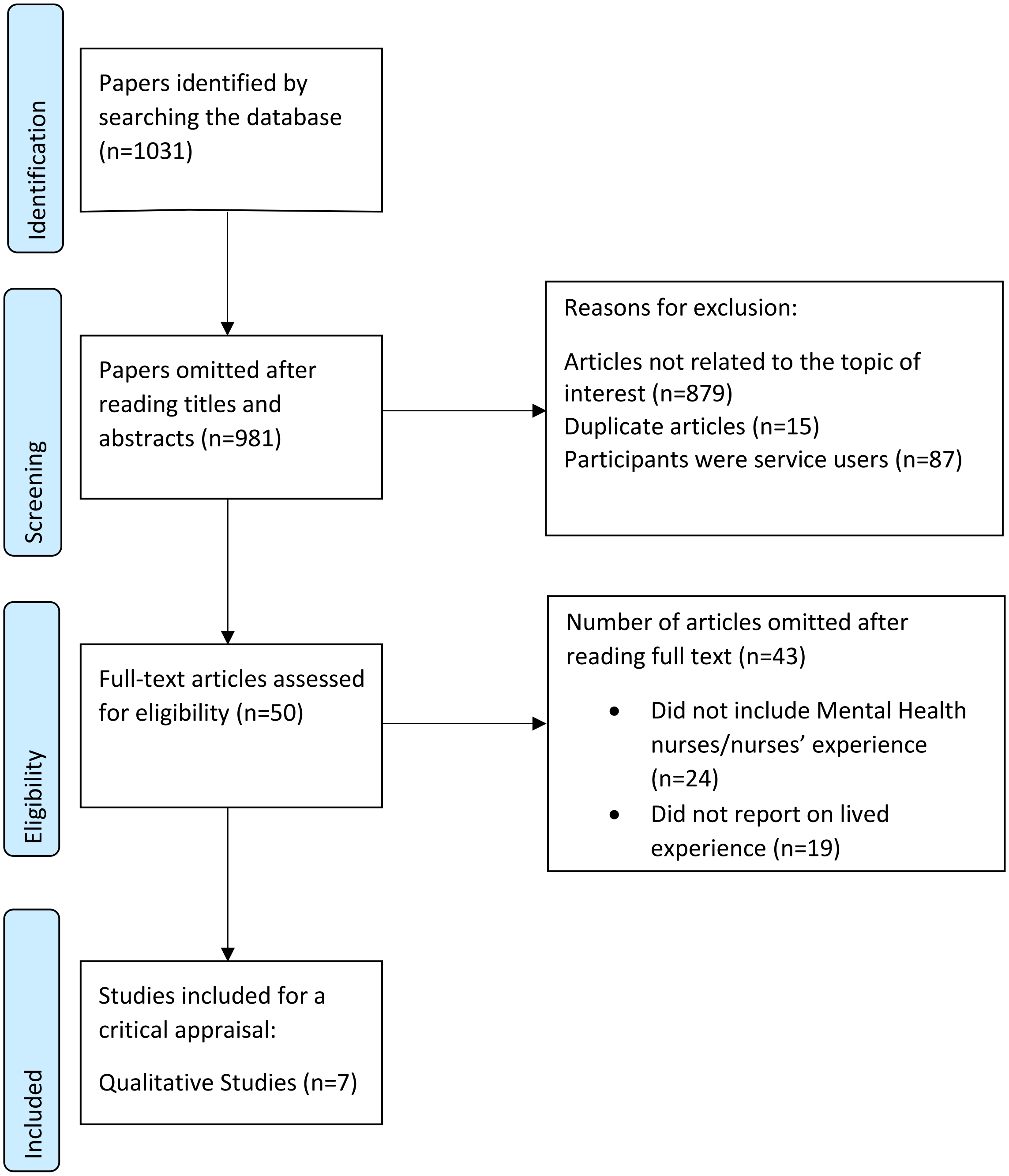
2.2.3 Search Strategy

An extensive literature search was conducted through the HyDi platform, an online database offered by the University of Malta's library services. Several databases were searched including CINHAL, EBSCO, Psych INFO, PubMed, ProQuest, Embase (Elsevier), and Web of Science. To amplify and guide the search process truncations, such as an asterisk (*), Boolean operators such as "OR" and "AND", different keywords, and their synonyms were used (Table 2.1). The search was limited to published literature within ten years (studies dated from 2012-2022), peer-reviewed articles, and studies written in English (Table 2.2). The search process was conducted from January 2021 to June 2022.

The flow diagram in Figure 2.1 presents information about the screening process that was adopted to identify pertinent articles for this literature review based on the PRISMA guidelines by Moher et al. (2009).

Using the keywords identified in Table 2.1 yielded 1,031 hits. Initially, these 1,031 studies were selected by title, and then the abstract of the most relevant studies was reviewed. Duplicate studies, studies that were not significant to the topic of interest, and studies focusing on service users were removed. After this part of the screening process, fifty (n=50) relevant papers were left. To determine the eligibility of these papers the full texts were read. This was followed by the further omission of papers. Forty-three (n=43) papers were excluded since MHNs, or nurses were not included in their participant groups or did not report on the lived experience of nurses.

Fig 2.1 Flow diagram with information about the screening process based on Moher et al. (2009) guidelines.



This search process identified seven qualitative studies which are represented in Table 2.3. The studies were conducted in Norway (2), Canada (2), and Australia (3). Finally, the researcher meticulously re-read these papers to critically discuss these studies.

Table 2.3 Characteristics of identified studies

Author/s Year Country	**Aim**	**Methodology**	**Sample**	**Setting**	**Main Findings**
Lessard-Deschenes & Goulet, (2021) Canada	To describe the therapeutic relationship in the context of involuntary treatment orders as viewed by nurses and patients	Secondary data analysis using content analysis	A subsample using two from the five groups of the primary study. Subsample consisted of 6 patients and 9 nurses.	3 institutes of mental health and forensic psychiatry.	The therapeutic relationship is influenced by a power imbalance brought about by the legal aspect of involuntary treatment and the healthcare contexts
Dawson et al. (2021) Australia	To explore how individuals on CTO, their relatives, and clinicians view concepts of risk and how its management influences the planning of care	Ethnographic methods, using observation and interviews	8 patients, 6 carers, and 16 clinicians. 6 of the clinicians were nurses.	2 community mental health teams	Care planning informed by risk impedes recovery
Light (2017) Australia	To examine stakeholder views on how aspects of the healthcare systems influence the use of CTOs.	Qualitative method using semi-structured interviews	5 patients, 6 carers, 12 members of the mental health review tribunal, and 15 clinicians. 8 of the clinicians were nurses.	Community mental health services	CTO use is highly influenced by deficiencies in health services
Francombe et al., (2018) Canada	To explore the experiences of service users and service providers with CTO	A qualitative study based on semi-structured interview	9 clients, 6 family members, and 12 service providers. 5 of the service providers were nurses	Community mental health team	The coercive aspect of the CTO may delay the recovery process
Stuen et al., (2018) Norway	To explore the experiences of service providers with CTOs within an assertive community team setting	A qualitative study based on a review of case files, in-depth interviews, and focus groups	15 case files, 8 service providers were interviewed and 20 participated in 4 focus groups. 8 of the service providers were psychiatric nurses	Community mental health team	CTO was found to challenge providers' decision-making, however, was seen as beneficial to secure care for patients who will be reluctant to access care
Stensrud et al., (2016) Norway	To examine health professionals' experience whilst caring for patients on a CTO	Qualitative study using a descriptive and explanatory approach	21 clinicians participated in 3 focus groups. 9 of the clinicians were mental health nurses and 2 nurses	Health specialist services and community health services	Healthcare professionals found difficulty in balancing control with care The emphasis on care was more on the need for treatment rather than on patients' autonomy

Lawn et al. (2015) Australia	To explore how patients on CTOs and professionals caring for patients experience CTO	A study that reports from data collected for a qualitative broader study	8 patients and 10 professionals. 3 of the professionals were nurses	Community mental health setting	Empathy and reflection are essential when caring for patients on CTO

Although the focus of this literature review was on Mental Health Nurses (MHNs), the identified literature mainly explored the experiences of service users (patients and their carers) alongside the experience of multiple clinicians (psychiatrists, occupational therapists, social workers, psychologists, nurses, and MHNs), highlighting a gap in research. For this review, the following critique is based on clinicians' experiences rather than solely MHNs due to the lack of studies available.

2.4 A Critique of Studies on the Views and Experiences of Clinicians Caring for individuals detained on a CTO

Initially, the study's critique will focus on studies exploring the influence of systems' culture and procedures on the provision of care within CTO's frameworks. Subsequently, studies exploring ethical dilemmas experienced by clinicians and the effects on the therapeutic relationship from the CTOs' coercive aspect will be discussed. Finally, the importance of empathy and reflection to overcome conflicts between care and control will be addressed.

CTOs refer to an array of legal provisions that require individuals with severe mental health problems and poor adherence to treatment to abide by a care plan and to be supervised regularly whilst living in the community. Failure to abide by the treatment plan could result in these patients being admitted involuntarily to a hospital facility (Francombe et al., 2018). According to Corring et al. (2018), the use of CTOs has brought about considerable controversy. Those in favor of CTOs present these schemes as the least restrictive measure compared to involuntary hospitalizations and believe that CTOs can lead to better treatment outcomes and recovery journeys (Geller, 2012). Conversely, opponents claim that CTOs impinge on human rights due to their coercive nature thus infringing on self-determination and the recovery process (Snow & Austin, 2009).

2.4.1 The System's Influence on CTOs

Dawson (2021) posits that CTOs are legislated in many countries worldwide. There are various frameworks of CTOs, and these are used in community settings to protect individuals who suffer from mental illness from the risk of harming themselves or others. Pilgrim (2018) posits that providing recovery-oriented care can be very challenging when services and public concerns with risk are significant. Risk assessments are performed for all individuals involved with mental health services but for patients on a CTO, the aspect of risk is more significant (Coffey et al., 2017). Health professionals make decisions and provide care within service contexts. Therefore, the constraints and culture within the system can influence care provision (Rugkasa & Burns, 2017).

2.4.1.1 System Insufficiencies

Light et al. (2017) conducted a qualitative study in New South Wales, Australia, and examined the views of stakeholders on how the procedures of mental health systems influenced the use of CTOs to improve CTO processes. The study was conducted, with four groups of participants. An invitation was disseminated through a range of networks and participants were recruited through a purposive sampling method, which was then complemented with new participants through snowballing. The sample consisted of participants (n=38), patients (n=5) with a previous or current experience with CTOs and their relatives (n=6), mental health professionals (n=15), and members of the Mental Health Review Tribunal (MHRT) (n=12). The mental health professionals' sample worked in various mental health settings and included psychiatrists (n=3), social workers (SWs) (n=2), psychologists (n=1), occupational therapists (OTs) (n=1), and nurses (n=8).

A limitation of this study was that the researchers failed to give further details on the financial compensation ($40) which was given to the patients and caregivers during the interviews. Saleh et al. (2020) claim that various ethical issues may arise from compensating individuals to participate in research. However, if there were any major concerns about ethical principles this research study would not have been approved by the university and ethics committees. Furthermore, the researchers tried to maintain a distinction between patients' voluntary participation in the study and their involuntary treatment position. Thus, to protect patients from harm and discomfort no patients were recruited or interviewed from clinical settings.

Data was collected using semi-structured interviews which were audio-recorded and then transcribed and coded. NVIVO 9 was used to manage the data. Data was analysed through grounded theory methods. A strength of this study was that biased decisions and personal interpretations were reduced as the analysis of data was performed through investigator triangulation hence the validity of this study was enhanced.

The "system" prevailed in most of the participants' accounts. The participants referred to the "system" as the background in which mental health services were offered. Participants mentioned the "system" when they wanted to refer to either a particular establishment or context, as well as the different mental health care professionals and individuals in positions of management and persons responsible for the operation of the system. To identify themes specific to this aspect further data analysis was performed by the main author. Two themes emerged and included, CTOs are utilised to increase care availability and CTOs are not the solution for insufficient services.

Clinicians described that due to a lack of adequate services within the "system," they had to use CTOs to guarantee care for some patients. One clinician said, "I think in an ideal world, we would have enough staff to manage all the people that are out there in the community effectively, but we don't. So, it's a way of prioritizing" (Light et al., 2017, p. 353). Some clinicians were in favor of this strategy as they thought of it as an effective way to engage both the patient and the system. Other clinicians tended to recognize that such strategies secured care provision; however, they were preoccupied with the fact that to respond to "system" insufficiencies they had to resort to forced treatment laws. This was accentuated in one clinician's response, "… to get the person some care in a system that's rationalizing its resources, prioritizing people on involuntary treatment over people on voluntary treatment, is one of the most non-sensible things I've seen" (Light et al., 2017, p.354). Participants claimed that if resources within the "system" were inadequate the provision of care in the community remains limited even though patients would be on a CTO. Therefore, professionals were left with no other options but to use more restraining options such as hospitalization.

Light et al. (2017) established that since CTOs occur within a system, their effectiveness is influenced by that system. If the system is disorganized, the process will negatively or worsen CTO schemes. Therefore, the researchers advised the development of monitoring procedures to secure reliable and consistent data on CTOs. Moreover, the researchers recommended that laws and system policies that support CTOs' procedures are reevaluated to target the current needs and circumstances of the patients.

2.4.1.2 Work cultures focused on Risk

Dawson et al. (2021) used an ethnographic qualitative design for their study and examined how the perception of risk and risk management affects the planning of care within the context of CTOs. One of the researchers provided information about the study to the two multidisciplinary teams in South Australia.

Data was collected through more than 40 hours of observation of care planning discussions and 37 interviews with patients (n=8), relatives (n=6), and clinicians (n=16) between June 2017 and December 2018 (18 months). Holloway and Todres (2010) posit that ethnographies usually involve widespread "fieldwork" with prolonged engagement until familiarity is developed between the researcher and the study's participants. Therefore, the length of time spent in observation is inconsistent with ethnographic methods, possibly affecting the credibility of the study.

The group of clinicians was made up of nurses (n=6), SWs (n=3), and medical staff (n=7). The experience of the clinicians within mental health care ranged between 15-30 years and the registered medical officer (RMO) (n=1), had 3-6 months of experience.

Data was collected using Carspecken's five-stage research process (Dawson et al., 2021). Vandenberg and Hall (2011) posit that Carspecken's critical ethnography approach involves merging a critical position with a qualitative approach to understand power relations. However, Vandenberg and Hall (2011) argue that this approach fails to address how researchers can adequately reduce researcher biases and authority when they are learning about power influences. To minimize this power difference, the researcher focused on the researcher's role instead of her occupational therapist's role. Another strength of this study is that patients and staff members known by the researcher were not included in the study and a re-consent was sought throughout the observation and interview process thus ensuring the participants' right to self-determination. Furthermore, ethics approval was obtained from the local health services and the University's Committees of Human Ethics.

Multiple observations of care planning discussions among the participants were conducted during stage one, of the study. The care planning sessions included urgent and routine clinical reviews in the absence of service users and reviews where patients and relatives would be present. During this stage, the researcher could observe most clinicians at their workplace and observe interactions between different professionals.

Stage two involved initial data analysis to recognize cultural themes. During the third stage, two focus groups were conducted with clinicians at their workplaces, and two meetings were conducted with the service users. The focus groups and meetings aimed to clarify the cultural themes identified through the initial stage of the research process.

The initial cultural themes, the feedback from the meetings, and the research question guided the development of the interview schedule. The interviews with each participant group covered aspects related to "insight, risk, decision-making, engagement, and trauma" (Dawson et al., 2021, p.1251). The "trauma and stress" theme was explored further in the clinicians' focus group.

Eight patients who agreed to be followed for a year were recruited at this stage. During this period, data was collected from observations of clinical reviews and through interviews with the recruited patients and their caring team. Relatives participated if the patient consented. Data was analyzed again, which subsequently informed the final stages of data analysis. To establish the roots of the cultural themes, inpatient settings, tribunal hearings, and reviews of significant policies were included. Finally, the findings were positioned within applicable theories to better understand how the system's culture can influence care planning. The trustworthiness of the study was enhanced since various reflexive methods were used throughout the study.

Results demonstrated that risk was a key component that informed care planning. Clinicians defined risk through the medical model and were mostly focused on lack of insight, harm to self and others, and functional and mental regress. Insight was used as an assessment tool that informed care decisions however, there were no attempts to reflect what insight might entail. The "preoccupation with insight" (Dawson et al., 2021, p.1250) continued through broad dialogues that focused on illness and risk. Furthermore, the patients were not present when clinicians discussed the aspects of insight and risk.

If there was a history of risk, this remained with the patients indefinitely and when decisions were taken, the possible risk was deemed as important as present risk factors. Patients were labeled as "risky" or "without insight" which encouraged a focus on limitations. The focus on deficits contributed to clinicians' beliefs that change could happen, and they focused on task-oriented care to ensure compliance. This intensified power differences and situated clinicians as experts whilst the patients agreed to clinicians' decisions.

Implied responsibility and blame culture led to a lack of trust, which influenced relationships both at individual and system levels and encouraged a paternalistic approach to care. Patients had the responsibility to comply with treatment and engage with services. Relatives ensured patients abided by the treatment and clinicians were responsible for regular assessments, managing risk, and attending to patients' everyday needs. This study highlighted the detrimental effects of work cultures rooted in risk, on care planning, especially for patients on a CTO. However, these results should be interpreted with caution, as this study did not include MHNs. Furthermore, it did not provide data solely from a nursing perspective.

Different perceptions of risk within contexts where recovery approaches were supposed to be given prominence, led to various conflicts. Participants (decision makers) from the Stensrud et al. (2016) study declared that they felt pressured by other healthcare professionals to extend the use of coercion within the OC framework to force patients to engage in activities and perhaps to stop their maladaptive behaviors.

In Lawn et al. (2015) study, participants described similar concerns. Professionals felt pressured to conform to the practices adopted within the system, which influenced their decisions as professionals. A professional said, "…that is sort of, almost an institutional response" and "mental health clinicians get habituated to depriving people of their liberty…we are convinced that we are doing the right thing" (Lawn et al., 2015, p.10). The effects of negative service culture were also evident in professional interactions with their colleagues. One professional declared, "The offer of clinical supervision is seen as having a punitive agenda. It's seen as implying criticism and judgment and fault finding" (Lawn et al., 2015, p.10).

2.4.2 The therapeutic relationship within the CTO Framework

Peplau (1997) describes the nurse-patient therapeutic relationship as the foundation of mental health nursing and is crucial in the treatment of mental health illnesses. Interpersonal relations between the nurse and the patient are based on mutual respect and trust, partnership, and empowerment. However, trust within the therapeutic relationship can be tarnished due to the coercive aspect of CTOs (Lessard-Deschenes & Goulet, 2021).

The qualitative study by Lessard-Deschenes and Goulet (2021) examined the secondary data derived from a bigger study, which explored the views on involuntary treatment (ITOs) of several stakeholders including service users, health professionals, psychiatrists, and attorneys. ITOs referred to different forms of involuntary treatment including involuntary hospitalizations and CTOs (Lessard-Deschenes & Goulet, 2021).

Participants (n=35) for the primary study were recruited through a convenience sampling method from three mental health and forensic settings in the region of Quebec in Canada. Data for the primary study was collected through semi-structured interviews. The interviews lasted 20 to 65 minutes and were conducted by the primary researcher, an assistant, and a service user. Ethical approval was granted for both studies and all the participants from the bigger study gave their consent for the re-utilization of data for future studies.

For their data analysis, Lessard-Deschenes and Goulet (2021) utilised a subsample from the primary study's sample. The subsample consisted of patients (n=6) on ITO or who have been on an ITO and nurses (n=9) who had experience working with such patients. The data derived from patients and nurses was analyzed to gain a deeper understanding of the therapeutic relationship in ITO contexts. Concepts of the "Recovery Alliance Theory" assisted the researchers to identify important aspects of the nurse-patient therapeutic relationships and to assign the initial codes from the data (Lessard-Deschenes & Goulet, 2021).

The researchers then compared the data from both participants' groups. Eventually, four themes and eight sub-themes emerged including, the influence of external aspects on the therapeutic relationship, challenges to the nursing role, and the complex relationship between the therapeutic relationship and ITOs. The credibility of the study was enhanced through data triangulation as data was collected from patients and nurses. Moreover, to ensure dependability and confirmability the processes of data collection and analysis were described in detail.

A limitation of this study results from the fact that the primary study aimed to explore the broader concept of ITO therefore data on the therapeutic relationship was limited. Nonetheless, the excerpts presented in the findings allowed for a better understanding of how nurse-patient therapeutic relationships are influenced by ITOs.

The results showed that nurses believed that a gradual approach is required to develop trust with patients on ITOs and work demands such as a lack of time, prioritizing risk management, and patients considering nurses as authority figures can delay the process.

Nonetheless, the participants described the therapeutic relationship as the most effective tool to operate within ITO frameworks. Some nurses described ITOs as opportunities to form relationships and provide treatment to patients who would otherwise be reluctant to comply and accept treatment due to a lack of insight.

Stuen et al. (2018) conducted a qualitative study to explore service providers' experience with CTOs within assertive community treatment teams (ACTs). This study formed part of a national assessment that was carried out with the first twelve (ACT) teams in Norway. Approval for this study was obtained from the Regional Committee for Medical and Health Research Ethics.

Data was collected from the review of fifteen patients' files, eight in-depth interviews, and four focus groups with different members from four (ACT) teams. The interviews were conducted with a sample of responsible clinicians (RCs) (n=8), psychiatrists (n=6), and clinical psychologists (n=2). The focus groups were conducted with other professionals from the (ACT) teams (n=20). Psychiatric nurses (n=8) participated in the four focus groups.

Individual interviews lasted 55-110 minutes and the focus groups 120-130 minutes. A richer collection of data was possible due to the length of time allocated for data collection which was assisted by the presence of a co-moderator during the focus groups. A modified grounded theory approach was used to analyze the data. Initially, the coding of data was carried out manually then NVIVO software was used. To improve the process of the development of categories memo writing was utilised. Comparative analysis was used until no new aspects emerged. The researchers used rigorous strategies during the data collection, coding, and analysis process thus enhancing the validity and credibility of this study. However, generalizability could have been affected due to the small number of teams. Another limitation was that the study's results focused on psychiatrists' experiences. Furthermore, when describing the experiences of other participants, the researchers failed to specify their role within the (ACT) team.

The participants of this study described that since patients were on a CTO, interventions were more frequent. Through this close contact, clinicians became more familiar with the patients. Thus, they felt more secure when they had to make risky decisions, especially when revoking CTOs.

Participants described that moving away from their professional roles enabled the process of engagement. To build trust and rapport, the participants viewed spending quality time with patients in different social settings as important, particularly during the initial engagement process. The participants continued to explain that the same approaches and skills were used to engage with patients on CTOs and those not on a CTO.

Of relevance is that to reduce tensions within the therapeutic relationship, professionals used certain strategies to ascertain a difference in role responsibilities when engaging with patients on CTOs. Participants explained that initial contact was undertaken by staff members other than those involved in the administration of treatment. Moreover, whilst patients were in the hospital, only one team member established contact. Participants used phrases such as “good cop, bad cop” and “hated the least” (Stuen et al., 2018, p.6). This aspect is highlighted in the findings by Francombe et al. (2018). Some case managers especially nurses tried to dissociate themselves from the CTO and preferred to take the passive role of “crewmen for the doctor” (Francombe et al., 2018, p.126). Nurses, who were responsible for medication administration and assisting the patient on a CTO, favored having a nurse to administer medication and another nurse who would manage the patient. The participants in the Stensrud et al. (2016) study applied the same strategy to minimize the negative effects of coercion on the therapeutic relationship.

The therapeutic relationship was challenged by medication resistance behaviors (Francombe et al., 2017; Stuen et al., 2018) and participants had to face both ethical and practical difficulties. Recommendations to overcome such difficulties included interventions based on interactions focused on achieving patients’ life goals instead of treatment adherence. Moreover, to improve rapport with patients on CTOs the researchers advised regular contact and comprehensive support, especially in times of crisis. To increase awareness about the effects of compulsion on the therapeutic relationship and ameliorate care for patients on a CTO, the researchers recommended further research focused on patients' and service providers' views on therapeutic relationships.

The importance of forming trusting relationships with patients on CTOs is pervasive in literature. However, views on the effects of CTOs on the therapeutic relationship vary. Some professionals believe that no ill effects result from CTOs, while others think that the controlling aspect of CTO's framework challenges the therapeutic relationship and their caring role.

2.4.3 A fine line between Care and Control

The conflicts faced by clinicians with meeting their clinical duties to provide treatment and support to reluctant patients whilst respecting their autonomy emerged from the study of Stuen et al. (2018). The ACT providers in this study believed that CTOs provided support, structure, and an opportunity for patients who would otherwise refuse to engage with services and therefore could get some stability in their lives. However, it was evident that although CTOs were regarded as a "safety net" and were used with some patients to reduce or stop treatment for a limited period, clinicians were still concerned with substance abuse behavior, history of violence, risk of stopping treatment, and early discharges from the hospital. Thus, clinicians found themselves in a difficult position in having to choose between respecting patients' wishes to refuse treatment or enforcing treatment so that patients stayed well. Phrases like "we face a lot of resistance to medication, there is a lot of coercion involved", "I sometimes feel uneasy because I don't think this always helps", and "…it's a difficult balancing act" (Stuen et al., 2018, p.5) were used. The ethical dilemma of balancing possible treatment benefits by exerting control was also evident in the study of Francombe et al. (2018). This aspect left case managers questioning the values of their profession. Nonetheless, they justified the use of CTOs claiming that they had the obligation to assist patients and accented that, “it’s a matter of explaining to yourself, this is part of my job, this person is on a CTO and this person will get unwell if they don’t receive treatment…” (Francombe et al., 2018, p.126). Some of the nurses in the study of Lessard-Deschenes and Goulet (2021) faced the same dilemmas and linked the use of coercion to the role of an “executioner” since it contradicted the values of care within the nursing profession, whilst other nurses viewed coercion as “necessary evil” (Lessard-Deschenes & Goulet, 2021, p.291).

Francombe et al. (2018) conducted a qualitative study to explore the different stakeholders’ views on the CTOs. This qualitative study was conducted using Participatory Action Research (PAR) principles thus enhancing knowledge and allowing for the collaboration between the different participants to bring about essential change. Members of an interdisciplinary research team and a Research Advisory Committee consisting of psychiatrists, social workers, peer support specialists, service users, and a researcher with experience in qualitative studies oversaw the design and the research process. The study was conducted in Toronto Canada, and the Research Ethics Board at St. Michael’s Hospital in Toronto approved it.

Participants were recruited from three CMHTs that offered services in the inner city. Services offered included, “Assertive Community Treatment, Intensive Case Management, and Early Intervention for Psychosis” (Francombe et al., 2018, p.123). The inclusion criteria for eligibility included service users or service providers from one of the three mental health teams who have been involved in a CTO for the past three years. A qualitative researcher recruited service providers whilst staff members from the three teams contacted service users. This could have led to sampling bias as service users who had a good therapeutic relationship with their service providers would have been more enthusiastic to participate in the study. Whilst the uncooperative service users would have been reluctant to participate resulting in over-amplification or a decreased representation of the population under study (Polit & Beck, 2018). Furthermore, the diverse number of participants from different teams and the relatively small sample could have influenced the generalizability of this study’s findings.

The purposive sample was made up of patients (n=9), family members (n=6), and service providers (n=12). The sample of the service providers consisted of nurses (n=5), OTs (n=4), psychiatrists (n=2), and SW (n=1). Twenty-seven interviews were conducted between February and July 2013, each lasting between half an hour and two hours. The qualitative researcher conducted the interviews and used NVIVO 9.2 software (QSR International) to code both field notes and transcripts until no newfangled codes or categories emerged. To ensure the study's credibility and trustworthiness, ongoing debriefing sessions were conducted until the research team members reached a consensus on the final themes and categories. Another strength of this study is that the themes were generated from the information of the three participants' groups collectively, rather than separately. Therefore, through the triangulation of information credibility and relevance were enhanced. Nonetheless, a limitation of this study is that it did not focus on the unique experience of MHNs, which further confirms that such a gap in the literature needs to be addressed.

Data produced five main themes and one sub-theme for each main theme. The five main themes included, CTOs are favored over hospital admissions, there are limited opportunities in the setting up of treatment plans, and there are different views on how CTOs influence the recovery process, the possible changes in therapeutic relationships, and self-determination within CTOs.

Whilst acknowledging CTOs' coercive aspects, some service providers preferred that patients were under a CTO rather than being admitted involuntarily to the hospital as they viewed CTOs as the least restrictive option. This was captured in what one provider said, "worthwhile tradeoff of a certain level of coercion (…) if they weren't on the CTO, they would be involved in the hospital, which is a more coercive environment" (Francombe et al., 2018, p.125). Service providers believed that CTOs enabled patients to manage their life better and increase their independence since they took more control of their mental health issues. Conversely, some clinicians voiced their concerns about the fact that some patients viewed the CTO as a form of stigma, making it difficult for patients to engage with services "…he is so preoccupied with being unhappy with the CTO when he's on it. I don’t know in terms of his level of happiness or quality of life if (CTO) has improved for him. And (it) certainly has not improved in terms of engagement with our services” (Francombe et al., 2018, p.126).

Patton (2002) posits that qualitative researchers are more interested in generating knowledge that might be valuable in other circumstances, rather than generalizability. Hence, to address this limitation the researchers recommend repeating this study using a bigger sample and including topics, which were not addressed in this study. Additionally, the researchers suggest a mixed methods study that can heighten understanding of the complex and multifaceted framework of CTOs. Principles of justice and recovery informed the recommendations for a better-quality practice where the focus would be on the strengths rather than the deficits of individuals and where service users are active participants in care (Francombe et al., 2018).

The qualitative study by Stensrud et al. (2016) aimed to describe and examine health professionals’ experiences with patients detained on Outpatient Commitment Orders (OC). This study formed part of a bigger study that examined patients’ and families’ perspectives of OC. This study was conducted in two counties in the east of Norway. Approval to conduct this study was gained from the regional Data Protection Officer. The mental health services included two hospitals, five psychiatric centres, and forty-eight health services (Stensrud et al., 2016).

Health professionals with at least one year of experience and responsible for the decisions and follow-up care of patients on an OC were recruited from one hospital, four district psychiatric centres, and four local health services. Creswell (2009) posits that qualitative research aims to discover the meaning and explore different experiences through the collection of rich information. Therefore, one could question the appropriateness of the sample since the inclusion criteria included participants with limited experience. The sample was divided into three focus groups. Health professionals (care providers) responsible only for the treatment and care of patients were allocated to focus group one. Professionals (decision makers) who were responsible for taking legal decisions on OC were allocated to focus group two. Focus group three was composed of those participants who were not present for the two initial interviews. By dividing the participants into two groups the researchers could explore the participants' experiences at the root of their different roles and responsibilities. Furthermore, the third group encouraged discussion and cooperation between care providers (n=14) and decision-makers (n=8). The sample of care providers consisted of mental health nurses (n=9), nurses (n=2), and nurse assistants (n=3).

The researchers and a staff member with experience with patients on an OC designed the interview schedule. The latter acted as a co-moderator during the interviews. The interviews within the focus groups lasted for an average of two hours. The interviews were conducted by the first author (moderator) and the co-moderator contributed by noting down field notes and encouraging participants to give detailed accounts of their experience. The moderator used a thorough process to analyze the data. The discussion between the moderator and co-moderator in the development of subcategories, categories, and main themes was ongoing. The research group validated the analysis and interpretation of data. NVIVO 10 software was utilised to help with the process of data analysis. These were compared to the original interviews to ensure that all the emergent themes were authentic. The rigorous process that was used by the researchers to collect and analyze data enhanced the trustworthiness of the study.

The first author was previously an employee of one of the hospitals and thus offered an insider view during the interviews. However, this aspect could have hindered academic distance and increased the possibility of personal bias, which arguably could have affected the validity of the study. Moreover, due to the indirect power from the researcher's previous position, the participants could have felt uncomfortable sharing their views in front of the researcher which possibly led to an insufficient collection of data. Moreover, the researchers failed to explain if reflexivity was adopted during the process of data collection and analysis. Nonetheless, it was noted that the study's interviews produced in-depth descriptions of experiences thus contributing to the authenticity of the study.

Three themes were identified which focused on the responsibility and difficult decisions within the OC framework, and the effects of OC on therapeutic relationships. Participants based their decisions of care on the perspective of their social responsibility. Participants felt that OC exerted minimal intrusion on patients' self-determination and saw it as a long-term solution to safeguard patients' health. Although participants recognized that patients might feel that the OC limited their autonomy, they still justified the use of OC and based their decisions on the patients' lack of insight and the notion that if patients were uncompliant to medication their mental health will regress. It was very difficult for them to terminate the OC since they were concerned that the patient might experience a relapse.

A mental health nurse said, "It means that they need a framework where they cannot opt out of treatment" (Stensrud et al., 2016, p.750). What was interesting is that care providers (mental health nurses, nurses, and nurse assistants) who acted as links between the decision-makers and the patients, directed any conflicts regarding treatment to decision-makers, as they preferred to focus on patients' everyday needs. A mental health nurse said, "We try to get the patient to accept OC as a measure, and then put it aside…we instead discuss with the patient …what might be useful" (Stensrud et al., 2016, p.751). All participants justified the need for OC when there was a risk of danger to the patient or others. However, participants found it more difficult to make decisions where the need for OC was based on treatment needs. Participants viewed the legal responsibility of CTOs as problematic since it exerted pressure on their clinical decisions. Phrases like "…having this responsibility affect my stomach a bit sometimes" and "What if you get a partial effect or a small effect from the coercion?" were expressed (Stensrud et al., 2016, p.751).

The impact on care planning of patients on CTOs from an overt focus on medication compliance and lack of insight are complementary to the results of previous studies (Francombe et al., 2018; Lessard-Deschenes & Goulet, 2021; Stuen et al., 2018). Stensrud et al. (2016) pointed out that if professionals continued to focus on these aspects a paternalistic approach to care might be adopted resulting in a detrimental effect on the rapport between patients and health professionals. Therefore, to improve treatment adherence and minimize control, the researchers advocated for focusing on patients' lack of autonomy rather than on lack of insight.

2.4.3.1 Empathy within the CTO Framework

The need for empathy and reflection to overcome conflicts between care and control was evident in Lawn et al. (2015) study. The researchers explored the perspective of patients and professionals from the meanings of the moral framings that emerged from data from a bigger qualitative study in South Australia.

The bigger study aimed to understand the views of patients and mental health professionals on aspects that facilitated or impeded patients from being active participants in care whilst being on a CTO. Ethical approval was obtained from the Health Human Research Ethics Committee.

The researchers were struck by the "moral language" used by the participants in the bigger study (Lawn et al., 2015). Thus, they decided to examine the language present in the data. Gray et al. (2012) claim that in healthcare settings "moral action" involves three domains: the agent, the action, and the patient. In this study, the researchers posited that the "moral agent" was the health care professional, "the action" was the exertion of the legal and clinical procedures of the CTO, and the "moral patient" was the patient on a CTO.

Participants were recruited from a multidisciplinary case management team and included patients (n=8) and professionals (n=10), including psychiatrists (n=2), nurses (n=3), OTs (n=3), and SWs (n=2). The credibility of this study was enhanced since the recruited participants had been employed for five years or more to ensure that they had experience in the field. However, since professional participants were recruited from one mental health setting, the results of this study cannot be generalized. Furthermore, the views of nurses may have been underrepresented since only three nurses were recruited for this study. The participants from the professionals' group were recruited via a universal email sent to the service's clinical lead.

The lead researcher, a Mental Health Consumer Advocate with ample experience in mental health, conducted the interviews. The lead researcher knew three patient participants and six professional participants since she used to work in one of the services. Although the researcher was acquainted with the participants (3 patients), she was never involved directly in their care. Furthermore, once the researcher left her previous employment, she had no connection with any of the participants of this study. Nonetheless, the indirect power from her previous employment could have led the participants to feel obligated to participate in the study.

To obtain an independent view the lead researcher was accompanied by another researcher during two interviews conducted with professionals. Patton (2002) argues that "researcher credibility" is accomplished if the report of the study contains information about the researchers' qualification and their relationship with the individuals, subjects, or communities under study. Therefore, the trustworthiness of this study was enhanced since ample information about the researcher's background was provided. Furthermore, all participants could review the transcribed interviews and provide feedback whilst reflexivity was maintained throughout the whole process.

Initially, four interview transcripts were assigned randomly to the researchers who worked separately to assign codes. When the initial coding process was finished the researchers agreed on the framework to code the rest of the interviews. NVIVO 10 software was used to assist with the coding process. The final themes were determined through an ongoing process of discussion between the researchers. The rigorous process by which data was analyzed enhanced the credibility of this study.

The CTO was viewed by the participants as positive, negative, or justifiable (Lawn et al., 2015). Four themes emerged from the exploration of the participants' moral language, including the clear use of moral language, acting for patients' benefit, the patient having to conform, and attempts to be empathic (Lawn et al., 2015).

Professionals used clear moral language to evaluate and justify their interactions with patients on a CTO. Participants felt pressured by the enforcing responsibilities placed on them by the CTO framework. Although it was evident that the professionals were concerned about the coercive aspects of CTOs. They came up with many reasons to justify the use of coercion. Phrases like "It's good for them" and "I like to think about it as more of a safety net" (Lawn et al., 2015, p.9) were used. Nonetheless, the language used by other participants highlighted the dilemmas and conflicts they faced whilst caring for patients on a CTO. This is reflected in the language used by a professional, "When does a person get a chance to prove that they can do this on their own? That stuff upsets me because I see it as total removal of your rights" (Lawn et al., 2015, p.9). Some participants tried to empathize with the patients to minimize coercion's effects. However, they struggled to balance care with the controlling aspects of their role. A professional claimed, "I would love to see everyone getting better and being able to self-manage if they can, but not everyone will be able to…I have a connection with them like I can see they struggle with the concept, so it is, it's really difficult…" (Lawn et al., 2015, p.12). Alternatively, some professionals choose to use persuasion or threats. This was evident in an interaction between a professional and a patient, "And I guess that's the question isn't it, what have we learned from this? You've been on three CTOs now, what are we learning from this [laughing]" (Lawn et al., 2015, p.11). Moreover, participants described that it was hard for them to engage in empathic relationships due to the system's culture. However, findings suggested that healthcare professionals were willing to engage in reflective practices to deal with these dilemmas if they were given the opportunity.

The researchers encouraged professionals to use empathy and to reflect on their perceptions and principles of mental illness. The researchers proposed ongoing training on empathy so that professionals can focus more on recovery principles rather than managing risk when caring for patients on CTOs.

Furthermore, Dawson et al. (2021) suggested that service user-rating tools could be used to get feedback from service users. The outcome measures can be utilised during critical reflective sessions to gain a broader understanding of the difficulties faced by service users. The benefits of reflective practice within teams were underlined in Stuen et al. (2018) study. Participants claimed that they experienced a gradual change in their practice through consistent critical team reflections and guidance from peer specialists. One participant claimed, “Since I started in ACT 5 years ago there has been a change in our mindset. Reflection broadened our focus, to see that medication is not the only effective ‘medicine’ in a person’s life. We focus more on …all the factors that bring safety to a person’s life” (Stuen et al., 2018, p.6).

2.5 Conclusion

Through this literature review, the researcher identified that clinicians believed that the therapeutic relationship is the most effective tool to operate within the CTO’s framework. However, the coercive aspect of the CTO challenged both the therapeutic relationship and their caring role, leading to conflicting views on the use of CTOs. Indeed, there is a fine line between caring and controlling within the CTO’s framework. Dilemmas often arose from the attempts to balance treatment benefits with compulsion. Clinicians had to face further challenges resulting from the influence of ineffective procedures within the care environment. Alternatively, clinicians considered team discussions and reflective practice as positive aspects to deal effectively with the multifaceted and complex CTOs framework. These overarching aspects were presented in three major categories in this literature review. Seven studies were critically discussed. Six studies reported on the combined experiences of service users and service providers. Three of the studies reported on the combined experience of patients and clinicians, two reported on the combined experience of patients, relatives, and clinicians, and one study focused on the combined experience of patients, relatives, clinicians, and MHRT members. The remaining study reported on clinicians’ experience. All studies included nurses in their clinicians’ participant groups however only two of the studies included MHNs. Hence, the researcher identified a gap in the literature, as there seems to be a limited number of studies that explored the experience of MHNs. Therefore, the present study will target this limitation by focusing on the experience of MHNs appointed as KHPs for individuals detained on a CTO.

CHAPTER 3. METHODOLOGY

3.1 Introduction

A comprehensive description of how the study was conducted and an explanation of the planning stages of this study will be presented in this chapter. The research question focused on the participant’s experiences and the meaning they give to their lived experience.

Smith et al. (2022) proposed some changes in the terminology for Interpretative Phenomenological Analysis (IPA). However, since this study was in the advanced stages the researcher decided to adhere to the old terminology and analysis in line with Smith et al. (2022) suggestions. Therefore, to address the research question the researcher used the old IPA terminology and analysis of Smith et al. (2009).

Furthermore, the aims and objectives of the study, the operational definitions, data collection, pilot work, data analysis, ethical considerations, quality assessment, and reflexivity will be presented and discussed.

3.2 Aim and Objectives of the Study

The research question of this study was, ‘What is the experience of MHNs who are appointed as KHPs whilst providing care to individuals who are sectioned under the Seventh Schedule of the MHA (2012), known as CTO’. This qualitative study aimed to explore the meaning that MHNs attribute to the experience of caring for individuals on a CTO. To answer the research, question the following objectives were identified:

- To explore the views of MHNs on CTO’s framework.
- To identify the challenges faced by MHNs whilst caring for individuals on CTO.
- To explore how these challenges influence the provision of care.
- To explore how MHNs, deal with emerging challenges.
- To identify ways to support MHNs in their role as appointed KHPs.

3.3 Operational Definitions

In this study, the term ‘Experience’ refers to the MHNs’ views and understandings of their experience when caring for individuals on a CTO.

The term ‘Community treatment Order’ refers to a concept of involuntary treatment in the community that was established with the reform of the Mental Health Act in 2012 (Office of Mental Health Commissioner, 2013).

The term ‘Patients’ refers to individuals with a mental health condition being cared for under a CTO.

The term ‘Key Health Professional’ refers to an appointed health care professional as stipulated by the MHA of 2012. KHPs assist the patient and responsible carers and coordinate patients’ care in the community (Office of Mental Health Commissioner, 2013).

3.4 Research Designs

Quantitative, qualitative, and mixed-method research approaches can be used to explore the topic of interest in nursing research studies. Creswell (2013) claims that the research approach depends on the researcher and the study objectives.

In quantitative research studies, researchers collect empirical evidence on the phenomena they are interested in, through scientific methods, thus following the positivist paradigm (Polit & Beck, 2018).

In qualitative research studies, researchers follow constructivist positions, and the focus is on understanding subjective and complex aspects of human life (Polit & Beck, 2018).

Mixed methods research integrates both quantitative and qualitative approaches and is used to address a complicated research question (Creswell, 2009).

The research question of this study focuses on eliciting the views and exploring the experiences of MHNs caring for individuals on a CTO, thus a qualitative method is preferred to address the aims and objectives of this study.

3.4.1 Research Paradigm

According to Polit and Beck (2018) by following paradigms, researchers seek to find the truth when exploring the phenomena under study. Researchers collect and examine gathered evidence through their senses, and they rely on the input of human beings.

3.4.2 Interpretive Framework

Philosophical assumptions are related to the interpretive framework (Creswell, 2013). Ontology, epistemology, axiology, and methodology vary according to the framework used by the researcher. In 'Social constructivism', individuals express their views and the meaning they impart to their lived experience. Their views and meanings can be numerous, and different and are influenced by situations and the meaning each imparts to that particular situation (Creswell, 2013).

3.4.3 Qualitative Research Designs

Although there are different types of qualitative designs, ethnography, grounded theory, phenomenology, and IPA are the prominent approaches used in nursing research (Polit & Beck, 2018).

Ethnography was developed in the 20th century by anthropologists such as Boas and Mead. Sociologists such as Dewey and Park continued to modify anthropological methods to study group cultures. This type of design is used by the researcher who is interested in exploring how a group of individuals live and interact with each other (Creswell, 2013).

Grounded theory was developed in 1967 by sociologists Strauss and Glaser. The grounded theory aims to create, change and widen current theories through the collection of different types of data. This approach is suitable to achieve information and gain new insights about certain situations (Holloway & Todres, 2010).

Phenomenology consists of descriptive phenomenology and interpretive phenomenology.

Descriptive phenomenology was created by Husserl and was further developed by Amedeo Giorgi in 1970 (Polit & Beck, 2018). The aspect of ‘bracketing’ in this approach, is what distinguishes descriptive phenomenology from interpretive phenomenology.

Heidegger developed interpretive phenomenology (IPA). The focus of this approach is on the detailed analysis of lived experiences, and the interpretation and meaning individuals impart to them (Smith,2011).

Various research designs could have been used to approach the research question. IPA was selected from other phenomenological approaches because it focuses on the explanation and meaning individuals give to their lived experiences rather than only describing their experiences (Langdridge, 2007). Since this study aims to explore lived experience, MHNs could convey the meaning they attribute to the experience of caring for individuals on a CTO.

The researcher was aware that eliminating her perceptions and preconceptions related to nurses’ experience whilst caring for individuals on CTO would have been difficult since she works in a community psychiatric setting and holds the CN position. She is responsible for a group of nurses who at times are appointed as KHPs for individuals on a CTO. In the past, she acted as a KHP and was directly involved in the care of patients on a CTO. Furthermore, the hermeneutic aspect of IPA (Smith et al., 2009) would allow the researcher to use her personal experience to interpret the findings during data analysis.

3.6 Philosophical Underpinnings of IPA Research

The three philosophical areas connected to IPA include phenomenology, hermeneutics, and idiography (Smith et al., 2009).

3.6.1 Phenomenology

Phenomenology represents a philosophical approach to studying the various aspects of human experience. Phenomenological philosophy offers various ideas on examining and understanding the lived experience.

Husserl was the founder of phenomenology, and through his work, he established the significance of the human experience and how it is perceived. He believed that meticulous examination is essential to identify the 'essential' qualities of experience. Husserl argued that to carefully examine human experience there is the need to step out of the '*natural attitude'* and adopt a '*phenomenological attitude'* so inquirers can engage and reflect on the taken-for-granted experiences. Husserl posits that inquirers need to 'bracket' to concentrate and reflect on their perception of the world. Husserl's work has been significant in phenomenology since it concentrates on the process of reflection. (Smith et al., 2009).

Heidegger, Merleau-Ponty, and Sartre also contributed to IPA research as through their work we realized that human experience is indeed complex and difficult to understand. IPA acknowledges that there is no straightforward way to experience therefore the inquiry aims to attain an 'experience close' rather than an 'experience far' (Smith, 2011).

3.6.2 Hermeneutics

Hermeneutics represents the theory of interpretation. Smith (2011) accents that the researcher must engage with others to be able to examine and interpret their experiences. Furthermore, Smith et al. (2009) posit that human beings are indeed sense-making creatures, and making meaning of their experience is influenced by their relationship with the world. Culture, language, and context will influence the meaning they give to their lived experience.

Heidegger, Gadamer, and Schleiermacher are three philosophers who contributed to the theory of hermeneutics in IPA.

Heidegger noted that the word phenomenology is made up of two parts, *phenomenon*, and *logos*. Heidegger defined the *phenomenon* as the way things present themselves and how these may have both noticeable and hidden meanings. Heidegger relates *logos* to the analytical thinking that is required to understand what is being examined (Smith et al., 2009). Moreover, Heidegger points out that the process of interpretation will be influenced by our experiences, beliefs, and prejudices. This enlivened form of bracketing is rooted in the belief that bracketing can be partially attained as opposed to Husserl's position on bracketing where predetermined views can be identified and suspended. Furthermore, Heidegger points out that since preconceptions are always present; there is the possibility that these will influence our interpretation (Smith et al., 2009).

According to Smith (2011), IPA poses another challenge to the researcher because whilst the participants are engaged in trying to make sense of their experience, the researcher would be attempting to understand the meaning that the participants are giving to their experience. This engagement process in IPA is described by Smith (2011) as a double hermeneutic. The researchers' interpretation of the participants' experience occurs from two positions. Researchers must be both empathic and curious to understand the participants' lived experiences (Smith et al., 2009).

Gadamer is interested in the way history and tradition affect the interpretive process. His focus is on understanding the text rather than the author. (Smith et al., 2009).

Schleiermacher believes that '*grammatical'* and '*psychological'* interpretations are implied in the process of interpretation. Schleiermacher's views are valid for the IPA researchers as the process of IPA involves both learning about individuals and understanding the meaning that individuals give to the accounts of their experiences (Smith et al., 2009).

3.6.3 Idiography

Idiography is the third philosophical area that has a major influence on IPA. Idiography is involved with what is distinct and unique. IPA gives prominence to a particular group of people in a specific circumstance and seeks to understand their experience from their perspective (Smith 2011). Smith et al. (2009) accent that although the idiographic nature of IPA is focused on individuals' experience, it also considers the relationship and interaction that individuals have with the world (Smith et al., 2009). Moreover, IPA is concerned with the detailed analysis of each case and is followed by an exploration of what is similar, different, and particular in the patterns of meanings that participants impart to their experience.

3.7 Sampling Technique and Inclusion Criteria

The study's sampling technique and inclusion criteria are presented in this section.

Smith et al. (2009) recommend selecting a purposive sample to provide reliable insights into the phenomena under study. Since IPA is concerned with a detailed account of individual experience, small sample sizes are utilised to focus on quality rather than quantity. Furthermore, Smith et al. (2009) recommend choosing a homogeneous sample of participants where the phenomena being studied is significant to them.

The inclusion and exclusion criteria of the participants are presented in Table 3.1. Seven MHNs were recruited for this study. The participants were “Key Health Professionals” caring for individuals on a CTO and have been working in a Mental Health Community setting for at least three years.

Table 3.1 Inclusion and Exclusion Criteria of Participants

Inclusion Criteria	Exclusion Criteria
• Mental Health Nurses registered with the Maltese Council for Nurses and Midwives. • Working in a Community setting for at least 3 years and acting as Key Health Professionals for individuals on a CTO.	• Nurses not registered as MHNs. • MHNs working in a community setting for less than 3 years. • MHNs working in a community setting but not acting as Key Health Professionals for individuals on a CTO. • MHNs working within the same clinic as the researcher.

3.8 Recruitment Process

A purposive sample was selected for the study. To recruit potential participants an intermediary (Appendix A) contacted MHNs who cared for individuals on a CTO.

Before starting the research, the research study was explained to the intermediary. A Community Nursing Manager has consented to act as an intermediary during the recruitment process of participants in this research project. The intermediary contacted potential participants according to the inclusion criteria. The intermediary imparted an explanation of the study to those participants who were interested in participating and then an information letter about the study was provided (Appendix B).

Informed consent procedures are intended to safeguard participants' rights to choose freely (Polit & Beck, 2018). Therefore, those participants who showed interest to participate were informed that participation in the study was voluntary and they could decline or cease to participate at any point without giving any explanation. Moreover, the researcher had no idea if any participants refused participation as participants were contacted via the intermediary. The intermediary took note of the contact details of those individuals who were willing to participate in the study. Then the researcher contacted those participants who were interested to participate in the study. An interview was scheduled at a place and time convenient to the participants. Before the interview, each of the participants was assured that confidentiality and anonymity will be maintained throughout the whole study. Before every interview, a consent form was signed by each of the participants.

3.9 Data Collection

Permission to conduct the study was granted on May 22 by the Faculty Research Ethics Committee (Appendix D). The collection of data started in June 2022 and lasted until August 2022. IPA's idiographic nature is concerned with grasping details and aspects of phenomena. To examine each case in detail a lengthy process is entailed (Smith et al., 2009) therefore a small sample size of seven participants was used.

Smith et al. (2009) accent that the IPA method necessitates 'rich data' that captures the views, concerns, and meaning that participants give to their lived experiences. Smith et al. (2009) posit that if a highly structured interview or questionnaire is used to collect data the participants will be limited in providing a detailed experience. To achieve valuable data Smith and Osborn (2003) recommend collecting data through semi-structured interviews. This enables the researcher and participants to form a rapport and is conducive to a profound and individual discussion. Hence, one-to-one, semi-structured interviews were utilised to collect the data for this study.

3.9.1 Interview Schedule

An interview schedule guides the interview and helps the researcher to address the research questions effectively (Smith & Osborn, 2003). As researchers construct the interview schedule, they can plan for any difficulties that can develop during the interview. This enables researchers to be less anxious and therefore during the interviews they tend to engage more with the participants. Moreover, an interview schedule aids novice researchers (Smith et al., 2009). The interview schedule aims to assist the interaction between the researcher and participants where prominence is given to the participant's accounts. To encourage the participants to talk and provide detailed accounts of their experiences open-ended questions are recommended (Smith et al., 2009).

Hence, after a comprehensive literature review, an interview guide was developed (Appendix C). The interview guide consisted of 11 open-ended questions. These questions were constructed to obtain the objectives of this research study. The objectives are to explore the views of MHNs on the CTO framework, to gain insight into challenges that MHNs might encounter, to explore the effects of these challenges on the provision of care, to explore how MHNs cope with any emerging challenges, and to explore ways to support them. Smith et al. (2009) posit that in the research study, the participants are the experiential experts, hence ample opportunity has to be provided so that they can give a detailed account of their experience. Therefore, throughout the interview, the participants were invited to describe, reflect and communicate on aspects of their experience. Interviews lasted from 60 minutes to 75 minutes. Smith and Osborn (2003) propose to start the interview with questions that are not too explicit but sufficient to encourage the participants to recognize that their contribution to the study is valuable. Smith et al. (2009) propose that questions that require more reflection are introduced when the participants are more comfortable. Hence, the interview began by tackling the general aspects of the CTO. Subsequent questions inquired about various aspects such as describing their personal views on CTO. These were followed by questions about the challenges encountered by MHNs and how they dealt with these challenges. Thereafter the focus was on aspects that facilitate their work and the support that can be provided to help them cope with these challenges. Smith and Osborn (2003) recommend that some prompts are prepared in the eventuality that participants have difficulty giving a satisfactory response. Hence, prompts were prepared to achieve comprehensive experiences.

Participants were all professionals, so the interview schedule was prepared in English. Smith et al. (2009) emphasize that to secure quality data a good rapport must be built between the researcher and participants before the interview. Therefore, before starting the interview, the researcher introduced herself, explained the objective of the study, and expressed interest in the participants and their experiences. Participants were encouraged to take time to reflect before sharing their experiences. Moreover, the researcher tried to learn the interview guide so that during the interview the focus would be on the participants. Smith et al. (2009) recommend that interviews are conducted in a safe and comfortable environment. Hence, the interviews were carried out in places and times preferred by the participants. After the participants gave their consent, the interviews were audio-recorded in the English language.

3.10 Pilot Work

In qualitative methods, pilot work is utilised to prepare the interviewer to acquire the different skills to conduct interviews which will seek to understand the lived experience of the individuals under study (Smith et al., 2009). Therefore, before starting the study the researcher interviewed a psychiatric nurse who works at her clinic. The pilot study lasted sixty-five minutes. The pilot study was valuable since the researcher could rehearse the interview questions. Hence, whilst conducting other interviews the focus was on the participants and their experiences rather than the interview schedule. During the pilot study, the participant answered the first question by referring to his views on CTOs rather than what he understood about CTOs. Therefore, the first question of the interview schedule was changed to reflect better the participants' views on CTOs. The transcript was then re-evaluated by the supervisor who advised the researcher to speak slowly and give herself time to phrase the questions to assist the participants to understand the questions and impart detailed accounts of their experiences.

3.11 Data Analysis

Smith et al. (2009) posit that the core of IPA is in its detailed analysis. To understand the context and complexities of the lived experience researchers must immerse themselves in the data and engage in a process of interpretation. Smith et al. (2009) claim that analysis of the data through IPA is subjective and truth claims are tentative since it is the product of the participants' lived experience, the interpretation and meaning they give to the lived experience. The researcher has to understand and interpret the participants' experience when they are still attempting to comprehend their own experience. This is described as a double hermeneutic. Moreover, IPA is idiographic, so before moving to the next case, each case is analysed in detail. To analyse the data the researcher adopted the six steps approach as recommended by Smith et al. (2009). A description of the data analysis will follow.

Step 1: Reading and re-reading

In the first step of the analysis process, analysts immerse themselves in the original data (Smith et al., 2009). To ensure that the focus of the analysis was on the participant, the researcher listened closely to the first recorded interview whilst she close read the transcript several times. To remain with the data, Smith et al. (2009) recommend that researchers record any prominent recollections from the interview and personal observations of the transcript in a notepad. This was utilised and assisted the researcher to bracket her own beliefs. Moreover, repeated readings allowed the researcher to engage with the data, thus furthering her comprehension of the narratives and recognizing how parts of the interview were connected.

Step 2: Initial noting

The next step involves a close analysis of the participant's narratives, focusing on semantic content, language use, and context. Smith et al. (2009) accent that although analysts use their thoughts, feelings, and experiences to reflect and interpret the data the focus of the analysis must remain on the participant.

Therefore, going through the transcript, the analyst started to grasp how each one of the participants perceived and expressed themselves on the diverse issues. Then she produced notes that encompassed exploratory comments on the participants' most relevant aspects and the meaning they imparted on those matters. Consequently, the analyst engaged in an interpretative stance to get closer to the participants' lived experiences. She was careful to concentrate on the participants' experiences.

Step 3: Developing emergent themes

In this next step, the analyst works with exploratory comments to identify emergent themes (Smith et al., 2009). The analyst developed concise phrases (emerging sub-themes) that captured and reflected upon what was important in the transcript by grouping and connecting statements. The emergent sub-themes were derived from the analyst's interpretation and the participant's accounts.

Step 4: Searching for connections across emergent themes.

This step aims to look for links between emergent themes (Smith et al., 2009). Themes were clustered according to their similarities or differences, and each cluster was assigned a descriptive title (super-ordinate theme). The super-ordinate themes captured the salient aspects of the participant's narrative. Furthermore, whilst searching for links between emergent themes, the analyst considered the contextual and narrative aspects to enhance the understanding of the participant's narrative.

Step 5: Moving to the next case

This step involves moving to the next participant's transcript and repeating the analysis process (Smith et al., 2009). The analyst looked for repeated patterns in the data to respect similarities and differences in participants' accounts. However, to keep with the IPA's idiographic commitment each case was treated individually thus allowing new themes to emerge. Therefore, whilst working on the next case the analyst attempted to bracket the ideas that emerged from the previous case. This process was repeated in subsequent cases.

Step 6: Looking for patterns across cases

Smith et al. (2009) explain that this stage entails the identification of patterns across cases. Superordinate themes and sub-themes were identified from each case, which was followed by searching for connections between themes across cases. Table 4.2 in Chapter 4 presents the themes from all the participants' interviews.

Since the focus of the analysis process was on the participants' experiences, the emerging themes recall the accounts of their individual experiences. Moreover, to enhance the trustworthiness of the study the researcher discussed the coding system with the supervisor who also audited the super-ordinate themes and sub-themes to ensure that these showed the findings of the transcripts.

Ethical issues related to the study will be discussed in the next section.

3.12 Ethical Issues

To conduct the study, permissions were acquired from the Chief Executive Officer, Data Protection Officer, and Nursing Director (Appendixes E, F, G). Data collection began after the University of Malta Research Ethics Committee (UREC) granted permission on May 22 to conduct the study.

When conducting a study, the ethical principles of beneficence, justice, and respect for human dignity have to be observed (Polit & Beck, 2018). Moreover, Smith et al. (2009) accent that ethical principles have to be observed throughout the research process, particularly during data collection and analysis.

Therefore, whilst conducting the study the researcher has to safeguard the participants from any harm and protect their rights to impartial treatment, their right to informed consent, their privacy, and their autonomy (Polit & Beck, 2018).

To observe ethical principles and satisfy the obligation to protect participants certain procedures were applied in this study.

3.12.1 Recruitment of Participants

Participants’ choice to participate in the study was voluntary as participants were recruited through an intermediary. Furthermore, the intermediary did not provide any details to the researcher of potential participants who refused to participate in the study.

The researcher has been a CN for more than 7 years at the Qormi Community Mental Health Clinic (a clinic that is part of the Maltese Mental Health Services) thus to protect participants from feeling obliged or coerced to participate in this study the MHNs working there were excluded from the study. Therefore, the study was conducted with MHNs from other CMHTs.

3.12.2 Ensuring Informed Consent

The intermediary gave interested participants an information letter detailing the study. Smith et al. (2009) advised gaining informed consent by providing information about the interview and data collection process as well as data analysis since verbatim extracts would be published in the study. Therefore, the participant’s rights and an explanation of what was expected of them if they choose to participate were outlined in the information letter. The participants were assured that participation was voluntary and that they could decide not to participate or withdraw participation at any time during the study. Participants were informed that there would be no negative repercussions if they choose to refrain from answering any of the questions or stop the interview. Moreover, their data would be deleted if they withdraw from the study. The participants were informed that the interview would take about 1 hour and would be audio-recorded and transcribed.

3.12.3 Confidentiality

Smith et al. (2009) claim that qualitative researchers can only offer anonymity to ensure that the participants’ details would not be connected to their data.

Therefore, transcripts for this study were coded, and pseudonyms were used to protect participants' identities. Personal data were kept separate from pseudonyms and transcripts. The research supervisor, co-supervisor, and examiners could verify the coded data, however, only the researcher could access the actual data.

For data protection purposes all data (audio recordings and transcripts) were kept on the researcher`s personal computer which is protected by an encrypted password. During the research period, all material in hard copy was placed in a locked cupboard and once the study is completed and the results are published data will be deleted.

3.12.4 Reducing Harm

According to Polit and Beck (2018), researchers have the responsibility to prevent or reduce harm, which can be physical, emotional, social, and financial in research projects with humans.

The participants were offered the assistance of a psychologist in case they experienced any psychological distress. They could make use of the services of the psychologist without having to incur any financial loss (Appendix H). The details of professional assistance were included in the participant's information letter. In addition, participants could choose the time and place where to conduct the interview. Participants were informed that they could refuse to participate in the study, refrain from answering any of the interview questions, and if they withdrew from the study their data, would be destroyed.

3.13 Quality and Trustworthiness

Smith et al. (2009) posit that validity and quality are indeed essential aspects of qualitative research. Therefore, for the proper evaluation of quality, adequate criteria must be used (Polit & Beck, 2018). Smith et al. (2009) recommend the four aspects of Yardley (2000) approach to evaluate quality and trustworthiness in qualitative research.

3.13.1 Sensitivity to Content

Yardley (2000) claims that qualitative researchers need to establish sensitivity to context by showing sensitivity toward the theoretical standpoints, the sociocultural settings, data obtained from participants, and the pertinent literature.

IPA is the method utilised for this study, and since the focus is on the idiographic, this exhibits sensitivity to context. Moreover, the participants for the study have a particular lived experience and were recruited from a specific setting. A substantial number of verbatim extracts emerged from the data analysis process thus ensuring focus on the participants' perspectives. All recordings and transcripts were kept in a locked cupboard and were coded for data protection purposes. Pseudonyms were used to protect the identity of the participants and the researcher's computer was protected by a password. Moreover, all the data would be destroyed once the study is finished. Findings from this study were related to the pertinent literature in the discussion section of this study.

3.13.2 Commitment and Rigour

During the data collection process, IPA focuses on the participants. Furthermore, the meticulous method in which the analysis of data is carried out enhances the commitment and rigour of the study (Yardley, 2000).

For this study, participants were recruited through an intermediary, and the interview was conducted at a convenient time and place for the participants. Furthermore, throughout this study, the researcher engaged in a reflexivity process to protect against personal bias, and to keep the focus on the participants' views.

Yardley (2000) claims that sample appropriateness, interview quality, and thorough data analysis enhance rigor.

A fairly homogenous sample was selected for this study and in-depth interviews were conducted to collect rich data. Data analysis was conducted systematically and thoroughly (Smith et al., 2009).

3.13.3 Transparency and Coherence

Transparency indicates the researcher's attempts in describing all the stages of the research process (Smith et al., 2009).

This is evident in the detailed account of this write-up, which presents how the participants were selected, the formulation of the interview guide, and the actual interviews. Furthermore, a detailed description of the data analysis process and the use of tables provided further clarity (Smith et al., 2009).

Yardley (2000) claims that coherence is determined by how closely the research study is consistent with claimed theoretical frameworks. Therefore, for IPA, the phenomenological and hermeneutic aspects should be present in the write-up (Smith et al., 2009). The excerpts in this write-up demonstrate commitment to the participants' subjective experiences. Furthermore, the researcher presented clear interpretations while attempting to understand the participants' experiences.

3.13.4 Impact and Importance

If the study has produced useful results for the reader and achieved the purpose of the study then validity is justified (Smith et al., 2009).

The experience of MHNs whilst caring for individuals on a CTO is underrepresented in literature therefore this study aimed to address this dearth in the literature. Guidance from the research supervisor ensured that the novel researcher maintained principles of trustworthiness and quality.

3.14 Reflexivity

Qualitative researchers are keen to learn about the human experience and to protect qualitative research against personal bias they engage in reflexivity. To preserve the trustworthiness and transparency of the study, qualitative researchers engage in a reflexivity process. The researchers are continually aware of their prejudgments, personal influences, and personal values that may influence the research process (Polit & Beck, 2018).

Thus, a reflective diary was kept where the researcher’s preconceptions and aspects from previous experiences were recorded.

3.14.1 Reflective diary summary

Before data collection.

I have been working in a CMHC for twenty-six years. Presently I hold the role of a CN. I witnessed the introduction of CTOs when the MHA was amended in 2012. Initially, nurses were quite concerned about the new responsibilities inherent to the role of KHP for individuals on a CTO. As we gained more experience, we became more confident in our KHP’s role.

In the last decade, policymakers were committed to providing mental health care in community settings, which led to deinstitutionalization. However, the present community services cannot cope with the influx of so many patients. Moreover, hospital stays are becoming shorter, and more patients are being placed on a CTO. Lately, nurses appointed as KHPs for patients on a CTO disclosed that they were facing challenges that left them disheartened and preoccupied. I was interested in exploring these issues in depth and I was inquisitive about how they managed to cope with the demands of their role. Moreover, I believe nurses needed more support to deal with certain challenges, particularly with legal issues.

Due to the limitations of my interviewing skills, a psychologist colleague offered me some tips. Furthermore, I had to train myself to formally conduct interviews for this research project.

I had to work on the fact that I had to keep silent, focus on the details, and use probes at the right time.

During data collection.

During the interviews, I was careful to differentiate between my role as a CN and my role as a researcher. Due to this dual role, I was careful not to discuss or give my professional views on issues that emerged during the interviews.

The MHNs were eager to share their views and experiences on their KHP's role. They shared their experiences and recalled stories of patients they cared for. I was captivated by the intensity and range of emotions that were expressed. Some of the participants expressed emotions of frustration, anger, sarcasm, and anxiety. One of the participants started crying while she was describing and disclosing her experience, which made me more conscious of the demands of this role. Alternatively, positive emotions were elicited through descriptions of assertiveness, unity, and compassion. I was moved by the empathy shown toward the patients and relatives.

During the initial interviews, I felt quite anxious. However, using a reflective journal helped to ease my anxiety and assisted me to prepare myself for subsequent interviews. Through the reflective journal and guidance from my supervisor, I delved deeper into the perceptions imparted by the participants and ameliorated the interpretation of the findings. Each interview was transcribed before the following interview was done. Thus, I could concentrate on each of the individual interviews.

After data collection.

At the end of the interviews, participants expressed the hope that some of the issues discussed during the interviews will be addressed to improve the quality of care. Thus, reconfirming their commitment to their patients. After the interviews, I became aware that MHNs need more guidance to deal with ethical dilemmas and legal responsibilities.

Furthermore, after attending to the experiences of the participants I acknowledged that I must be as empathic towards staff members as I am with patients. I also commit myself to introduce one-to-one sessions to assist and guide MHNs to cope with the demands of this role.

3.15 Conclusion

IPA was deemed to be the best phenomenological approach, to address the research question. The philosophical underpinnings and rationale for this method were explained, followed by the description of the sample recruitment process, interviews, and data analysis. Careful consideration of ethical issues was employed. Several criteria were employed to ensure rigor and trustworthiness.

The findings emerging from the interview transcripts will be presented in the following chapter.

CHAPTER 4. FINDINGS

4.1 Introduction

The interpretation of data gathered from MHNs' experiences of caring for individuals on a CTO will be presented in this chapter. The IPA framework as described by Smith et al. (2009) guided the data analysis. Three superordinate themes and several sub-themes emerged from the MHNs' experiences. The extracted superordinate themes and sub-themes presented in this chapter represent the participants' voices and my interpretation.

To assist the readers to gain a better understanding of the participants' experience, several excerpts derived from the transcripts were included. Moreover, the excerpts ensured that the participants' voices are represented in this study (Smith et al., 2009). When the participants' excerpts were presented, pseudonyms were used to protect the participants' identities. Peter, Dani, Violet, Benna, Katie, Terry, and Sue are the pseudonyms used in this chapter. Table 4.1 provides the participants' demographic characteristics and their years of experience working with individuals on a CTO.

Table 4.1 Demographic data of study participants

Pseudonym	**Years of experience as a 'Key Health Professional'**
Peter	11
Dani	11
Violet	6
Terry	6
Sue	6
Benna	4
Katie	4

The participants were all MHNs caring for individuals on a CTO. The participants' group consisted of seven MHNs, a male nurse, and six female nurses. To establish a degree of experience in CTO procedures and its administration the MHNs who participated in the study have been working in community settings for more than 3 years. Years of experience in CTO procedures ranged between 4 to 11 years. To further protect participants' anonymity, their ages were not included since the pool of MHNs in Malta is relatively small.

According to Reid et al. (2005) to understand participants' experience researchers must consider the study's context. Therefore, it is important to point out that the study was being carried out when a nurse was being arraigned in court for an incident involving a patient's safety whilst in the hospital. This led to an uproar within the nurses' community since nurses believed that the incident occurred due to failures in the system's procedures. Thus, nurses felt that they were being exposed to liability and used as scapegoats for a faulty system.

All interviews were conducted in English and all excerpts are presented in English. Excerpts will appear in italics, enclosed within quotation marks, and identified with the pseudonym. For editorial reasons, some text from the excerpts was omitted, in such cases, an ellipsis will be utilised ("…").

Smith et al. (2009) claim that it is important that researchers note how the participants made use of language as this leads to a better understanding of their lived experiences. Therefore, before presenting the themes that emerged from the participants' experiences, some of the linguistic components used by the participants during the interviews are highlighted.

4.2. Linguistic Components

Nevalainen et al. (2008) posit that when individuals want to emphasize their point, they often repeat the same words in the same sentence. In fact, during the analysis process, the researcher noticed that participants used similar words repeatedly in the same sentence when they wanted to make an explicit claim.

In the following excerpt, Dani repeats the words "problem" and "issue" to describe the difficulties she deals with, resulting from her lack of involvement in decision-making. Moreover, she uses "disadvantage" and "big disservice" to highlight the negative effect on care provision. She accents the word “now” when she describes her encounter with the consultant. The linguistic comments used by Dani may indicate that although she did not agree with the process by which patients are being discharged, she was feeling pressured to continue to provide care even though this challenged her nursing values.

> *“We have a problem; we have an issue. Frequently, the consultant phones me as the charge nurse and tells me that they have a person, and they need a Key Health Professional **NOW**!!! He needs to go out on leave or be discharged from the hospital. That is a disadvantage, a big disadvantage!!! and in my opinion, is a big disservice to the patient.”* (Dani, p.2, lines 34-38)

Likewise, Benna uses repetition of the phrase “not aware of it” to emphasize that when she is appointed as KHP to patients on a CTO, she feels that she must follow more closely due to pressure from legal responsibility. However, her biggest concern results from a fear that either patients or others would be at risk, and she would be blamed for circumstances beyond her control.

> *“…every time you must be extra careful with this kind of patient because if something happens and you are not aware of it, they will say how come you were not aware of it? The doctor can ask you how come, and when did you last see the patient?”* (Benna, p.1, lines 28-30)

Another linguistic component that assisted the researcher to understand the participants’ lived experiences is metaphors. The metaphors in the text could be grouped under these super-ordinate themes which include: 1. Paving through Responsibilities, 2. Targeting the Challenges and 3. Attempts at Maintaining Balance.

The first super-ordinate theme, “Paving through Responsibilities” produced two sub-themes “Juggling between Care and Control” and “Therapeutic Relationship is Key”. These sub-themes describe the ethical dilemmas experienced by the participants from their dual roles as enforcers of the CTO’s framework and providers of care. Furthermore, it describes how the participants tried to safeguard the therapeutic relationship within the CTO’s coercive framework. Participants used metaphors to express how they empathized with patients and tried to understand patients’ perceptions of being controlled.

> *“But some people see it [the CTO] as something hanging over their heads. For us to use it [the CTO] to bring them back to the hospital.”* (Sue, p.2, lines 58-59)

The second super-ordinate theme “Targeting the Challenges” produced three sub-themes mainly “Involvement in Care Decisions”, “Resources” and “Validation and Understanding”. These sub-themes focused on the insufficiencies present within the care context which influenced the delivery of care and left the participants questioning their nursing role and clinical abilities. Indeed, the researcher noted how the participants used metaphors when they wanted to highlight aspects that challenged their nursing role, particularly when they felt they were being appointed as KHPs for the wrong reasons.

Violet felt stripped of her professional role and her clinical judgment abilities and compared herself to the passive role of a camera. This was demonstrated by how Violet described her experience as the appointed KPH but not being involved in the decision-making process.

> *“At times, we are not at times involved in final decisions, so why am I appointed as the KHP? …they put us as cameras sometimes, so their mind is at rest that the patient would not get them into trouble.”* (Violet, p.7, lines 245-248)

The last super-ordinate theme “Attempts at Maintaining Balance” was elicited mainly from the coping mechanisms adopted by the participants to continue caring for patients despite the challenges and give voice to their recommendations. Two sub-ordinate themes emerged: “Support Systems” and “Hear Us Out”. The participants repeatedly accented how the support provided by members of their team, helps them to overcome challenges and deal with stress. Participants also regarded having a good relationship with patients’ relatives as supportive since this assisted them to cope with the complex situations of this group of patients. Nonetheless, the participants expressed the need for formal supportive sessions to cope with challenges and continue to provide care. The metaphors in this excerpt reflect the psychological burden experienced by the participants.

> *"Sometimes it happens. I mean our job you are touching people's lives so you cannot just switch off and not worry about what is going on in someone's life, unfortunately. It is not possible. I wish this was possible, but I find it hard to do so. I feel that sometimes it is a bit of a load, comes in phases obviously, sometimes I feel ok, sometimes I feel that I am shouldering a lot of people's problems on my shoulder, holding people's problems on my shoulder but it is not always the same. Even now, talking about it is a means of catharsis to release the tension" (Sue, p.16, lines 513-518)*

The super-ordinate themes and sub-themes elicited from the experience of MHNs appointed as KHPs to individuals on a CTO are presented in Table 4.2.

Table 4.2 The experience of Mental Health nurses whilst caring for individuals detained on a CTO

Super-ordinate themes	**Sub-themes**	**Excerpts from participants' interviews**
Paving through Responsibilities	• Juggling between Care and Control • Therapeutic Relationship is Key	*"It is like having a knife cutting from both sides, you have to choose what is best for them even if the patient does not agree due to a lack of insight. You have to explain to him, but this remains difficult for us."* (Violet, p.3, lines 79-81). "…sometimes it is challenging as certain people continuously do not accept it (CTO). … but again, I have learned that if you sit with the patient, let him talk…let them know you are understanding, what they are feeling." (Sam, p.9 lines 279-283)

Targeting the Challenges	- Involvement in Care Decisions - Resources - Validation and Understanding	“We are not always present when care plans are drawn… (Benna, p.4 line 130) “…there are certain shortages in the system…Frustration is from the lack of services available to meet patients’ difficulties.” (Peter, p.8 lines 281-286)
Attempts at Maintaining Balance	- Support Systems - Hear Us Out	“My colleagues, we discuss a lot in our team…We support each other.” (Violet, p.8 lines 279-280) “Mostly, it is helpful that there are relatives…they can call if they are concerned…for me, it is a good source of information…” (Peter, p.5 lines 164-169)

The super-ordinate themes accompanied by excerpts are presented in detail in the next section.

4.3 Paving through Responsibilities

This theme was elicited from how the participants viewed their role when being appointed as KHPs within the CTO framework. This role placed multiple responsibilities on the participants since they were the coordinators of care. Moreover, they had the legal responsibility to monitor if patients complied with treatment and followed their care plan. Participants experienced ethical discomfort since the use of coercion within the CTO framework is incompatible with the caring values of the nursing profession.

4.3.1 Juggling between Care and Control

CTOs are mandated by law and the appointed KHP is required to oversee the patient’s care plan and ensure that patients are compliant with treatment thus ensuring that patients continued to receive adequate care. Hence, the participants considered the CTO framework as a safety net, especially for those patients who would otherwise be unwilling to accept care and support due to their severe mental illness. However, the participants identified more with the role of care providers rather than enforcers.

> *"Being the KHP you are the coordinator of care, so the person (KHP) is the one-stop shop for the person [patient] and anything that happens to the patient and the family, the KHP coordinator of care. So, if a person on a CTO needs to look for a job needs the SW, needs the food bank, or anything that he needs the KHP will coordinate the care as required. If you go to the patient and see that he needs an earlier review or requires psychotherapy you are the one, the KHP is the person that refers to the psychologist and does an earlier appointment. She is the coordinator of care."* (Terry, p.2, lines 43-49)

They viewed themselves as points of contact and felt responsible to help and assist patients during their recovery process. The participants were satisfied and found it rewarding that patients were more in control of their mental illness through multiple nursing interventions. Participants adopted an attitude of "to do whatever it takes" for patients to recover.

> *"We had youths that have been admitted to MCH because of drug-induced psychosis and when we started working with them, we started going nearly every day, to get them out of bed, because they were in a depressive state, were not taking drugs, lost their friends because they were abstinent, they lost their communication with the outside world, so they ended up in bed. We tried to help them by going for walks and going for coffee…." (Dani, p.11, lines 323-328)*

Moreover, participants acted as patient advocates in various situations, especially when relationships between family members were shattered due to the consequences of the mental health condition.

> *"… We do a lot of things, this person we ended up encouraging him to go back to work and he did. We supported the parents in trusting him again. It was not easy to try to help them gain trust in their son. Nowadays he is working…It's a big change from when we met, we try to educate him about*

> *harm reduction… and his family is involved as well." (Dani, p.12, lines 332-339)*

Nonetheless, all the participants continued to face difficult situations when due to lack of insight, patients were reluctant to accept care. The participants experienced different emotions, ranging from frustration to compassion. The negative emotions resulted from ongoing attempts to involve the patient as much as possible in their care plan without succeeding therefore having to resort once again to enforcing treatment. Thus, the participants felt weary and disheartened.

> *"You will get them involved because you will know them by then and you will know what their needs are, and you can do a better care plan. However, they still do not agree with you and certain things that you feel are beneficial... You try to explain to the patient however if they insist that they are feeling good you must continue to explain that they feel good because they are taking their medication. You try to explain but it remains difficult, it is not easy at all."* (Benna, p.6, lines 207-220)

All participants considered treatment to be an important factor in the patient's recovery process. Participants were genuinely concerned that patients would regress if they continued to refuse treatment and would end up being admitted to the hospital or even worse incarcerated.

> *"The patient hates to take the treatment but without it, he becomes psychotic. As a psychiatric nurse, I want him to function in the community. I hate the fact that I have to tell him to take the depot injection but on the other hand, I like to see that he is stable and participating in the community*." (Violet, p.2, lines 66-69)

> *"…he already got involved in a fight which led him to prison. He is not the type to be in prison, he ended up there due to his psychosis. He has no insight at all, that is why you get concerned if he gets into trouble."* (Violet, p.3, lines 103-105)

Moreover, the participants knew that some patients would cooperate with the care plan due to being on a CTO and out of concern that they would be admitted again if they opposed it. The participants tried to empathize with and reassure the patients, however, they acknowledged that the compulsory aspect and fear of being re-admitted could jeopardize patients' recovery process.

> *"They accept you because you are legally appointed, they do everything you say, or they say they are doing it or taking treatment just because they are afraid that we put them back in the hospital. So, you explain again and again… we are not going to put you in hospital unless you are a risk to yourself or others."* (Terry p.4, lines 140-143)

Then again, participants explained that there are patients who prefer to be on a CTO as this gives them a sense of containment and stability. Although the participants explained that it was much easier to care for these patients, they felt responsible to encourage the patients to adopt other coping mechanisms to remain stable. Three participants Peter, Terry, and Violet opposed the fact that CTOs are being used to secure follow-up for patients with complex needs. Furthermore, if the patient had a history of risk, there seems to be a hesitancy to revoke the CTO even though the patient would have been stable for a long time. The participants believed placing patients on a CTO is not a solution and might impede recovery. The following excerpt indicates that in these circumstances participants considered protecting patients' rights as one of their main responsibilities.

> *"If the patient's rights are involved, I have the responsibility to be the patient's advocate. I have to be the voice of my patients."* (Violet, p.7, lines 273-274)

When the participants had to execute the role of enforcer, they all faced ethical dilemmas especially when patients refused treatment and did not abide by the care plan. Some participants found it difficult to choose between protecting the patients' autonomy and treatment benefits especially when patients lacked insight into their mental health condition. Some participants were guided by the principles approach to ethics whenever they faced this dilemma. However, the following excerpt reveals that it remained challenging for the participants to balance respect for patients’ autonomy with the professional and moral responsibility to safeguard them when their judgment was impaired.

> *“It is like having a knife cutting from both sides, you have to choose what is best for them even if the patient does not agree due to a lack of insight. You have to explain to him, but this remains difficult for us.”* (Violet, p.3, lines 79-81)

Two participants tried to cope with this dilemma by trying to shield the patient from the coercive aspect. They empathized with and encouraged the patients to focus on their recovery rather than focusing on the controlling aspects of the CTO.

> *“So, it is important to start reassuring them that the primary reason for the CTO is not for them to return to the hospital but rather the opposite. To help them stay away from the hospital because, with the right support and continuous assessment throughout their rehabilitation in the community, we try to help them, you know with anything that happens.”* (Sue, p.2, lines 59-63)

> *“We both know it’s there [CTO], no need to mention it continuously as it could be a trigger as well. But for their safety, overall well-being, general improvement, and ability to cope in the community, I think it is extremely helpful. It helps us monitor closely and make sure that everything is ok.”* (Sam, p.10, lines 297-301)

Moreover, the participants felt burdened by the legal responsibility placed upon them by CTO’s framework. They felt pressured when they had to make clinical decisions, especially when they had the obligation to make sure that the patient is indeed taking treatment and abiding by the care plan.

> *“…you tell the patient that you understand his views, but still, he needs to take the prescribed treatment. It is awkward that you have to tell him to take it [the treatment], but in the long run, we are responsible...”* (Violet, p.2, lines 66-69)

Dani seemed unsure of how much pressure she could exert so patients adhered to treatment. There seemed to be a contradiction between her respect for the patient's autonomy and the covert coercive tactics she used to convince the patient to take the prescribed treatment. This could have stemmed from the legal obligation of the CTO thus the emphasis on medication compliance and patients' lack of insight rather than focusing on patients' goals. This is exemplified in the following excerpt:

> *"In the past, he used to have a depot injection, but he experienced various side effects and he is adamant that he does not want these side effects. That is why we continue telling him the importance to take his treatment otherwise the last option would be to take depot medication. We try to reinforce that as long as he is managing in one way or another to live his life…"* (Dani, p.6, lines 163-167)

However, when there was a risk to the patient or others, the participants' social and legal responsibilities to protect the patient and keep others safe prevailed. Assessing risk and being responsible for overall safety was very prominent in the interviews which showed how much the participants felt responsible to manage perceived risk when caring for patients. However, this was accompanied by vast feelings of fear. All the participants were constantly worried about being held accountable for any undesirable and harmful circumstances that could happen to the patient and/or the relatives.

> *"Sometimes the legal issue subsides the caring aspect. It overtakes it because when there is a legal issue you are afraid that something can happen to the patient, and this puts pressure on you. You are afraid that you will be sued, for anything. Therefore, the care aspect is minimized. I have patients on outreach service, and I have patients on CTO. I treat them all the same as if they are all on CTO. However, the CTO places more pressure on you."* (Violet, p.5, lines 170-176)

The fear of litigation and blame placed a huge psychological burden on the participants. Therefore, at times, to safeguard themselves they focused more on their legal responsibilities rather than their caring role. This is reflected in Terry's words:

> *“Providing care to these patients, I prefer to do interventions quite often because of the risks that it brings. You have the legal aspect behind your neck, so you need to be careful that you see these patients regularly.”* (Terry, p.1, lines 20-23)

Moreover, to feel safer and in control of such situations, most of the participants (Terry, Katie, Benna, Sue, and Dani) restored to constantly checking the patients, ruminating, doubting their clinical judgment, and risking the rapport with their patients.

> *“I just try to find a date when we can meet, even if I spend a whole day texting her, to try to convince her to meet. At times I do this every day and ask if she can meet me after work. She replies that no she can’t as she would be going to the dentist. Then I try again the day after, I keep on trying. In case someone asks me did I text or call the patient to see how she is doing I would have proof that I have tried.”* (Benna, p.2, lines 70-74)

> *“I even call the patient 3 times a day, she does not tell me verbally, but I can see she is not liking the way I am calling her. At first, they say ok, then they tell me “I am ok, don’t call me and ask me again”. I tend to ask them the same questions. They say please do not repeat the same thing. I know I should work on this, but on the other hand, I feel safe that I asked them... Sometimes when I am not sure I even ask their relatives.”* (Katie, p.8, lines 239-246)

In addition to the concerns about possible litigation, Dani conveyed concerns about the reactions from the general public and the media if she were to be involved in unwary situations. Possibly feeling that her work as a psychiatric nurse is underestimated and only acknowledged through fault-finding endeavors. Hence, she ends up feeling vulnerable and helpless.

> *“I try not to worry, but certain things, if not at the front stay at the back of my mind. Then you listen to the media. The media is always against you, they never say how many people are managing to live decently in the community with our support. It is very tiring.”* (Dani, p.24, lines 705-708)

4.3.2 Therapeutic Relationship Is Key

Throughout the interviews, the participants also described how the therapeutic relationship remains pivotal, especially in the CTOs' context.

> *"The therapeutic relationship is standard. There is where we have to start with our patients. Because when we establish that, we would have established a major part of the care towards a service user."* (Sam, p.5, lines 152-154)

The participants explained that they adopt the usual therapeutic skills to engage with patients. However, the participants described that these skills are more essential with individuals on a CTO. The participants described that the initial CTO is the most challenging period for the therapeutic relationship. With time, the rapport with patients improves however some patients would continue to refuse support.

> *"Sometimes the patients do not accept the CTO… and sometimes it is challenging as certain people continuously do not accept it. … but again I have learned that if you sit down with the patient, let him talk to you. You listen, you let them know that you are listening, let them know that you understand what they are feeling. You let them feel that their emotions and thoughts are valued…"* (Sam, p.9, lines 276-284)

The participants emphasized the importance of being genuine, respectful, and empathic. Another aspect that was deemed essential by Dani was the personal attributes of the nurse who claimed that these can either make or break the therapeutic relationship.

> *"It is very important, not only the experience but your character. You have to be careful how you present yourself. If you are going there with a certain attitude, you say listen I am the boss and, it's not going to be a nice relationship. But if you are going to be there and show that that you are going to be available and that you are there for his need. Then it is more likely, you will be in a good relationship for sure."* (Dani, p.15, lines 418-423)

Peter considered the procedure of the CTO as an opportunity to start engaging with patients who would otherwise continue to refuse any kind of assistance due to a lack of insight.

> *"So, by the actual mechanisms of the CTO, you start building a good relationship. With time most patients appreciate that they have a named nurse, that is responsible for their care plan and because you tend to have more regular contact with most of the time it helps with the therapeutic relationship."* (Peter, p.3, lines 78-82)

Peter claimed that gaining trust within a coercive context is much more difficult and attributed this to a lack of insight rather than to the coercive aspect.

> *"Cause if a patient doesn't want to engage with the services, CTO is not going to help and the CTO is not going to hinder. I have someone on a CTO, and he does not have any insight and he does not want to be on a CTO and does not want my involvement."* (Peter, p.3, lines 107-110)

Nonetheless, all participants deemed that any support and care offered to the patients would be futile unless trust is gained.

> *"You know if we do not have that trust we are not able to help the patient. That is the biggest barrier."* (Sam, p.2, lines 42-43)

Participants claimed that frequent contact, being there in times of crises, and offering comprehensive support provided opportunities to engage with patients. Although participants had to invest more time and patience to build rapport, seeing patients engaging in their treatment plans was very rewarding when the trust was eventually built.

> *"It all depends on how you portray yourself as a nurse, because if you show them that you care… even though she seems reluctant to engage. When something bad happened, she called ME. So, when she was arguing with her mother and she was crying, she contacted me and asked me to "please B. speak to my mum!!!" and she was crying and upset. When she needed help, she phoned ME. It's because I showed her that I cared for her over these past 6 months, even though there were times when she did not want to meet me. Even when she may feel that sometimes I am "watching her". But when she needed help, she knew she could find me."* (Benna, p.3, lines 105-113)

Relationships with patients were deemed to be satisfactory in most areas. Disagreement mostly originated when patients resisted medication or when there was the need to issue a conveyance order. To preserve the therapeutic relationship, the participants tried to separate themselves from the coercive aspect of the CTO. One of the participants, (Peter) explained how he and the patient's psychiatrist agreed to adopt different roles. The psychiatrist took the role of the administrator whilst the participant acted more as a link between the patient and psychiatrist:

> *"…as long as he knows [the patient] that I am not the person who is prescribing the medication. At times I and the psychiatrist are kind of "the good cop and the bad cop" I am the one that says…it's not a nice thing to have an injection. But at the same time, it is something that is prescribed for you, and you are on a CTO, so you need to take it. We use that approach otherwise if he is not on a CTO, he will go off the rails*." (Peter, p.4, lines 115-122)

The process of admitting patients to the hospital through a conveyance order was one of the most challenging aspects faced by the participants. All participants used the conveyance order as a last resort and only to safeguard the patient and others from harm. The participants did everything they could to avoid hospital admissions and felt responsible to protect the patients and their families from the trauma caused by involuntary admissions.

> *"If it is safe, we do an urgent appointment for review because we aim to keep the patient in the community. If we need to go daily to see the client, we go daily. If he needs a telephone intervention in the morning and the evening or even a home visit, we do that to prevent admission. We do understand that admission is traumatic so yes, we try to meet the patient's needs."* (Terry, p.5, lines 190-192)

The participants sometimes were directly involved in the involuntary admission, however, most of them preferred not to be present due to the negative impact on the therapeutic relationship. One of the participants Sam disclosed that every time a conveyance order is issued, she ends up feeling distraught. She feels she has failed the patient and starts to question her clinical judgment abilities. Sam's experience highlights the conflict resulting from the contradiction between her values as a healthcare professional and the compulsory powers gained through the CTO.

> *"To be honest, it happened quite a several times. I discuss with my colleagues after they [conveyance order] happen because I feel guilty that I have not done my best. I worry that I might have made the situation worse rather than better. I worry that I could have done something different, I don't know. I worry it happens a lot." (Sam, p.10, lines 317-320)*

> *"When we issue a conveyance order, the patient is very distressed. Sometimes there is even friction between us because they would know that we referred them to the hospital, and you would have built a therapeutic relationship with them, so you feel that you have let them down kind of. Because we aim to let them stay away from the hospital so when someone is admitted, it goes against what we are working for, and it is not easy." (Sam, p.11, lines 321-326)*

The aspect of stigma emerged again in both Peter and Dani's interviews. Both participants felt responsible to protect the patients and their relatives from the stigma associated with admission to the hospital.

> *"If a person needs an admission, we try to do it without intervention from the police. Because we respect the fact, that in Malta everyone knows everyone. If someone sees a police officer knocking on someone's door and taken into a police car it is not nice to anyone and we try to persuade them [the patients] to seek help early as much as possible."* (Dani, p.13, lines 375-379)

Both participants felt responsible to defend the patients' rights. Peter's vociferous response could have been a reaction to the recent incident where a nurse was presumed to have been negligent whilst on duty. He seemed resolute to want to restore the integrity of mental health nursing in the eyes of the public.

> *"Because a conveyance order is not a joke, it's quite a heavy mechanism on someone's liberty. To be able to have that power to admit someone to a hospital against their will and when we issue a conveyance order it means that the police are involved it's a delicate situation. It's not nice at all, not for*

> *the patient, not for the relatives, and even for society. It's quite scary that the state has the power to send the police to get someone and admit them to a psychiatric hospital. So, we need to reassure the patient, relatives, and society that we do not take this thing lightly. That we are careful how we use it and when we use it."* (Peter, p.7, lines 251-258)

The findings presented in the first super-ordinate team described the views of MHNs on the CTO framework and the challenges related to their role as appointed KHPs. This theme demonstrated that balancing care with control is indeed a complex endeavor.

4.4 Targeting the Challenges

The second super-ordinate theme focused on the various difficulties faced by the participants due to aspects within the care environment. Lack of involvement, limited support, and resources influenced care provision, and the participants were subjected to emotional distress. Alternatively, when they were involved and supported, they felt empowered and validated.

4.4.1 Involvement in Care Decisions

The participants accented that both themselves and the patients have limited opportunities to participate in decisions regarding care planning. Involvement in care planning decisions was inconsistent throughout the CTO process, especially during the initial CTO.

The participants described that when they are appointed as KHPs for the first time, frequently they would not know the patient and would not be involved in care planning decisions. Participants are usually informed about this new responsibility by the CN. The participants continued to explain that the referring process of the first CTO is usually rapid. The caring team at the hospital would contact the CN to appoint a nurse to act as a KHP. As required by the MHA unless there is a designated KHP, the CTO application cannot be completed and sent to the Commissioner of Mental Health for approval.

Therefore, the patient cannot be discharged or sent on leave. Since the participants are not involved in the discharge process and patients' care plan, they feel they have no other option but to do as they are told.

> *"Yes, I think that's rather difficult, certain care plans are being done without the involvement of KHP, because most CTO is elicited when the patient is still in the hospital before he is discharged. The KHP will kind of inherit that CTO with an already established care plan, not done by himself but by the hospital staff without any consultation with the KHP. So when the care plan is received by the KHP, he will have to kind of abide by whatever is written in the care plan even if these are difficult to manage."* (Peter, p.1, lines 35-41)

The participants claimed that handing over of patients can vary quite a lot since no proper handing-over process is in place. Therefore, the participants have to chase after the history and personal details of the patients when this information is lacking. To make matters worse, some patients are being placed on a CTO without having a permanent address or a telephone contact thus making it impossible for the KPH to communicate with the patient.

> *"Little information is given, so we have to do a file review at MCH. For every patient that we receive, we must do a file review because when they discharge them, we only get minimal information."* (Violet, p.2, lines 47-49)

> *"I think one of the main problems which I mentioned earlier is first of all if the person is sent on leave and he is on a CTO and is without a permanent address and a mobile number which makes it difficult to reach the patient."* (Sue, p.4, lines 95-98)

The participants dealt with these challenges by adopting different coping approaches. Certain coping strategies hinted that not being involved was such a common occurrence that it became ingrained in the participants. Benna accepted to follow what was written in the care plan without questioning anything.

> *"To be honest I have never thought that I truly have a say in the process first CTO process... when I am assigned the patient for the first time, I just receive the care plan and just read it. I say to myself these are the rules and I have to follow them."* (Benna, p.5, lines 180-185)

Alternatively, Peter felt that since being appointed as KHP was part of his job requirements he had to take on that responsibility even though his involvement in the decision-making process was limited.

> *"Yes, the reality is being a KHP for patients on CTO is our job and we are getting paid for it. As it happens, we don't tend to choose who the patients are. Some of the patients are ones we know; some are completely new. So, in that sense is kind of being imposed on us. It's like we get a call, and they say we have a patient who is placed on a CTO can you appoint someone as KHP? …We obviously can say no, if we are not sure or uncomfortable but most of the time we accept, but in reality, it's not something that we agree about. Decisions would already have been taken..."* (Peter, p.4, lines 152-159)

The interviews with Dani, Benna, Violet, and Terry were charged with a variety of negative emotions rooted in an enduring experience where their clinical judgment is ignored. Thus, they felt like passive recipients rather than active participants in patients' care. This was not limited only to the hospital context, but it compromised other settings and professionals involved in the provision of care. When a patient on a CTO went missing, Dani and Terry were subjected to the same passive reaction from the police. The police response indicates that the medical model is still very influential in the Maltese context.

> *"Because we have not mentioned the hurdle that you go through with the police. That is another stressor, we have to call the police every day, and either they do not have the papers, or they have no handing over from the other shift or just to go to knock on the patient's door they want a nurse with them. There were attempts from our end to contact the police, but it is difficult… often they do not take you seriously."* (Terry, p.7, lines 259-265)

> *"One challenge that we have is when conveyance orders are issued, and the police do not find … the person. At times we have had people that had a conveyance order for a month. We have had various issues about that, and we try to see other ways to get the message through to the police. When you tell them that the consultant is asking for the patient to be reviewed, they take you more seriously."* (Dani, p.9, lines 241-244)

Terry faced the same challenge when a patient experienced a regress in his mental state, and she summoned him to the emergency department for an urgent review.

> *"You send him (the patient) to Mater Dei Hospital for an assessment and to be admitted. However, the patient is discharged home… you feel disrespected because you did an assessment and from your professional point of view the patient required admission and your opinion and your assessment wouldn't have been respected… That does sometimes make you doubt yourself if you are in the right place or not"* (Terry, p.6, lines 214-223)

The below excerpts seem to indicate that lack of involvement, disregard for clinical judgment, and uneven power distribution could have led to subtle conflicts between various professionals.

> *"Sometimes, certain psychiatrists, think they can rule the world. It's useless to say we are a team but then you dictate everything. Saying one thing and doing another, gives misleading messages. Because if we are a team, we would all participate in the decision-making process. We give our opinions; we discuss them and then we find the best solution."* (Violet, p.7, lines 239-244)

> *"Sometimes you feel angry, and you feel you are the one most involved and responsible for the patient from all the multidisciplinary team members. However, the last time I had a case, I needed to discuss the social difficulties of a particular patient. The consultant told me" Listen B... we are here for the clinical meetings, so we only tackle mental health issues. I had to stay quiet on that day, however, I am still angry about what happened."* (Benna, p.7, lines 244-247)

According to the participants, the process of how the initial CTO is executed is central to the therapeutic relationship and patients' recovery process. Inadequate participation and ineffective communication could influence the rapport with individuals who are already reluctant to accept assistance and which may result in a hospital re-admission.

> *"That is why the initial stages are so important..., although I do not have any statistics, I think most frequently it is in the first CTO that we end up with police to convey the person."* (Dani, p.13, lines 382-384)

The participants gave multiple reasons why some of the patients resisted assistance including lack of insight and the complex and compulsive CTO’s nature. However, participants believed that the lack of opportunity to meet with their appointed KHP impacted the therapeutic relationship and contributed to patients’ resistant behavior.

> *“There will be some patients who have no idea what a CTO is. So, then you have to call them and tell them yourself. They will ask you “who are you and I do not know you” “No, No I do not need a nurse, no one told me. I just try to explain that I will be the one taking care of them whilst they are outside in the community. Then the first time we meet face to face I explain to them more about this care plan, the CTO, and legal issues.”* (Benna, p.4, lines 148-152)

It was interesting to note that Peter and Sam had a more positive experience when compared to the other participants since the psychiatrists involved them in the decision-making process. From the below excerpt, one notes that because responsibility was shared both participants took more initiative and were more willing to take calculated risks.

> *“As long as the person is not posing a risk to himself or others and you know that there is a plan in place that we can follow closely and we develop a plan with, the firm, make sure to have close contact with them I think if it is organized it can work”*. (Sam, p.16, lines 488-491)

4.4.2 Resources

The importance of resources to respond effectively to patients’ needs including the number of professionals and adequate services was evident in all the interviews. The participants voiced their concern when there was a lack of resources due to the impact on patients’ recovery process. Therefore, despite the system’s insufficiencies, the participants felt responsible to continue to provide care.

> *“In our team, we do not have a social worker, so we have to be the social worker. We are limited because we do not know what the social worker does. We do our best but even if we refer someone there is a long waiting list and it takes time. So, most of the time you have to take over to help the patient as much as possible. There is a lack of professionals in the community, which is a*

> *big problem. As you cannot look only at the mental health you have to look at them from a holistic level."* (Katie, p.15, lines 459-466)

> *"If there are certain shortages in the system, for example, I have a patient who due to his mental illness is at home and cannot engage in mainstream work or study. There aren't many alternatives for that person to have structured activities during the day. It's frustrating trying to help that patient and you know that there is nothing much to offer to meet his needs. Frustration is from the lack of services available to meet patients' difficulties."* (Peter, p.8, lines 281-286)

The participants felt that it was unjust that they were ignored when they were supposed to be involved in care decisions. However, they were allocated the responsibility to fill in the gaps in the system. Furthermore, the lack of shared responsibility generated a range of negative emotions as participants felt they were being burdened with all the care and legal responsibility.

> *"There are times when the firms feel safer to put patients on CTO because it's safer for them because they discharge them from the hospital in the hands of another health professional. This comes again when the patient is discharged early from the hospital due to a shortage of space, under CTO in the hands of a KHP. So, it is safe for the hospital to discharge them, but it is unsafe for the KHP. And that is not fair when you go to a patient, and you see that he is still psychotic. You think how the hell they discharged this patient".* (Terry, p.9, lines 368-375)

The below excerpt shows how Violet felt stripped of her dignity as a professional in her remit when she is appointed as a KHP, merely to check that the patient is keeping himself out of trouble. She felt so powerless and used that she compared herself to an animal being used in a lab.

> "At times I feel like a guinea pig in a lab!!!...they [the patients] can be troublesome and the psychiatrist may be concerned that he [the psychiatrist] may end up in court, so he [the psychiatrist] places him [the patient] on a CTO" (Violet, p.7, lines 254-259)

The participants explained that to counteract shortages in the system, patients at risk are sometimes detained on a CTO to ensure that they are getting adequate support and monitoring. Furthermore, the participants felt pressured by the system to prioritize patients on involuntary treatment over patients on voluntary treatment which is incompatible with the nursing principles.

> *"If you look at teams who have so many patients, and there are only 4 nurses to deal with those patients, that is impossible to do. You have to be selective, with whatever service you have; you give it to those patients that need it the most. But you get into the situation where how are you going to decide who gets the service and who does not*." (Peter, p.8, lines 296-300)

> *"The thing is that the person has to be discharged as soon as possible and these patients have the right to skip the waiting list for Outreach. And this is putting more pressure on us. Because the doctor tells you that he needs a KHP now. In one way or another, you have to overload the staff or yourself…Management tells you to place the Outreach patients on the waiting list"*. (Dani, p.23, lines 674-681)

4.4.3 Validation and Understanding

The participants explained that most individuals are placed on a CTO due to increased risk resulting from their mental health condition including psychosis, dual diagnosis, forensic history, and complex social situations. The participants posited that it is challenging to provide care in a community setting with limited resources to individuals with such complex needs. Frequently, they felt pressured by expectations that were impossible to achieve. Therefore, the desire for more support and understanding was evident throughout the interviews.

> *"Because if you have someone who has complex needs, and he is quite chaotic, as KHP you feel responsible to, kind of make some sort of sense out of that chaos. It might be difficult so it might put the KHP in a very difficult position trying to help a patient whose needs might be very difficult to meet in the community."* (Peter, p.1, lines 20-24)

> *"Yesterday the consultant sent me photos of a super neglected home, so it's time to put this patient again on CTO. So, what does he expect me to do, to clean the house? The demands on the KHP are impossible because you need to consider that there is a lack of social workers in the organization and the KHP is expected to be a community worker and thus that means that you must be the social worker, the psychologist, the family worker because we do the holistic thing. So, we are the ones who are expected to do miracles with the patients*." (Katie, p.10, lines 373-380)

Safety concern was evident in all interviews and this aspect triggered a lot of anxiety in the participants. The participants claimed that community settings are more unstructured compared to hospital settings thus they felt more at risk working in the community.

> *"It is a different scenario to meet a person in a ward or to meet them at home. It's a completely different thing. In a ward it's different, when you go to their home, you go there, and you are the foreigner. You do not know who is present in the house. This can be risky."* (Dani, p.18, lines 518-251)

They were worried about getting physically hurt on the job when either the patients or their relatives exhibited challenging behavior.

> *"His father called me and he was threatening me and swearing: "Why did you tell the doctor that he is not taking the treatment, are you going to provide my son with money." At that moment I felt cold, this happened on the telephone. I felt I couldn't continue to speak, I was really afraid."* (Katie, p.14, lines 404-407)

Moreover, they were concerned for patients' safety since patients in the community would be less contained and thus more vulnerable.

> *"…when you are in a ward you are in a structured setting, you have everything at your disposal, everything is there in a relatively safe place but in the community, there are so many variables. Anything can happen. They can have things they can hurt themselves with, they can run into traffic, or have tablets that they can take, they are in a vulnerable state. You cannot control much the variables…"* (Sam, p.11, lines 351-356)

In the following excerpt Terry's repeated use of the words 'suicide' and 'burden' shows that suicide is a major factor for concern. When participants cannot contact the patients, they become overly concerned for their safety and consider this an emergency.

> *"…when you can't contact the patient, it gives you hassle and panic when you know that a patient is not answering the phone. Then you go to their house and still they do not answer the door. You can't go to the police to open the door. When they have relatives somehow you can contact the relatives to come open the door, however when they do not have anyone it is hectic. Cause we get worried because it gets risky. It's risky, suicide is the number one burden on us professionals being on a CTO or not that is the number one burden, that a patient may commit suicide"*. (Terry, p.2, lines 68-74)

The participants described that at times support was provided to cope with these challenges however this was scant, inconsistent, and more available in times of crisis. However, the allocation of blame sabotaged support, especially when there were concerns about possible litigation. Therefore, the participants became troubled since a blame culture would be keener to find faults rather than providing support. One would notice that throughout the interviews the participants explained that they try to do all interventions in pairs to support each other and act as witnesses to protect each other.

> *"Sometimes when a client is found dead, and the client is of a particular firm we meet with the consultant and discuss how we are feeling about this… But most of the time you are just left there without any support. Sometimes when it is something extreme like finding someone dead, the middle management asks you if you are ok and if not to come over and talk. But then the higher management the first thing that they tell you is when was the last time the KHP has seen the patient? This blaming culture is always there and that worries you."* (Terry p.9, lines 339-346)

Terry, Dani, and Katie felt that sometimes the management fails to acknowledge the burden experienced by MHNs working in the community.

> *"The concept they know it, but the actual energy, and mindset you need to work in the community. At times they do not have the time to realize what goes on."* (Dani, p.18, lines 526-527)

Dani was so overwhelmed during the interview that she started crying. It was evident that having to cope with all the challenges with minimal support and understanding was taking a toll on her emotional well-being and perhaps she was experiencing burnout.

> *"It is tiring!!! (Crying)...Talking about it brings it up (Crying) ...In the long run, it gets to you. I must try to put myself in a better position. I have to take care of myself."* (Dani, p.23, lines 658-664)

Alternatively, Benna and Violet seemed to have lost hope that things could change for the better because their attempts to make their voices heard seemed in vain or because they were disappointed with the response they received when they asked for support.

> *"We also discussed with community management, that we need to be given the necessary information, and they are still working on this issue. However, I am afraid this issue will be tackled in about 10 years as it always takes a long time for things to happen* (laughing)." (Violet, p.9, lines 322-325)

4.5 Attempts at Maintaining Balance

The third super-ordinate theme describes how the participants adopted several strategies to cope with difficulties whilst caring for individuals on a CTO. They regarded their teams as major support structures. Team dynamics allowed for shared decision-making and shared responsibility. In addition, participants made several recommendations to help them cope with their KHP role and improve care delivery.

4.5.1 Support Systems

All participants were certain that the other team members would support them to cope with practical difficulties and daily stressors. The support from their teams was a major aspect that helped the participants to continue to provide care despite the challenges.

> *"It does affect me, it is stressful, and it is very stressful I will be lying if I said otherwise but I cope because we have a good team. We work very well together I mean I won't be able to cope if it was not for the team. We have a*

> *good team… If they need someone for a home visit, they know they will find me. On the other hand, if I need someone to accompany me for a home visit, I know that I will find them. If there is a new case, I know they are ready to take the case. It's the team, the team that makes all the difference."* (Terry, p.7, lines 274-279)

The following excerpt shows how much the participants were committed to protecting and supporting one another.

> *"And it depends on the referred case of the CTO, when it is a difficult case, we do not give it to the new nurses... If we have a patient who is psychotic, with a forensic history, we do not give them to the new nurses, usually, the senior nurses take them."* (Violet, p.4, lines 149-151)

Furthermore, Katie explained that regular team meetings organized by the CN are valuable and provide time for discussion. Thus, pointing out that good leadership skills are pivotal to effective teamwork.

> *"In the morning we discuss together, and the nurse in charge organizes meetings. So if we have further issues we have these scheduled meetings. Yes, if we have any concerns and we tell her, she organizes meetings when most staff are on duty. If we encounter a problem we can discuss and she is always there to listen to help out."* (Katie, p.11, lines 326-330)

Two participants (Dani and Katie) accented that nurses' attributes could influence group dynamics. They claimed that humbleness was an important aspect since it assisted in sharing experiences and encouraged team learning.

> *"I feel it is important that someone listens and helps to identify and come up with a plan of action. Because things can always change. So, it is important to discuss maybe we can share opinions. Even after being a long time in the service, I think it is important to discuss."* (Dani, p.18, lines 509-513)

> *"So you learn from the experience of others, a kind of reflective practice."* (Katie, p.12, line 357)

In addition, the participants explained that reflection guides them to deal with complex patient cases and situations. Thus, indicating that it is essential for them to have adequate space and time to engage in reflective practice activities both individually and in groups.

> *"So, for me finding some quiet time and reflecting. I think about what happened, what should have been done better, and how the situation could have been different, that helps me a lot …"* (Sam, p.12, lines 358-360)

Dani and Katie described that unless they kept certain boundaries it was very easy for them to become overwhelmed with work demands and for patients to become dependent on services. Alternatively, during challenging times, Benna found support from family members. Thus, indicating that maintaining a life-work balance is at times difficult. Whilst Violet stated that physical activity helped her to cope whenever she feels overwhelmed.

> *"My husband, because after a long day and when something bad happened, a very hectic situation occurred. I usually go home and speak to him, and he just listens."* (Benna, p.8, lines 279-280)

> *"Sometimes I do take some leave and some time off from work because it is important to care for your mental health. At times I go for a walk to free my mind."* (Violet, p.7, lines 263-264)

Documentation was perceived by Terry and Sam as an important aspect to safeguard themselves from possible legal actions, indicating yet again the preoccupation from this aspect.

> *"…you document everything that is very important, something that we take very seriously. We document every intervention that we carry out and doctors*

> *every feedback that we receive from the doctors. So that we are covered as much as possible."* (Sam, p.15, lines 455-458)

The participants felt more supported when patients' relatives were active participants in patients' care, to the point that when patients either refused or had no relations, the participants became discouraged and preoccupied. Alternatively, when relatives were present in patients' lives the participants felt assured that relatives would provide regular feedback and inform them of any risk.

> *"When there are no relatives, it is a different story. In a particular case, he does not have any family members so I am more worried about him."* (Kate, p.9, lines 253-254)

> *"So, these people will be central aspects of patients' life. So, I do feel it is important for me to communicate with them. Mostly it's helpful that there are relatives. For the relative, it is nice that they have a professional staff that they can call if they are concerned about something or they need to ask something, etc… But for me it is a good source of information, sometimes the patient might not tell you everything that is going on or there will be things that they might not inform you about, but relatives will notice things that patients will not."* (Peter, p.5 lines 165-173)

4.5.2 Hear Us Out

Ultimately it was evident that the participants yearned for changes to the current CTO procedures. They asked for more support and validation to deal with challenges, protect their mental health, and improve care outcomes for individuals on CTO.

All participants explicitly re-confirmed the need for patients, relatives, and themselves to be involved in all stages of the care planning process. Particularly, in the initial CTO where most difficulties are encountered. The participants claimed that meeting with their patients before they are discharged could lead to better care outcomes, enhance the therapeutic relationship, and improve risk assessment.

> *"…in my experience, I have learned that when you meet someone in the review and you get introduced and you meet with the relatives in front of the whole team, I think it helps them. They would know we are part of the same team; we have the same care plan, and we will continue to work together even when we are outside the hospital. I think the patient will feel more reassured in that way. Obviously, he would have established a relationship with the in-patients' team. So, seeing us working with them might help to improve our quality of care when they are in the community."* (Sam, p.2, lines 45-52)

The participants claimed that due to ineffective communication between inpatient and outpatient settings, they were struggling to fulfil the obligations of their role as KHPs. Therefore, they recommended a structured procedure where the KPH would be notified with important information such as discharge or leave permission dates, changes in treatment plans, and risk factors.

> *"It's like we have two systems. One in, one out but no bridging. There is a need for better communication"*. (Violet, p.9, lines 326-327)

Peter suggested that the Office of the Commissioner for Mental Health adopts a more direct role in the CTOs' process to observe patients' situation and monitor for any misuse of CTOs.

> *"…I find the office of the commissioner is a bit too robotic and is more concerned about making sure that there are all the right papers in place, all signatures than what is actually going on in that patient's life, or patient's care. They don't really go into it. Why I don't know, could be that it is not their remit either. So not sure exactly but there is minimal contact with the commissioner. I would find it good practice if they get more involved in what is actually going on when a patient is on CTO"*. (Peter, p.5, lines 181-187)

The difficulties encountered by the participants, when they asked for police assistance during conveyance orders, were prominent in the interviews. The lack of cooperation and consideration from the police somewhat hindered the work of the participants. Thus, Dani and Terry suggested the need for police officers to enhance their awareness of mental health. Participants hoped that the police would be more willing to assist the KHPs to deal with difficulties and emergencies if they would be more knowledgeable on such issues.

> *"Maybe through meetings between psychiatric services and police services. Because police need more education on mental health problems. I believe their knowledge is limited and it might be one of the reasons that they take it lightly in conveyance orders… you can note a different response from those who are more aware of mental health issues."* (Dani, p.21, lines 612-617)

Ultimately, to cope with the emotional burden the participants preferred they would receive psychological support from outside the system. Thus, highlighting once again their lack of hope in the system. All the participants considered clinical supervision necessary to carry out the responsibilities and cope with the difficulties of their role.

> *"Since we work in a stressful and hectic environment, we do need psychological support. How can you be strong psychologically strong all day long, how can you do it? When you are facing these hectic situations every single day. So, if there is a walk-in service where you can go and speak to someone...A separate service from the organization as you will feel more comfortable speaking about any situation."* (Benna, p.8, lines 288-295)

> *"I think it would be helpful, to have clinical supervision… I think formal supervision is essential."* (Peter, p.9, lines 329-330)

4.6 Conclusion

Three super-ordinate themes emerged from the data analysis of this study. The first super-ordinate theme "Paving through Responsibilities" described the conflicts between care and/ or control and the importance of the therapeutic relationship with the CTO's framework. "Targeting the Challenges" focused on the challenges faced within the care context. The last super-ordinate theme "Attempts at Maintaining Balance" explored the participants' coping mechanisms and their recommendations to improve present CTO practices. Therefore, this chapter enhanced the understanding of the lived experience of MHNs whilst caring for individuals on a CTO.

The next chapter will present a discussion of the findings in relation to theory and existing literature.

CHAPTER 5. DISCUSSION

5.1 Introduction

This chapter provides a dialogue between the results of this study and my interpretation alongside existing literature and the "Person-Centred Nursing Framework" (PCNF) (McCormack & McCance, 2016).

This study focused on the lived experiences of MHNs caring for individuals detained on a CTO. This enabled the researcher to explore the views of MHNs on the CTO's framework. Another objective of this study was to identify challenges faced by MHNs and how care provision is influenced by these challenges. Moreover, the researcher wanted to explore how MHNs dealt with these challenges and identify how they can be supported to cope with the responsibilities of their role.

The results derived from the study are discussed alongside existing literature and my interpretation of the results as per Smith et al. (2009) recommendations.

Although the focus of the literature review was on Mental Health Nurses (MHNs), the identified literature yielded results from the mixed experiences of service users (patients and relatives) and service providers (various mental health professionals and members from regulatory bodies) highlighting a gap in research. The literature review was based on clinicians' experiences rather than solely MHNs due to a lack of available studies. Therefore, the data derived from the present study will contribute to the existing literature due to its focus on the experience of MHNs.

Furthermore, it seems that since the introduction of CTOs in 2012, no local studies have been conducted to explore MHNs' experience appointed as KHPs for individuals on CTO even though nurses are usually appointed as KHPs. The qualitative approach of this study offers an in-depth account of the experience of MHNs caring for individuals on CTO.

Light et al. (2017) claim that the usefulness of CTOs is affected by the system in which these exist and if the system is dysfunctional, it will not make up for their negative effects but can aggravate them. Since this study explored the views and challenges faced by local MHNs it evaluates present practices and offers guidance for changes and the introduction of new practices. Eventually, nurses may feel more supported to cope with encountered challenges which ultimately will influence the quality of care offered to patients on a CTO.

A comparison of the findings from the extant literature in Chapter 2 and the findings from the present study are presented in Table 5.1

Table 5.1 The experience of Mental Health nurses caring for Individuals detained on a CTO: comparison of findings in the existing literature and the present study.

Findings from extant literature	**Findings from the current study** ***Aspects emerging from the superordinate theme 'Paving through Responsibilities'.***
	Juggling between Care and Control.
Studies participants considered the CTO a measure to provide care, especially when patients refuse treatment due to a lack of insight into their mental health condition (Francombe et al., 2018; Lessard-Deschenes & Goulet., 2021; Stensrud et al., 2016; Stuen et al., 2018).	The participants considered the CTO's framework as a platform where patients who are reluctant to accept care, due to their severe mental health problems can access needed assistance.
Case managers expressed ethical discomfort when they had to balance the coercive aspect of the CTO with possible treatment benefits. They felt that this challenged the caring values of the nursing profession (Francombe et al., 2018).	The participants faced ethical dilemmas when they had to execute the role of enforcer. Especially when the patients refused treatment due to lack of insight and therefore had to enforce treatment. The participants found it challenging to balance respect for patients' autonomy with the responsibility to safeguard them when their judgment was impaired.
The moral language in this study revealed that to deal with ethical dilemmas, some of the participants empathized with patients. Whilst others used many arguments to justify its use and ended up using threats and deals (Lawn et al., 2015).	The participants used various methods to cope with the ethical dilemmas. Some tried to empathize with the patients, and some were guided by the principles approach to ethics. Whilst one of the participants resorted to using covert coercive tactics.
The participants in this study described the legal responsibility as challenging and undesirable and felt that the legal responsibility influenced their clinical judgment. (Lessard-Deschenes & Goulet, 2021).	The participants felt pressured by the legal responsibility and felt challenged with having to choose between patients' right to refuse treatment and making sure patients took treatment.

	Therapeutic Relationship is Key.
The nurses described the therapeutic relationship as the most important aspect of mental health nursing. A good therapeutic relationship assisted their work with patients (Lessard-Deschenes & Goulet, 2021).	The participants claimed that the therapeutic relationship remains essential to engage with patients, especially in the CTO context.
Nurses emphasised that nursing skills are more important with persons detained on involuntary treatment since these can ameliorate care outcomes (Lessard-Deschenes & Goulet, 2021). The care providers in these studies tried to direct any conflicts about treatment to the decision-maker so that they could focus more on their caring responsibilities. Others attempted to resolve the dilemma between care and control by allocating treatment and administrative responsibilities to different professionals (Francombe et al., 2018; Stensrud et al., 2016; Stuen et al., 2018).	The participants highlighted the importance of the personal attributes of the nurse and claimed that providing care will be futile unless trust is achieved. To safeguard the relationship the participants tried to distance themselves from the coercive aspect of the CTO and directed conflicts about treatment to the psychiatrist.
	Aspects emerging from the superordinate theme 'Targeting the Challenges'.
	Involvement in Care Decisions.
The participants in this study valued the initial contact with patients due to the positive effect on the therapeutic relationship (Stuen et al., 2018). This study showed that work cultures focused on risk, influenced care decisions, and led to blaming behavior (Dawson et al., 2021)	Lack of communication and involvement in decisions, during initial contact were deemed detrimental to the therapeutic relationship and patients' recovery process as patients found it more difficult to engage in care. Due to the presence of a blaming culture within the local mental health settings, to safeguard themselves from possible litigation and blame, the participants focused more on legal responsibilities than care responsibilities.
	Validation and Understanding.
Negative work cultures created conflicts and impacted professionals 'relationships (Lawn et al., 2015)	Lack of validation and understanding resulted in subtle conflicts between different professionals.

	Resources.
Although CTOs were viewed to be beneficial for those patients who have difficulty accessing services, participants pointed out that a lack of system resources could lead to more restraining or insufficient care (Light et al., 2017).	The participants claimed that the lack of resources could influence the patient's recovery process. They pointed out that to counteract insufficiencies in the system and ensure patients' safety and provision of adequate care, more patients are detained on a CTO.
	Aspects emerging from the superordinate theme 'Attempts at Maintaining Balance'.
	Support Systems.
The participants described how regular team discussions and critical reflection improved care practices and enabled calculated risk-taking through shared decision-making (Stuen et al., 2018)	Participants claimed that support provided by team members enabled them to cope with challenges and explained how self-reflection and team discussions helped them to cope with complex situations.

The contents in Table 5.1 demonstrate that the results of the present study supported the extant literature by providing a comprehensive exploration of MHNs' lived experiences whilst caring for individuals on a CTO.

In the next section, the "PCNF" (McCormack & McCance, 2016) will be described since it will be used for the discussion of this chapter.

5.2 The Person-Centred Nursing Framework

The PCNF developed by McCormack and McCane in 2006 is utilised in this chapter's discussion.

The framework consists of four constructs including "prerequisites", "care environment", "person-centred processes" and "person-centred outcomes" (McCormack & McCance, 2016).

The emphasis of the first construct "prerequisites" is on the nursing qualities and skills. Effective interpersonal skills, professional competency, dedication, and authenticity are pivotal to building good therapeutic relationships and providing effective care.

The “care environment” focuses on how team composition and dynamics, decision-making processes, and culture of organizational systems can affect the delivery of care. According to McCormack (2004), the type of leadership style used in the workplace will constrain or enhance processes leading to person-centred care.

The next construct “person-centred process” highlights service users’ partnership in care and skills utilised by nurses to engage with their patients. This construct accents nurses’ “sympathetic presence” where nurses take into consideration patients’ values and beliefs to enable patients to participate in their care as much as possible. It promotes individual and holistic care and emphasizes respect for patients’ rights and persons’ self-determination.

The last construct “person-centred outcomes” focuses on the results attained through person-centred nursing. McCormack and McCance (2006) posit that positive outcomes are achieved when patients are satisfied with the provided care and care providers feel valued and supported within ‘healthful’ working cultures.

Hence, this nursing framework was utilised in this chapter as it challenges the coercive aspect brought about by CTOs as the framework’s focus is on patients’ autonomy. Nurses face various challenges when caring for individuals on a CTO, the PCNF highlights the importance of nursing abilities to make decisions and provide care within different care contexts whilst keeping the patient at the centre of the caring process. The framework also acknowledges that care provided by nurses is heavily influenced by characteristics within the care environment and will ultimately affect care outcomes (McCormack & McCance, 2016).

The next section discusses the findings of this study in relation to the existing literature.

5.3 Balancing Care with Control

"Balancing Care with Control" explores the ethical dilemmas, legal responsibilities, and therapeutic relationship difficulties encountered by the participants of the present study in relation to the existing literature.

5.3.1 Ethical dilemmas

Participants including nurses and other clinicians in various studies (Francombe et al., 2018; Lessard-Deschenes & Goulet, 2021; Stensrud et al., 2016; Stuen et al., 2018) considered CTOs as measures to support, safeguard and ensure treatment adherence for those patients who are unable to accept and access care due to severe and complex mental health problems. Nonetheless, participants had to deal with ethical dilemmas caused by the coercive aspect inherent to CTOs' framework. They described that combining care with coercion was challenging for them since the compulsory powers gained through the CTO were inconsistent with the caring aspects of their profession. Participants described how ethical dilemmas emerged when patients had no insight into their mental health condition and they refused to comply with treatment (Francombe et al., 2018; Stuen et al., 2018). Hence, participants had to choose between protecting patients' autonomy and possible treatment benefits. Participants dealt with ethical dilemmas differently. Some felt uncomfortable and continued to question the values of their profession and compared the use of coercion to the role of an "executioner". Whilst others viewed coercion as a "necessary evil" (Lessard-Deschenes & Goulet, 2021). Others considered coercion as part of their job responsibility to ensure patients remained well (Francombe et al., 2018).

The results of the present study concur with the above findings. All the participants considered the CTO framework as a safety net for patients with complex mental health problems. Participants explained that when they are appointed as KHPs they identified more with the caring role rather than the role of enforcers.

Similar, to extant research, ethical and practical difficulties resulted when patients refused treatment. One participant (Violet) used the following metaphor to describe her experience with having to balance care and control, *"It is like having a knife cutting from both sides, you have to choose what is best for them even if the patient does not agree due to a lack of insight. You have to explain to him, but this remains difficult for us."* (Violet, p.3, lines 79-81).

Stensrud et al. (2016) claim that overt focus on medication adherence and lack of insight might encourage paternalistic approaches to care, which could be detrimental to the therapeutic relationship. Furthermore, Snow et al. (2009) claim that it is difficult for mental health professionals to balance respect for patients' autonomy while trying to safeguard them when patients are unable to make and comprehend the consequences of their decisions. However, they advised mental health professionals to be vigilant and not to resort to paternalistic approaches to care, especially in involuntary care contexts such as the CTO.

In their study about coercion, Molewijk et al. (2017) found that professionals who are exposed to coercive measures are more prone to accept coercion as a necessary aspect to deliver care and ensure safety. Therefore, they could develop a normative outlook toward the use of coercive measures.

The discourse used by one of the participants of the present study pointed to a paternalistic approach to care. Whilst asserting her beliefs on the respect for the patient's autonomy she kept contradicting herself by simultaneously mentioning covert coercive tactics to convince the patient to take his medication, *"…he is adamant that he does not want these side effects. That is why we continue telling him the importance to take his treatment otherwise the last option would be to take depot medication…We try to reinforce that…"* (Dani, p.6, lines 163-167).

Dani's behaviour could have resulted from the legal obligation of the CTO framework to enforce treatment. However, one cannot overlook the fact that all the participants of this study regarded treatment as an essential aspect for patients to remain well and avoid hospitalization.

Furthermore, the participants of this study tried to protect the patients from the coercive aspect by using empathy and encouraging them to focus more on their recovery process. To cope with ethical dilemmas, the participants of Lawn et al. (2015) study adopted the same approach.

Participants in the qualitative study by Francombe et al. (2018) viewed the CTO as the least restrictive option. Therefore, they preferred that patients would rather be on a CTO than be admitted involuntarily to the hospital. Alternatively, three participants (Peter, Terry, and Violet) of this study opposed the fact that to make up for insufficiencies in the system and ensure follow-up of patients with complex needs, some patients are placed on a CTO. Moreover, they encouraged those patients who preferred to remain on a CTO, to adopt other coping mechanisms to remain stable such as focusing on their rehabilitation process. Protecting patients' rights was a responsibility they took seriously, especially when the CTO was not revoked due to fear of possible risk and relapse even if patients were stable for a long time.

Moreover, participants of the present study mentioned they were guided by the principles approach to ethics to deal with ethical concerns, indicating that they faced similar ethical dilemmas found in the extant literature. Thus, it was difficult for them to try to strike a balance between respecting patients' autonomy and meeting their clinical responsibilities. Indeed, Francombe et al. (2017) claim that it is difficult to provide care for patients who lack insight. Dawson et al. (2016) recommend relating the CTO goals to the patient's goals to promote collaboration in care planning and enable person-centred care.

However, the ethical dilemma related to the compulsion aspects of the CTO whilst still considering that these are essential (Francombe et al., 2018) was more evident in the present study. Participants accented that admitting patients through a conveyance order was a very challenging aspect. They tried to avoid it at all costs and used it only when there were safety concerns. One of the participants (Sam) disclosed that when a conveyance order is issued, she feels she has failed the patient, feels distraught, and starts to doubt her clinical judgment. Stigma toward mental health problems is still significant in Malta; therefore, this could have amplified this ethical dilemma. The participants clearly showed their concern for the trauma experienced by the patients and their relatives, and the stigma associated with the hospital admission process. This is evident in Dani's account, *"If a person needs an admission, we try to do it without intervention from the police. Because we respect the fact, that in Malta everyone knows everyone"* (Dani, p.13, lines 375-377).

5.3.2 Legal responsibility

Lessard-Deschenes and Goulet (2021) found that due to the legal responsibility inherent to involuntary treatment orders, nurses feel pressured to ensure treatment compliance when patients refused medication. The nurses explained that the legal responsibility placed them in a difficult position and described it as complex and undesirable since it influenced their clinical judgment. Similarly, the participants in this study felt pressured by the legal obligation and were challenged with having to choose between patients' right to refuse treatment and making sure patients took treatment. One participant highlighted the burden of the legal responsibility and accented, *"…you tell the patient that you understand his views, but still, he needs to take the prescribed treatment. It is awkward that you have to tell him to take it (the treatment), but in the long run, we are responsible..."* (Violet, p.2, lines 66-67). Another finding, which concurs with the results of Lessard-Deschenes and Goulet (2021) study, is that the participants felt that they had the social and legal responsibility to manage risk to ensure everyone's safety.

However, in the present study, it was evident that fear of possible litigation and concerns of being blamed influenced care decisions. These findings coincide with Morrissey and Higgins (2019) study results, regarding the legal concerns experienced by MHNs. The results of this latter study showed that MHNs worked in persistent fear of having to face legal proceedings.

To safeguard themselves, the participants of the present study focused more on their legal responsibilities rather than their caring role.

This aspect was identified in the present study by metaphors used by participants, "*You have the legal aspect behind your neck, so you need to be careful that you see these patients regularly"* (Terry, p.1, lines 21-23) and by phrases "*We think and care for the patient, but we are worried legally"* (Terry, p.6, line 233). The preoccupation about possible litigation and blame may have been influenced by a recent incident where a nurse was accused of negligence in the workplace. However, work procedures and communication styles adopted within the care context could have contributed to this persistent preoccupation.

Hallam (2002) accents that if an incident occurs and it involves individuals with mental health problems the repercussions for those involved are high. Such situations are compounded by media reports which intensify public concern and urge the use of restrictive care practices. Moreover, Hannigan et al. (2018) claim that aspects within service contexts such as different approaches to care within teams, time constraints, limited bed space, and concern about political and media reactions to incidents can influence clinicians' care decisions. In fact, during the interview, with Dani, I could tell from her facial expressions that she dreaded unwary circumstances involving the patients. Her concerns stemmed from possible negative public and media reactions and the presence of a blaming culture within the work setting. She claimed, *"I try not to worry, but certain things, if not at the front stay at the back of my mind. Then you listen to the media. The media is always against you… It is very tiring"* (Dani, p.24, lines 705-708).

Therefore, the system's practices, culture, and perceptions of broader structures could have led the participants to focus on their legal responsibilities to safeguard themselves from possible litigation.

Another aspect that emerged from this study was that participants perceived community settings as more unstructured when compared to hospital settings thus they were concerned for their safety and increased risk to patients. The participants adopted various measures to try to ensure patient safety, prevent incidents and feel safer. They restored to constant monitoring, rumination, and doubting their clinical judgment, which took a toll on their emotional well-being and risked their rapport with the patients.

In the literature, this excessive degree of monitoring is described as “therapeutic stalking” (Graham, 2006, p.41). Geller et al. (2006) claim that this behavior is related to the perceived lack of social control in community settings and argue that the therapeutic effect of excessive monitoring is difficult to determine. In fact, two of the participants (Benna and Katie) risked jeopardizing the nurse-patient relationship.

5.3.3 Safeguarding the therapeutic relationship

Participants in Lessard-Deschenes and Goulet (2021) study describe the therapeutic relationship as pivotal in working with patients with mental health problems, especially in compulsory treatment frameworks. The nurses claimed that patients’ cooperation within compulsory frameworks is influenced by the quality of the therapeutic relationship. Other nurses claimed that the CTO offered the opportunity to build relationships with those patients who would be difficult to reach due to the severity of their mental illness.

Likewise, the participants in my study established that unless a therapeutic relationship is formed, any nursing interventions would be futile. The findings of the present study echo the findings of Stuen et al. (2018) study. Participants in both studies claimed that the most challenging period is the initial CTO. Participants also claimed they needed to invest more time and had to persevere to build rapport with patients who would be reluctant to accept care.

In their study within ITO contexts, Lessard-Deschenes and Goulet (2021) found that all patients were dissatisfied with the therapeutic relationship. The researchers claimed that nurses might believe that rapport is established when in fact patients would only be conforming. In contrast, the participants in my study were aware that some patients conformed to their care plan due to being on a CTO and because they were afraid of being re-admitted to the hospital. One of the participants (Terry) tried to empathize and repeatedly reassure patients, *"They accept you because you are legally appointed, they do everything you say, or they say they are doing it or taking treatment just because they are afraid… So, you explain again and again… we are not going to put you in hospital…"* (Terry p.4, lines 140-143). However, one of the participants (Peter) attributed difficulties within the therapeutic relationship more to a lack of insight rather than to the patients feeling coerced. Thus, this points to a need for ongoing critical reflection to encourage professionals to challenge their perceptions of coercion and its influence on the relations between them and their patients (Lawn et al., 2015; Molewijk et al., 2017).

Furthermore, the participants in my study were explicit in pointing out the influence of nursing skills, personal attributes, and nursing experience on the therapeutic relationship. Two of the participants emphasized that *"It is very important, and not the experience only but your character, you have to be careful how you present yourself. If you are going there with a certain attitude, you say listen I am the boss and, it's not going to be a nice relationship…"* (Dani, p.15, lines 428-423) and *"It all depends on how you portray yourself as a nurse, because if you show them that you care… even though she seems reluctant to engage.* (Benna, p.3, lines 105-107).

The prerequisites of the nurse are highlighted in the PCNF (McCormack & McCance, 2006). Nurses use interpersonal skills, professional competence, reflection, and self-awareness to make decisions and provide care to patients. By focusing and engaging authentically with patients, nurses can respond to the patient's needs in their situations. These attributes promote a positive rapport and support individuals to cope with difficult situations. Therefore, the person-centred framework approach to care is particularly relevant in the multi-layered and challenging context of CTOs.

Furthermore, it was noted that the participants acted as advocates in various situations especially when family relations were negatively affected by the adverse consequences of mental illness. The participants narrated various patients' experiences and explained that despite severe mental health problems such as psychosis, substance misuse, and complex social situations recovery was possible through the various nursing interventions. Furthermore, participants claimed that frequent contact, being present in times of crisis, and offering comprehensive support provided opportunities to engage with patients.

The PCNF describes the nurse's ability to be sympathetically present to engage with patients which is an important aspect of the nursing profession. Even though nurses do not experience the same patients' situations, they will seek to understand what the particular experience means to each individual to help them achieve their potential. Therefore, such positive experiences seem to demonstrate that despite ethical struggles and challenging work contexts, the participants in this study were trying to comprehend service users' difficulties whilst attempting to meet their needs through the provision of person- centred care or rather person-centred moments (McCormack & McCance, 2016).

It was interesting to note how the participants in the present study tried to safeguard the therapeutic relationship from the negative effects of the coercive aspects, particularly when having to ensure treatment compliance and carry out conveyance orders. They adopted approaches similar to those used by participants in several studies (Francombe et al., 2018; Stensrud et al., 2016; Stuen et al., 2018). Participants preferred to take the passive role and directed any conflicts with treatment to the administrator (doctor). One of this study's participants (Peter) and the patient's psychiatrist agreed to adopt different roles to encourage treatment compliance. The psychiatrist took the role of the administrator whilst the participant acted as a link between the patient and the psychiatrist. These echo the findings of Francombe et al. (2018) study where the participants distanced themselves from the CTO by embracing the clients' perception that case managers are "crewmen for doctors" (Francombe et al., 2018, p.126).

The findings from the present study confirm that the therapeutic relationship remains the cornerstone of mental health nursing and is essential in the treatment of mental health illnesses (Peplau, 1997). The participants of this study specifically explained how ineffective communication and lack of involvement in the initial CTO are detrimental to the therapeutic relationship, which concurs with the findings of Stuen et al. (2018) study. The participants in the latter study recognized that the initial encounter with patients was essential to building trust and good therapeutic relationships, particularly for individuals who are already reluctant to accept care. Therefore, to facilitate this process it is recommended that initial contact between KHPs and their patients is given due importance by allocating adequate time and space to enable the formation of a therapeutic relationship.

5.4 Care Environment

“Care Environment” discusses the difficulties faced by the participants within the care context of the present study and tackles their supportive strategies in relation to the existing literature.

5.4.1 Limited Involvement and Support

The participants in this study accented that opportunity to be involved in care planning decisions was restricted for them and the patients throughout the course of the CTO, especially in the initial CTO. Communication about important aspects such as personal details, psychiatric history, and risk assessments was lacking thus the participants had no choice but to chase after the information themselves. Findings also suggest that the biomedical model is still very relevant in the local mental health scene since care decisions were mostly taken by psychiatrists and were based on “insight”. Research showed that the medical model gives a lot of importance to “insight” which can result in reduced opportunities for recovery and can lead to negative judgments and a focus on weaknesses rather than on patients’ strengths (Dawson et al., 2018).

The present study’s participants adopted different coping mechanisms to cope with these challenges. One of the participants (Benna) abided by the care plan instructions. Another participant (Peter) accepted the responsibility of being appointed as KHP without any objections as he viewed this role as part of his job. Whilst interviews with three participants (Dani, Violet, and Terry) were charged with a gamut of negative, emotions rooted in an enduring experience where their clinical judgment was repeatedly ignored.

Situations became more complicated when some patients were discharged from the hospital on a CTO only to ensure that somebody is merely checking on them or because there were not enough bed spaces. The participants thought that it was unjust that they are not being involved in decisions but are being allocated the responsibility to make up for deficiencies in the system. The lack of shared responsibility left them feeling powerless and burdened with all the care and legal responsibilities. One of the participants claimed, "At times I feel like a guinea pig in a lab!" (Violet, p.7, line 254) indicating that she might be feeling that she is not being valued as a professional by the system and thus compared herself to an object of experimentation.

Furthermore, lack of involvement, disregard for clinical judgment, and uneven power distribution led to subtle conflicts between professionals. This corroborates the results of Lawn et al. (2015) study, where the effects of negative work cultures were affecting professional relations and clinical supervision was being seen as having a disciplinary schema.

Dall' Ora et al. (2020) claim that research consistently establishes that negative job characteristics including low job control, high job demands, and negative relationship between professionals are related to burnout in nursing. This research sheds light on why the participants of the present study exhibited such negative reactions related to the context of care.

McCormack and McCance (2006) posit that although the prerequisites of nurses are important aspects of the person-centred framework, these are influenced by the organizational procedures and culture. The researchers claim that systems that enable shared decision-making, encourage communication and supportive relationships between staff and management, provide workers with learning opportunities and facilitate person-centred processes. However, the findings of the present study seem to illustrate that aspects within the care context may be hindering 'healthful cultures' and negatively influencing both care providers and service users and thus limiting the provision of person-centred care.

The present study also indicates that the participants had to deal with challenges present in the wider mental health system. When two of the study participants (Dani and Terry) asked for assistance from the police during conveyance orders both were subjected to the same passive reaction. Moreover, Terry experienced a disregard for her clinical judgment when she summoned a patient to the emergency department. The negative and dismissive attitudes of other professionals point to stigma related to the mental health profession and to a local culture, which supports a medical model of care. These aspects seem to amplify difficulties for MHNs to manage psychiatric emergencies.

On a more positive note, two of the study participants (Peter and Sam) took more initiative and were willing to take calculated risks since they were involved in the decision-making process, and responsibility was shared among various mental health professionals.

Indeed, the effectiveness of person-centred nursing depends on the weaknesses and strengths of the care environment (McCormack & McCance, 2016).

5.4.2 Lack of Resources

Research demonstrates that lack of adequate services within the system results in clinicians restoring to using CTOs to guarantee care for patients with complex needs. Although adopting this strategy is considered an effective way to engage both patients and the system there are concerns about coercive approaches. Moreover, research indicates that if resources within the system are restricted, the care offered in the community will be limited even if patients are detained on a CTO (Haynes & Stroud, 2022; Light et al., 2017).

The findings from the present study compared to the extant literature as the participants voiced their concern about the continued or prolonged use of CTOs. Moreover, participants were concerned that a lack of resources such as health professionals, hospital bed space, and community rehabilitation services would be detrimental to patients’ recovery process. Therefore, the participants felt responsible for continuing to provide care despite lacking resources. Indeed, MacNeela et al. (2010) accentuate how finances, organizational aspects, and different policies influence MHNs' practices, frequently placing nurses in reactionary positions where they must improvise and adapt to changes.

Nonetheless, the participants of the present study claimed that their nursing values were challenged since they were pressured by the system to prioritize patients on involuntary treatment over patients on voluntary treatment. Similarly, the participants in Lawn et al. (2015) study claimed that they felt pressured to conform to the practices adopted within the system.

Furthermore, the participants of this study felt pressured by expectations they considered difficult to achieve. This was highlighted by a phrase used by one of the participants (Katie), "…we are the ones who are expected to do miracles with the patients" (Katie, p.10, line 380). Such work demands exerted more pressure on the emotional well-being of the participants.

Although the participants wished that psychological assistance is readily available for them to deal with the psychological burden, they preferred to receive psychological assistance outside of the system, re-confirming distrustfulness in the system. Thus, highlighting once again the importance of systems that support and value care professionals (McCormack & McCance, 2016).

5.4.3 Focus on risk

The findings from a qualitative study by Dawson et al. (2018) indicated that when care environments prioritized risk, clinicians found it challenging to focus on patients' recovery. Furthermore, the focus on risk influenced the allocation of responsibility. Clinicians' responsibilities focused on monitoring, managing risk, and attending to the general needs of patients. Patients had to abide by treatment and relatives had to ensure treatment compliance. Moreover, the blame culture negatively influenced relationships at the individual and system levels.

As discussed in the previous sections, aspects within the service context where the present study was conducted seem to have influenced care decisions. The participants were inclined to focus more on legal responsibilities. In addition, the blame culture contributed to the complexity of this aspect. Hence, participants' descriptions of the local care contexts might indicate that care planning within the local mental health settings is focused on risk.

One of the participants (Terry) claimed that when an incident happens, such as a death by suicide, the system does offer some support however it would be sabotaged by behaviors inclined to faults finding, "*…the higher management the first thing that they tell you is when was the last time the KHP has seen the patient? This blaming culture is always there and that worries you"* (Terry p.9, lines 343-346). This further indicates why the participants felt vulnerable and were constantly concerned and to safeguard themselves they focused on legal responsibilities.

Subsequently, these experiences left this study's participants thinking that the system is underestimating the difficulties experienced by nurses working in the community setting. Thus, they felt unsupported, disillusioned, and disheartened that their situation will improve which further affected their emotional well-being. This was evident when one of the participants (Dani) started crying during the interview, "It is tiring! (Crying)…Talking about it brings it up (Crying)…In the long run, it gets to you." (Dani, p.23, lines 658-663). Furthermore, two study participants (Terry and Sam) obsessively mentioned documentation to safeguard themselves from possible legal actions. Participants also explained that community interventions are done in pairs not only to support each other but also to act as witnesses in the eventuality of litigation.

Findings from McTiernan and McDonald (2015) study on stressors, burnout, and coping mechanisms between hospital and community psychiatric nurses revealed that nurses identified lack of resources, workload, organizational practices, and cultures as key stressors. Participants experienced more stress and decreased self-esteem and self-efficacy due to organizational issues rather than client issues.

One notes how the psychological burden experienced by MHNs kept emerging in my study.

A systematic review (studies n= 91) on burnout in nursing by Dall' Ora et al. (2020) identified high workload, indifference to one's values, limited control over own work, lack of involvement in decisions, ineffective work relationships and support, minimal rewards as predictors of burnout. Other predictors of burnout included time pressures, high job and psychological requirements, low task diversity, role conflict, low independence, poor support from supervisors, ineffective leadership and team relations, poor nurse-physician relationship, and job insecurity.

The current study identified that challenges experienced by MHNs caring for individuals on a CTO stemmed from the complexity of their role, patient-related difficulties, lack of resources, and organizational issues. If these findings are compared to the extant literature, there is the possibility that participants from this study may be at a higher risk of burnout. Moreover, a recent local quantitative study by Scerri et al. (2022) supports the present study's findings. Findings from the latter study indicated that nurses experienced some degree of stress (37.5%), anxiety (50%), and depression (35%) respectively at baseline. Burnout scores showed that nearly half of the study participants experienced emotional exhaustion (55.8%) and felt withdrawn from work (52.5%) at baseline. Most of the participants of the latter study worked in acute or chronic inpatient settings, hence further research is recommended to evaluate the level of burnout and its impact on the well-being of MHNs working in local community settings.

5.4.4 Support Factors

Shared decision-making, collaborative staff relations, and effective leadership are important aspects that promote positive care outcomes (McCormack & McCance, 2016). Furthermore, study results from Dall' Ora et al. (2020) claim that supportive and good working relations at the workplace might protect from burnout.

Thus, the present study's findings extend the existing literature's results. Participants of this study described that the support they received from other team members helped them to cope with practical difficulties and daily stressors. This aspect served as a protective factor and assisted the participants to continue to provide care despite all the challenges. One of the participants (Terry) claimed, *"It does affect me, it is stressful, and it is very stressful I will be lying if I said otherwise but I cope because we have a good team… It's the team, the team that makes all the difference"* (Terry, p.7, lines 274-279).

Moreover, participants felt supported by regular team meetings as they provided a learning space to share experiences and make decisions. One of the participants (Katie) deemed the approachable attitude of the CN as supportive. Two participants (Dani and Katie) considered humbleness as pivotal to effective team relations since it facilitates learning and decision-making. Whilst (Dani and Katie) claimed that keeping, boundaries helped them to cope. Indicating again the importance of nursing prerequisites for nurses to be able to communicate in numerous ways and cope with challenges in their everyday work (McCormack & McCance, 2016).

All participants claimed that reflection guided them to deal with complex situations. However, they tended to engage in reflection individually rather than in groups. The PCNF posits that self-reflection helps nurses to develop their self-awareness and enhance their interaction with others. However, nurses must be willing to give and receive feedback from others to continue to grow both as persons and as professionals (McCormack & McCance, 2016).

Moreover, the study by Stuen et al. (2018) accentuated the advantages of reflective practice within teams. Participants in the study by Stuen et al. (2018) claimed that critical reflective sessions within their team helped them to change their care approaches from being focused on treatment to a more holistic one. Thus, the need for approaches that promote critical reflection in local mental health settings is recommended.

Findings from extensive research on relatives' experiences, when their family member is on a CTO, show that relatives feel responsible for the patient. However, they sense a lack of acknowledgment from mental health professionals for their input in treatment plans (Schaffer, 2020; Stensrud et al., 2015).

Contrary to the extant literature, the participants of this study considered the relatives as partners in care and regarded their contribution as valuable since it assisted them to manage the challenges of this group of patients. This divergence may reflect the Maltese culture since the Maltese population greatly values family relations. Furthermore, local mental healthcare services recognize relatives’ contributions as essential to improving care outcomes (Cachia, 2006). In a study focusing on local nurses’ views on the development of the nurse-patient relationship during home visits, Demicoli (2011) recommends, further training to strengthen family-oriented care since the involvement of relatives in patient care has a positive impact on patient’s quality of life. Indeed, participants described that when patients either refused or did not have any contact with significant others, the provision of care became complicated and influenced the patients’ recovery process.

One participant (Peter) highlights this aspect, “*So these people will be central aspects of patients’ life. So, I do feel it is important for me to communicate with them… for the relative, it is nice that they have a professional staff that they can call if they are concerned … relatives will notice things that patients will not”* (Peter, p.5 lines 165-173). Nonetheless, one cannot dismiss the findings from the extant literature. Furthermore, it seems that since the revision of the MHA, no local research was carried out on the influence of CTOs on patients and relatives. Thus, it is recommended that further research is undertaken locally to explore the experience of patients and significant others in CTOs’ contexts.

The participants yearned for modifications to the current CTO procedures. They yearned for adequate support to deal with challenges to continue providing effective care and improve patients’ care experience in the complex CTO context. All participants highlighted the importance for the patients, significant others and themselves to be involved in all care decisions during the CTO process, particularly in the initial CTO. They advocated for better communication processes among professionals. Participants proposed structured referral procedures, to target the difficulties present in the current work practices.

Light et al. (2017) recommend the need for a more inclusive mental health policy, which conveys the values and aims of CTOs, to better guide and monitor their use. Likewise, one participant (Peter) suggested more direct involvement by the Office of the Commissioner of Mental Health since the focus of this office seems to be on the administrative aspect of the CTO process. To target the lack of mental health awareness in the local health and social sectors, the participants proposed educational programs for officers within the Police Department and for health professionals in the various departments.

A qualitative study by MacLaren et al. (2016) on MHNs' work-related emotions found that if supervision is provided in a safe and professional context it might assist nurses to manage their emotions and maybe reduce burnout. In this regard, the participants of this study wished that clinical supervision would be available for them to cope with the responsibilities of their role and work demands.

5.5 Conclusion

The findings of this study featured findings found in the extant literature and provided an in-depth exploration of the lived experience of MHNs who care for individuals on a CTO in Malta. Whilst most of the available research explored the combined experiences of care providers and service users on the CTO's framework, this study focused on the experience of MHNs. The main findings of this study shed light on the challenges faced by MHNs, including ethical dilemmas, pressure from legal responsibilities, difficulties with therapeutic relationships, and aspects related to the care environment. Moreover, the findings seem to indicate, that there is a possibility that MHNs working in the local community setting are at risk of burnout, which compels the need for adequate support, validation, and an immediate change to present practices.

CHAPTER 6. CONCLUSION

This chapter summarizes the research study carried out among MHNs caring for individuals followed by recommendations for education, clinical practice, and future research.

6.1 Summary of the Research Study

A gap in the literature exploring the lived experiences of MHNs caring for individuals on a CTO was identified. International literature on CTOs' experiences is mostly based on the combined experiences of different service providers (psychiatrists, social workers, psychologists, occupational therapists, nurses, and tribunal members) and service users (patients and their carers). The seven qualitative studies reviewed by the researcher included nurses in their participant groups however only two studies included MHNs in their sample (Stensrud et al., 2016; Stuen et al., 2018). Since the revision of the Maltese Mental Health Act in 2012, no local research on the topic was identified. This was the driving force for choosing to conduct this qualitative phenomenological study. The author believes that this study will provide a voice to Maltese MHNs by highlighting difficulties within the CTO framework. Semi-structured interviews were utilised to gather data from a purposive sample of seven MHNs. Data was analysed using IPA as described by Smith et al. (2009). Three super-ordinate themes emerged "Paving through Responsibilities", "Targeting the Challenges" and "Attempts at Maintaining Balance". This was followed by a discussion and a comparison between the emergent themes, the existent literature, and the Person-Centred Practice Framework (McCormack & McCance, 2006).

In the first super-ordinate theme, "Paving through Responsibilities" the participants expressed their views about the CTO framework. They considered the CTO as a measure to support, protect and ensure treatment compliance for patients with severe mental illness. However, participants described that combining care with coercion was challenging. They faced ethical dilemmas resulting from the compulsory powers gained through the CTO. Most ethical and practical difficulties occurred when patients refused treatment. To deal with ethical dilemmas, the participants tried to protect the patients from the coercive aspect of CTOs by empathizing with and guiding patients to focus on their recovery process. Furthermore, the participants described challenges from the legal responsibility as this influenced their clinical judgments. These findings complemented the findings in the extant literature (Lessard-Deschenes & Goulet, 2021). However, the concern about possible litigation and blame was more noticeable in the present study's findings than in the existing literature's findings. To safeguard themselves, the participants focused more on their legal responsibilities than their caring role, leading to "therapeutic stalking".

In addition, participants established that the therapeutic relationship is crucial in the delivery of care within a CTO framework. Participants viewed the initial stages of the CTO as the most challenging period for the therapeutic relationship. To safeguard the therapeutic relationship from the negative effects of coercive aspects and to resolve ethical dilemmas the participants adopted a passive caring role and directed any conflicts with the treatment to the administrator of the CTO. These findings concur with the current literature (Francombe et al., 2018; Stensrud et al., 2016; Stuen et al., 2018).

In the super-ordinate theme "Targeting the Challenges" the participants shared their insight on the aspects of the care environment and its' influence on care provided within the CTO context. Participants emphasised that involvement in care decisions for themselves and the patients was limited, especially in the initial CTO application, where psychiatrists took most decisions. Participants claimed that ineffective communication was detrimental to the therapeutic relationship and could have led to hospital readmissions of certain patients. Furthermore, the lack of shared responsibility and a disregard for their clinical judgment left the participants feeling unsupported and feeling burdened with all the caring and legal responsibilities. Nonetheless, the participants felt responsible to continue to provide care despite the lack of resources. At times, they also felt pressured to compensate for insufficiencies within the system. Findings hinted that care planning within the local care context is focused on risk and participants felt unsupported and disheartened by a system that tends to prioritize risk and is gripped by a blaming culture. Moreover, the psychological burden experienced by the participants kept emerging in this study. The difficulties experienced by MHNs resulted from the complexity of their role, patient-related aspects, procedural issues, and system insufficiencies. These factors corroborated findings in the extant literature on predictors of burnout (Dall' Ora et al., 2020). Such findings further confirm that caring for individuals on a CTO may expose MHNs to higher burnout risks.

The final superordinate theme "Attempts at Maintaining Balance" explored how the participants coped with challenges. All the participants regarded their teams as major support structures, which assisted them to cope with difficulties. The participants valued regular team meetings as these provided time for discussion. Participants found that reflective practice helped them to deal with complex situations. The participants also wished for the introduction of clinical supervision to assist them to deal with the responsibilities of their role and work demands. These findings from the present study confirm findings from the extant literature (MacLaren et al., 2016; Stuen et al., 2018). Conversely, to the extant literature (Schaffer, 2020; Stensrud et al., 2015) participants of this study considered most of the relatives as partners in care and viewed their contribution as essential to patients' recovery process. Moreover, the participants of this study yearned for a change in the current CTO procedure. They recommended a structured referral process to enhance communication between inpatient and outpatient settings, facilitate risk assessment, assist the therapeutic relationship, and improve patients' care outcomes.

6.2 Strengths and Limitations

The next section outlines the strengths and limitations of this research study.

6.2.1 Strengths

The strengths of this study included:

- This study is potentially the first to focus solely on the lived experiences of MHNs caring for individuals on a CTO. Therefore, the results generated from this study contribute to the gap in the literature on this topic both locally and internationally.

- This study provided insight into the challenges experienced by Maltese MHNs when they are caring for individuals on a CTO and expressed their voice in suggesting improvements to the current system approaches.

- Consistent with IPA methodology, a homogenous sample of seven participants was used for this study, which provided an in-depth exploration of the lived experiences of MHNs caring for individuals on a CTO. Confidentiality was ensured throughout face-to-face interviews, which led to rich data collection. A pilot interview assisted the researcher to test the interview guide, indicating the possible duration of the interviews and providing an opportunity to practice interviewing skills.

- All interviews were conducted in English; therefore, all excerpts retained the profound meaning of the participants' experience.

- During the research project, a reflective diary was kept with the researcher's reflections to reduce the risk of possible bias. Furthermore, the periodic reviews on data analysis conducted by the academic supervisor helped to further reduce this risk.

6.2.2 Limitations

The limitations of this study are presented in the next section.

- The researcher considers herself a novice researcher since this was her first attempt at IPA research; hence this is considered a limitation. However, conducting the pilot interview made the researcher more confident and improved her interviewing skills.

- Qualitative research does not offer generalizable findings. Hence, findings may not represent the experiences of all MHNs caring for individuals on a CTO.

- IPA's idiographic nature is concerned with grasping details and aspects of the phenomena being studied (Smith et al., 2009). Due to the complexity of the CTO framework, there is the possibility that the participants were not able to delve into the specific details of their experience. Hence to titer such limitations the researcher used prompts to achieve detailed participants' accounts.

6.3 Learning Experience

Reflections on the learning experience are outlined in the following section.

- This study enabled the novice researcher to enhance her knowledge of phenomenological research through face-to-face interviews and an understanding of the importance of ethical issues when conducting a research study. Moreover, in her dual role as a CN and psychiatric nurse, the researcher gained more insight into the difficulties experienced by MHNs responsible for individuals on a CTO and the influence of these challenges on care delivery. Thus, the researcher gained more awareness of supporting both patients and staff through person-centred approaches.

- Through the collection and analysis of participants' experiences, the researcher became more sensitive and appreciative of certain language components used by individuals to emphasize aspects that are important to them such as the repetition of words and the use of metaphors. For example, now it would be easier to understand the conflict between care and control experienced by nurses in involuntary treatment contexts.

- Whilst analyzing data and developing themes the researcher improved her synthesis skills.

- Having a reflective diary assisted the researcher to improve her analytic skills and assisted self-reflection. This helped the researcher during the collection of data, data analysis, and during face-to-face interviews.

- Reflecting on her performance after each interview enabled the researcher to enhance her interviewing skills. Moreover, the researcher is accustomed to using communication skills in everyday practice thus this contributed to attaining in-depth interview content.

- Whilst working on her research study the researcher noticed a gradual increase in her ability to evaluate her work and she became more capable to use her critical skills whilst discussing and interpreting the study results.

- The screened literature for this project assisted the researcher to increase her knowledge of the multilayered CTO frameworks. The researcher noticed that she could bridge the gap between theory and practice with more ease and therefore could use evidence-based approaches in her work setting.

In addition, to the learning experience, this research study offers several recommendations for education and clinical practice. These are imparted in the next section.

6.4 Recommendations for Education

The following are the recommendations from this research study for education.

- It emerged that within the CTO context, the participants found it difficult to balance care with control, which led to various ethical dilemmas. Participants referred to the principles approach to ethics to try to resolve moral doubts. However, the covert coercive tactics used by one of the participants showed that it is more likely that coercion is considered a care and safety measure in coercive contexts. This might lead to a paternalistic approach to care and possibly have detrimental effects on the therapeutic relationship. To overcome ethical dilemmas, it is recommended that there is more awareness of ethical issues within coercive contexts. This could be achieved through continuous education on this aspect.

- The findings of the present study showed that forming a therapeutic relationship within a CTO context is difficult. To facilitate the nurse-patient therapeutic relationship it is recommended that there is more awareness regarding these difficulties. This could be addressed by offering educational sessions on these issues.

- The findings showed that legal responsibilities exerted more pressure on the participants' clinical decisions. They tended to focus more on the legal aspect rather than the care aspect. Continuous education is recommended to ease the burden of legal obligations and increase familiarity with the legal aspects of the CTO framework.

6.5 Recommendations for Clinical Practice

The following are the recommendations from this research study for clinical practice.

- The findings of this study accented the presence of the blaming culture present within the local care settings. This aspect could have led the participants to focus more on their legal responsibilities. Nurses can share their experiences, reflect, and receive support by encouraging reflective practice within teams. This could help them to focus on the patients' goals rather than the CTO's goals. However, for this to be fruitful there needs to be a radical change in the present culture that is focused on risk and blame to one that views negative experiences as learning opportunities. Moreover, the assistance of a legal advisor is recommended so that nurses can readily access legal advice whenever they have work-related legal concerns.

- The study findings showed that a lack of a formal CTO procedure jeopardised the therapeutic relationship, posed more risks to MHNs and service users, and influenced care outcomes. Therefore, it is recommended that a CTO standard operational procedure is established leading to a much-needed change to the present modus operandi. Moreover, considering the suggestion of one of the participants, one could also recommend more direct involvement by the Office of the Commissioner of Mental Health where the procedure of CTOs can be monitored and reconsidered according to the patient's needs.

- The present study hinted that challenges faced by MHNs might expose nurses to higher burnout risks. It is recommended that MHNs are aware of the symptoms of burnout and how to respond accordingly. Self-reflection needs to be encouraged to enable nurses to remain mindful of their inner selves, of the importance of self-care and boundary setting. Furthermore, the introduction of supervision sessions is recommended so that nurses are provided with a space where psychological distress is addressed, and they can be guided to receive adequate support.

- The present study highlights the fact that despite the challenges the participants still tried to continue to provide care and tended to accept the status quo. It is recommended that MHNs start challenging the present practices and strive for approaches that promote shared decision-making. Regular team meetings between inpatients and outpatient caring teams can be considered to enable consensus building, reduce tensions between teams, and encourage patient involvement.

- Participants claimed that disregard for their clinical judgment was not limited to mental health settings. They encountered the same challenges when asking for police assistance during involuntary hospital admissions and at the Emergency Department during patients' assessments. It is recommended that there is more awareness about mental health problems and more information about mental health services throughout the medical and social environment. For example, this could be achieved by providing educational programs through seminars and establishing formal meetings between different teams involved in patients' care.

6.6 Recommendations for Future Research

- A similar study might be conducted with service users to establish if service users also share the challenges reported by MHNs.

- Future studies may be conducted to explore the lived experience of individuals on CTO and that of their significant others. This will offer a better understanding of their experience, informing present clinical approaches to address their needs.

- Conducting a mixed methodology to evaluate possible burnout and its impact on the psychological well-being of MHNs working in local community settings would specifically target the psychological concerns of nurses working in challenging work contexts.

6.7 Conclusion

Exploring the lived experience of MHNs caring for individuals on CTO confirms findings in existent literature. Indeed, the complex and coercive CTO framework challenges MHNs' clinical judgment and caring role. Furthermore, interaction with individuals on a CTO is influenced by the work and culture of the organizations from where MHNs operate which extends to the broader medical, social, and legislative arenas.

One hopes that this research's findings and recommendations stimulate the implementation of appropriate approaches to support nurses to deal with challenging situations within the CTO framework, which will ultimately influence the quality of care received by individuals on a CTO.

References

Cachia, J. (2006). *Family support needs in mental health care*. [Bachelor's Dissertation, University of Malta] https://www.um.edu.mt/library/oar/handle/123456789/84828.

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A. & Barlow, S. (2017). Ordinary risks and accepted fictions: How contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations, 20*, 471-483.

Corring, D., O'Reilly, R.L., Sommerdyk, C. & Russel, E. (2018). What Clinicians say about the experience of working with Individuals on Community Treatment Orders? *Psychiatric Services, 69* (7), 791-796.

Creswell, J.W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (3rd ed.). Sage Publications Inc.

Creswell, J. W. (2013). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (3rd ed.). USA: Sage Publications.

Dall' Ora, C., Ball, J., Reinius, M. & Griffiths, P. (2020). Burnout in nursing: a theoretical review. *Human Resources for Health* 18:41. doi: 10.1186/s12960-020-00469-9

Demicoli. S. (2011). *Views of nurses working in Maltese community psychiatric teams about nurse-patient relationships which develop during home visits.* [Bachelor's Dissertation, University of Malta] https://www.um.edu.mt/library/oar/handle/123456789/55238.

Dawson, S., Muir-Cochrane, E., Simpson, A. & Lawn, A. (2021). Risk versus recovery: Care planning with individuals on community treatment orders. *International Journal of Mental Health Nursing 30, 1248-1262.* doi: 10.1111/inm.12877

Francombe Pridham, K., Nakhost, A., Tugg, L., Etherington, N., Stergiopoulos, V. & Law, S. (2018). Exploring experiences with compulsory psychiatric community treatment: A qualitative multi-perspective pilot study in an urban Canadian context. *International Journal of Law and Psychiatry, 57,* 122-130. https://doi.org/10.1016/j.ijlp.2018.02.007

Geller, J. L., Fisher, W. H., Grudzinskas, A. J., Clayfield, J. C. & Lawlor, T. (2006). Involuntary outpatient treatment as 'deinstitutionalized coercion': the net widening concerns. *International Journal of Law and Psychiatry 29*, 551–562. doi: 10.1016/j.ijlp.2006.08.003

Geller, J.L. (2012). Patient-centered, recovery-oriented psychiatric care and treatment are not always voluntary. *Psychiatric services, 63* (5), 493.

Graham, J.H. (2006). Community care or therapeutic stalking: two sides of the same coin? *Journal of Psychosocial Nursing and Mental Health Services 44*, 41–44, 45–50.

Gray, K., Young, L. & Waytz, A. (2012). Mind perception is the essence of morality. *Psychol Inquiry 23(2)*:101-124. doi: 10.1080/1047840C.2012.651387

Hallam, A. (2002). Media influences on mental health policy: Long-term effects of the Clunis and Silcock cases. *International Review of Psychiatry, 14,* 26-33.

Holloway, I. & Tedros, L. (2010). Ethnography. In K. Gerrish, K & A. Lacey (Eds.), *The Research Process in Nursing (6th ed.)* (pp. 165). Oxford, UK: Blackwell.

Holloway, I. & Tedros, L. (2010). Grounded Theory. In K. Gerrish, K & A. Lacey (Eds.), *The Research Process in Nursing (6th ed.)* (pp. 156). Oxford, UK: Blackwell.

Hannigan, B., Simpson, A., Coffey, M., Barlow, S. & Jones, A. (2018). Care coordination as imagined; care coordination as done: Findings from a cross-national mental health systems study. *International Journal of Integrated Care, 18*, 1–14.

Haynes, P. & Stroud, J. (2022). Practitioner Perspectives About Managing Community Treatment Orders (CTOs) in England and the Importance of Social Influences. *Community Mental Health Journal.* doi: 10.1007/s10597-022-00974-2

Langdridge, D. (2007). Phenomenological Psychology: Theory, Research and Method. Harlow, UK: Pearson.

Lessard-Deschenes, C & Goulet, M.H. (2021). The therapeutic relationship in the context of involuntary treatment orders: The perspectives of nurses and patients. *J Psychiatr Mental health Nurs, 29*:287-296. doi: 10.1111/jpm.12800

Lawn, S., Delany, T., Pulvirenti, M., Smith, A. & McMillan, J. (2015). A qualitative study examining the presence and consequences of moral framings in patients' and mental health workers' experiences of community treatment orders. *BMC Psychiatry* 15:274; 1-17. doi: 10.1186/s12888-015-0653-0

Light, E.M., Robertson, M.D., Boyce, P., Carney, T., Rosen, A., Cleary, M., Hunt, G.H., Connor, N., Ryan, C.J. & Kerridge, I.H. (2017). How shortcomings in the mental health system affect the use of involuntary community treatment orders. *Australian Health Review, 41*, 351-356. http://dx.doi.org/10.1071/AH16074

Maclaren, J., Stenhouse, R. & Ritchie, D. (2016). Mental health nurses' experiences of managing work-related emotions through supervision. *Journal of Advanced Nursing 72(10)*, 2423–2434. doi: 10.1111/jan.12995

MacNeela, P., Morris, R., Scott, A., Treacy, M.P & Hyde, A. (2010). Seen as core; Delphi consensus study of essential elements of mental health nursing in Ireland. *Archives of Psychiatric Nursing 24*, 339-348. doi: 10.1016/j.apnu.2010.02.001

McCormack, B. & McCance, T.V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing 56(5)*, 472-479. doi: 10.1111/j.1365-2648.2006. 04042.x

McCormack, B. & McCance, T.V. (2016). *Person-Centred Practice in Nursing and Health Care: Theory and Practice*. John Wiley & Sons, Incorporated.

McTiernan, K. & McDonald, N. (2015). Occupational stressors, burnout and coping strategies between hospital and community psychiatric nurses in a Dublin region. *Journal of Psychiatric and Mental Health Nursing 22,* 208-218. doi: 10.1111/jpm.12170

Mental Health Act 2012. Explanatory Notes for healthcare professionals (2013). Office of the Commissioner for mental health & older persons.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement British Medical Journal Publishing Group. doi: 10.1136/bmj. b2535

Molewijk, B., Kok, Almar., Husum, T., Pedersen, R. & Aasland, O. (2017). Saff's normative attitudes towards coercion: the role of moral doubt and professional context- a cross-sectional survey study. *BMC Medical Ethics 18:37.* doi: 10.1186/s12910-017-0190-0

Morrissey, J., & Higgins, A. (2019). "Attenuating Anxieties": A grounded theory study of mental health nurses' responses to clients with suicidal behaviour. Journal of clinical nursing, 28(5-6), 947-958. https://doi.org/10.1111/jocn.14717

Nagra, M.K., Pillinger, T., Prata-Ribeiro, H., Khazaal, Y. & Molodynski, A. (2016). Community Treatment Orders- A pause for thought. *Asian Journal of Psychiatry, 24* 1-4. doi: 10.1016/j.ajp.2016.08.013

Nakhost, A., Simpson, A.I.F & Sirotich, F. (2019) Service Users' Knowledge and views on Outpatients' Compulsory Community Treatment Orders: A cross- Sectional Matched Comparison Study. *The Canadian Journal of Psychiatry, 64*(10), 726-735. doi: 10.1177/0706743719828961

Nevalainen, T., Taavitsainen, I., Pahta, P., & Korhonen, M. (2008). *The dynamics of linguistic variation*. John Benjamins Publishing.

Patton, M.Q. (2002). *Qualitative research and evaluation methods (3rd Ed).* Thousand Oaks, CA: Sage.

Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly, 10* (4), 162-167.https://doi.org/10.1177/089431849701000407

Pilgrim, D. (2018). Are kindly and efficacious mental health services possible? *Journal of mental Health, 27*,295-297.

Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: Appraising evidence for nursing practice.* Lippincott Williams & Wilkins.

Polit, D. F & Beck, C. T. (2018). *Essentials of Nursing Research: Appraising Evidence for Nursing Practice* (9th Ed.). Wolters Kluwer.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience: An introduction to Interpretative Phenomenological Analysis. *The Psychologist, 18*, 20-23.

Relevo, R. (2012). Chapter 4: Effective Search Strategies for Systematic Reviews of Medical Tests. *Journal of General Internal Medicine, 27(S1)*, 28-32. doi: 10.1007/s11606-011-1873-8

Rugkasa, J. (2016) Effectiveness of Community Treatment Orders: The International Evidence. *The Canadian Journal of Psychiatry, 61*(1), 15-24. doi: 10.1177/0706743715620415

Rugkasa, J. & Burns, T. (2017). Community Treatment Orders: Are they useful? *BJ Psych Advances, 23*,222-230.

Rugkasa, J & Dawson, J. (2013) Community treatment orders: Current evidence and the implications. *The British Journal of Psychiatry, 203*(6), 406-408. doi.org/10.1192/bjp.bp.113.133900

Saleh, S., Sambakunsi, H., Nyirenda, D., Kumwenda, M., Mortimer, K. & Chinouya, M. (2020). Participant compensation in global health research: a case study. *International Health 12*:6, 524-532. https://academic.oup.com/inthealth/article/12/6/524/5962068

Scerri, J., Sammut, A., Mangion, M., Galea, M., Grech, P., Cilia Vincenti, S. & Camilleri, L. (2022). Targeting Burnout and Emotional State in Nurses within a Mental Health Care Setting: A Quasi-Experimental Study. *Humanities and Social Science Research*; 6:1 https://doi.org/10.30560/hssr.v6n1p1

Schaffer, M.A. (2020). Family perspectives of healthcare for relatives living with a mental illness. *Perspectives in Psychiatric Care 57:* 1547-1557. doi: 10.1111/ppc.12718

Smith, J.A., & Osborn, M. (2003). *Interpretative Phenomenological Analysis*. Sage Publications.

Smith, J. A., Flowers. P. & Larkin. M. (2009). *Interpretative Phenomenological Analysis: Theory, Method, and Research.* Sage Publications, London.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis*. Health Psychology Review*, *5:1*, 9-27. https://doi: 10.1080/17437199.2010.510659

Smith, J. A., Flowers. P. & Larkin. M. (2022). *Interpretative Phenomenological Analysis: Theory, Method, and Research. 2nd Edition*. Sage Publications, London.

Snow, N., & Austin, W. J. (2009). Community treatment orders: the ethical balancing act in community mental health. *Journal of Psychiatric and Mental Health Nursing, 16* (2), 177-186.

Stensrud, B., Høyer, G., Granerud, A. & Signe Landheim, A. (2015). 'Responsible, but Still not a Real Treatment Partner': A Qualitative Study of the Experiences of Relatives of Patients on Outpatient Commitment Orders. *Issues in Mental Health Nursing, 36:8*, 583-591. doi: 10.3109/01612840.2015.1021939

Stensrud, B., Hoyer, G., Beston, G., Granerud, A. & Signe Landheim, A. (2016). Care or control? : A qualitative study of staff experiences with outpatient commitment orders. *Soc Psychiatry Psychiatr Epidemiol 51*; 747-755. doi: 10.1007/s00127-016-1193-8

Stuen, H.K, Landheim, A., Rugkasa, J. & Wynn, R. (2018). Responsibilities with conflicting priorities: a qualitative study of ACT providers' experiences with community treatment orders. *BMC Health Services Research 18:290*. https://doi.org/10.1186/s12913-018-3097-7

Vandenberg, H.E.R & Hall, W.A. (2011). *Critical ethnography: extending attention to bias and reinforcement of dominant power relations.* Nurse Researcher 18:3 https://go.gale.com/ps/i.do?id=GALE%7

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*, 215-228.

Appendices

Appendix A: Intermediary Letter

14th March 2022

Ms. Josephine CassarNursing Manager,

Mental Health Community

ServicesMount Carmel

Hospital

Dear Ms. Cassar,

My name is Josephine Mifsud, I am a Charge nurse working at Mount Carmel Hospital at Qormi MentalHealth Clinic. I am presently reading for a Master of Science Degree in Mental Health Nursing at the University of Malta and as part of its fulfillment requirements, I will be conducting a research study. The proposed title is “Caring for patients on "Community Treatment Order '' in Malta - “Key Health Professionals” experience". Through this research study I intend to explore the lived experiences of nurses who are appointed as “Key Health Professionals” whilst caring for serviceusers sectioned under the Seventh Schedule of the Mental Health Act (2012), also known as a “Community Treatment Order”. This will be carried out by conducting in-depth audio recorded interviews to six to eight “Key Health Professionals”, who have been working in a Mental Health Community setting for at least three years.

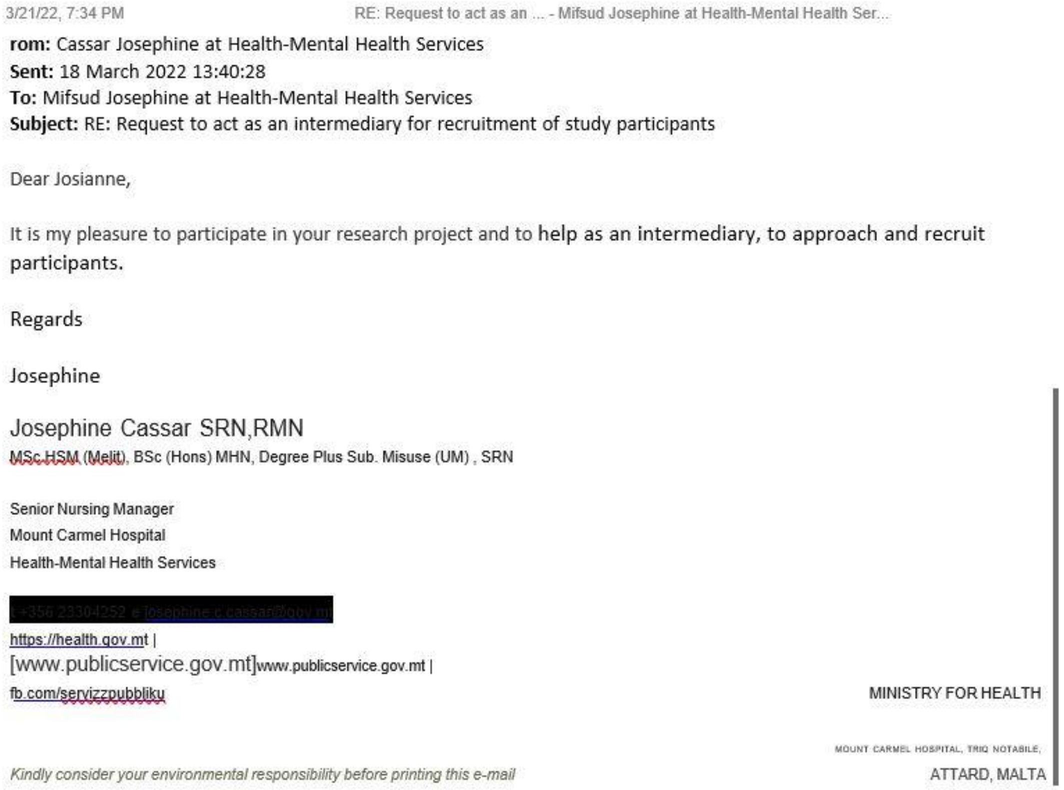
To fulfil research and ethical requisites, I would appreciate your help as an intermediary to approach and recruit participants working in Mental Health Community services. I will be providing an information letter explaining the nature of the study and your part will be to giveout the information letters and then provide contact details of any participant who accepts to be involved in the study.

Whilst thanking you in advance, should you require further details regarding my study, please do not hesitate to contact me on the mob. [redacted] my supervisor Dr. Alexei Sammut on [redacted].

Kind Regards,

Josephine Mifsud

M.Sc Mental Health Nursing student



3/21/22, 7:34 PM RE: Request to act as an ... - Mifsud Josephine at Health-Mental Health Ser...

rom: Cassar Josephine at Health-Mental Health Services
Sent: 18 March 2022 13:40:28
To: Mifsud Josephine at Health-Mental Health Services
Subject: RE: Request to act as an intermediary for recruitment of study participants

Dear Josianne,

It is my pleasure to participate in your research project and to help as an intermediary, to approach and recruit participants.

Regards

Josephine

Josephine Cassar SRN,RMN
MSc.HSM (Melit), BSc (Hons) MHN, Degree Plus Sub. Misuse (UM) , SRN

Senior Nursing Manager
Mount Carmel Hospital
Health-Mental Health Services

[redacted]
https://health.gov.mt |
[www.publicservice.gov.mt]www.publicservice.gov.mt |
fb.com/servizzpubbliku

MINISTRY FOR HEALTH

MOUNT CARMEL HOSPITAL, TRIQ NOTABILE,
ATTARD, MALTA

Kindly consider your environmental responsibility before printing this e-mail

Appendix B- Participants’ Information Sheet and Consent Form.

Participants` Information Sheet

Dear participant,

My name is Josephine Mifsud, and I am currently reading for a Master’s degree in Mental Health Nursing at the Department of Mental Health Sciences, University of Malta. As part of my course requirements, I am conducting a research study entitled, **“**Caring for Patients on "Community Treatment Order '' in Malta – “Key Health professionals' experience". This study aims to explore in-depth the lived experience of “Key Health professionals” whilst caring for service userssectioned under the Seventh Schedule of the Mental Health Act (2012), also known as a “Community Treatment Order”. Your participation in this study would help us gain a better understanding of the challenging aspects of your role as the “Key Health professional” whilst providing care to service users detained under a “Community Treatment order”. Furthermore, all data collected from this research shall be used solely for this study.

You are being invited to participate in an interview exploring your lived experiences as a “Key Health Professional” whilst caring for patients detained under a “Community Treatment Order”. The interview will take approximately 1 hour and will be held at a time and place most suitable for you.

You are not obliged to answer all the questions and may withdraw from the study at any time without giving a reason. Furthermore, withdrawal from the study will not have any negative repercussions on you and any data collected will be erased.

Data will be stored anonymously and once the study is completed and the results are published, the data will be deleted by August/September 2023.

Unless you have any objections, this interview will be audio recorded. I can assure you that confidentiality will be maintained throughout the study and that your identity and personal information will not be revealed in any publications, reports, or presentations arising from this research. All data collected will be pseudonymized meaning that the transcripts will be assigned codes and that this data will be stored securely and separately from any codes and personal data.This data may only be accessed by the researcher. The academic supervisor/s and the examinerswill typically have access to coded data only. There may be exceptional circumstances that allow the supervisor and examiners to have access to personal data too, for verification purposes. The coded audio recordings and transcripts will be stored on the researcher`s personal computer whichis password protected and in an encrypted format. Any material in hard-copy form will be placedin a locked cupboard.

If you feel distressed due to participation in this study, you can contact me on 99800934 and the service of a healthcare professional, Ms. Tania Farrugia (Clinical psychologist) will be offered. There will be no financial cost on your part.

Participation in this study is completely voluntary and you are free to accept or refuse to take part without giving a reason. A copy of the information sheet and consent form will be providedfor future reference. As a participant, you have the right, under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, to access, rectify, and where applicable ask for the data concerningyou to be erased.

This study has been approved by the Research Ethics Committee of the Faculty of Health Sciencesat the University of Malta.

Thank you for your time and consideration. Should you have any questions or concerns do not hesitate to contact me on [redacted] or by e-mail on [redacted] or my supervisor Dr. Alexei Sammut on [redacted]

Yours Sincerely,

Jmifsud

Ms. Josephine Mifsud
Researcher

Dr. Alexei Sammut
Research Supervisor

L-Università
ta' Malta

Participants` Consent Form

Caring for Patients on "Community Treatment Order '' in Malta – Key Health Professionals' experience.

I, the undersigned, give my consent to take part in the study conducted by Josephine Mifsud. Thepurpose of this document is to specify the terms of my participation in this research study.

1. I have been given written and verbal information about the purpose of the study and all questions have been answered.
2. I understand that I have been invited to participate in an interview, in which the researcher will ask questions to explore in-depth the lived experience of “Key Health Professionals” whilst caring for patients who are detained under a “Community Treatment Order”.
3. I am aware that the interview will take approximately 1 hour. I understand that the interview is to be conducted in a place and at a time that is convenient for me.
4. I am aware that this interview will be audio-recorded and transcribed (written down as ithas been spoken).
5. I am aware that the transcripts will be coded, and that this data will be stored securely and separately from any codes and personal data.
6. I am aware that the researcher is the only person who has access to this data. The academic supervisor/s and examiners will typically have access to coded data only. Theremay be exceptional circumstances that allow the supervisor and examiners to have accessto personal data too, for verification purposes.
7. I am also aware that the coded audio recordings and transcripts will be stored on the researcher`s personal computer which is password protected and in an encrypted format. Any material in hard-copy form will be placed in a locked cupboard and kept until the results are published.
8. I am aware that my identity and personal information will not be revealed in anypublications, reports or presentations arising from this research.
9. I also understand that I am free to accept, refuse or stop participation at any time withoutgiving any reason. This will have no negative repercussions on myself and any data

collected from me will be erased. Data will be stored anonymously if it is impossible to delete (e.g., if it has already been anonymised).

10. I also understand that my contribution will serve to gain a better understanding of the role of the “Key Health Professionals” whilst providing care to this group of patients.
11. If I feel that the interview has distressed me in any way, a clinical psychologist, Ms. Tania Farrugia will be available to provide a service at no financial cost on my part.
12. I understand that under the General Data Protection Regulation (GDPR) and national legislation that implements and further specifies the relevant provisions of said regulation, I have the right to access, rectify, and where applicable ask for the data concerning me to be erased.
13. I also understand that once the study is completed and results are published the data willbe retained in an anonymous form. Any personal details will be destroyed.
14. I will be provided with a copy of the information letter and consent form for future reference.
15. I have read and understood the points and statements of this form. I have had all the questions answered to my satisfaction, and I agree to participate in this study.

Participant: ____________________________________

Signature: _____________________________________

Date: ____

Jmifsud .

_____________________________ _____________________________

Ms. Josephine Mifsud

Researcher

Dr. Alexei Sammut

Research Supervisor

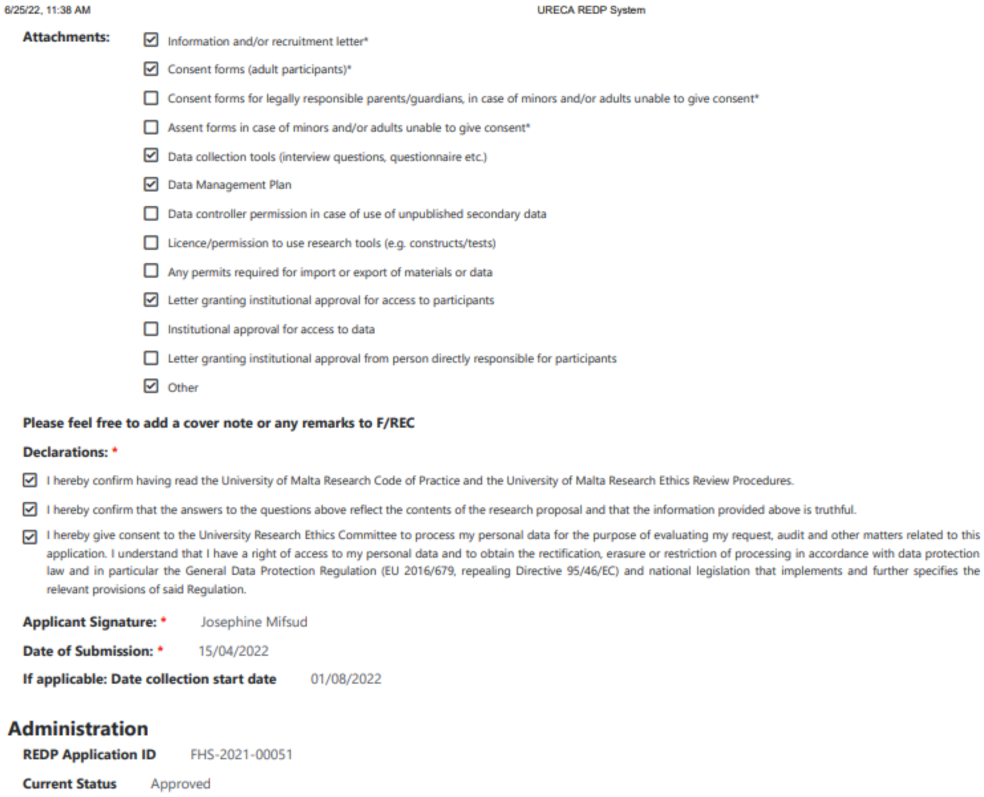
Appendix C: Interview Guide

1. What are your views on "Community Treatment Orders”?
2. Describe your experience of providing care to service users sectioned under a “Community Treatment Order”?
    - Prompt- How long have you been in this role?
    - Prompt- How many patients on a “Community Treatment Order” do you usually care for?
3. What are your views on how services users are affected by “Community Treatment Order”?
    - Prompt- Benefits? Concerns?
4. What are the challenges you encounter whilst caring for patients on a “Community Treatment Order”?
    - Prompt-What are your thoughts on how the therapeutic relationship is influenced by the “Community Treatment Order”?
    - Prompt- How do you manage to respect patients’ autonomy whilst also managing the legal provisions of the “Community Treatment Order?
    - Prompt- What are your views of patients’ involvement in their care plan?
5. How do these challenges impact the care you provide for service users?
6. How do you feel when your responsibilities are not met due to these challenges?
7. What coping strategies do you use to manage these challenges?
8. In your opinion what are the factors that facilitate your work?
9. What kind of support is available to assist you in shouldering the

responsibility ofthis role?

10. What other support and assistance can be provided to improve care for serviceusers on a “Community Treatment Order”?
11. Do you have anything else to add?

Appendix D: UREC Approval



6/25/22, 11:38 AM URECA REDP System

Attachments:

- ☑ Information and/or recruitment letter*
- ☑ Consent forms (adult participants)*
- ☐ Consent forms for legally responsible parents/guardians, in case of minors and/or adults unable to give consent*
- ☐ Assent forms in case of minors and/or adults unable to give consent*
- ☑ Data collection tools (interview questions, questionnaire etc.)
- ☑ Data Management Plan
- ☐ Data controller permission in case of use of unpublished secondary data
- ☐ Licence/permission to use research tools (e.g. constructs/tests)
- ☐ Any permits required for import or export of materials or data
- ☑ Letter granting institutional approval for access to participants
- ☐ Institutional approval for access to data
- ☐ Letter granting institutional approval from person directly responsible for participants
- ☑ Other

Please feel free to add a cover note or any remarks to F/REC

Declarations: *

☑ I hereby confirm having read the University of Malta Research Code of Practice and the University of Malta Research Ethics Review Procedures.

☑ I hereby confirm that the answers to the questions above reflect the contents of the research proposal and that the information provided above is truthful.

☑ I hereby give consent to the University Research Ethics Committee to process my personal data for the purpose of evaluating my request, audit and other matters related to this application. I understand that I have a right of access to my personal data and to obtain the rectification, erasure or restriction of processing in accordance with data protection law and in particular the General Data Protection Regulation (EU 2016/679, repealing Directive 95/46/EC) and national legislation that implements and further specifies the relevant provisions of said Regulation.

Applicant Signature: * Josephine Mifsud

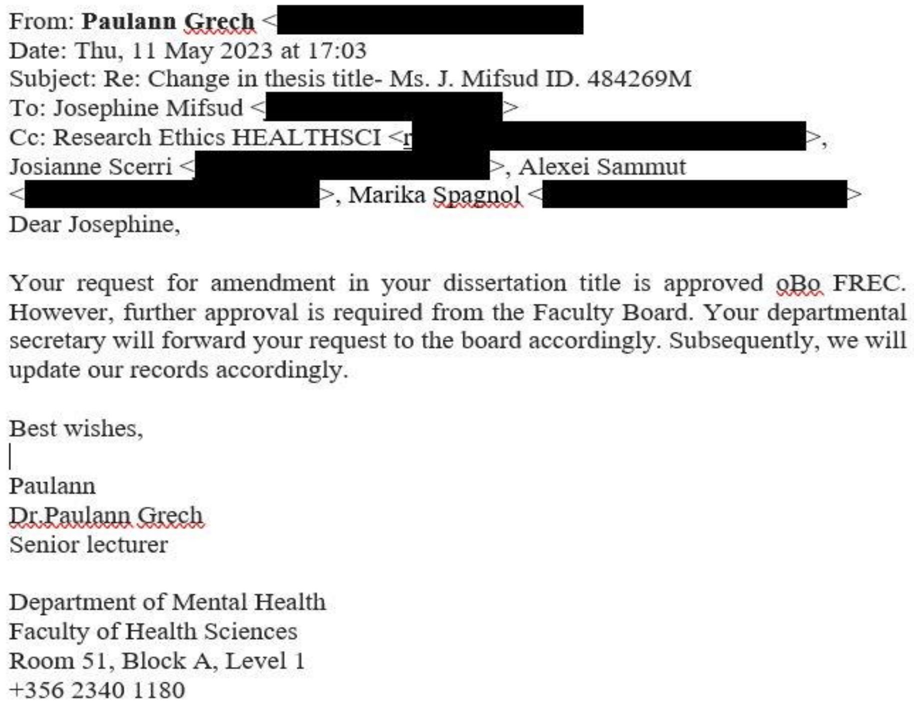
Date of Submission: * 15/04/2022

If applicable: Date collection start date 01/08/2022

Administration

REDP Application ID FHS-2021-00051

Current Status Approved



From: **Paulann Grech** <[redacted]
Date: Thu, 11 May 2023 at 17:03
Subject: Re: Change in thesis title- Ms. J. Mifsud ID. 484269M
To: Josephine Mifsud <[redacted]>
Cc: Research Ethics HEALTHSCI <[redacted]>,
Josianne Scerri <[redacted]>, Alexei Sammut
<[redacted]>, Marika Spagnol <[redacted]>

Dear Josephine,

Your request for amendment in your dissertation title is approved oBo FREC. However, further approval is required from the Faculty Board. Your departmental secretary will forward your request to the board accordingly. Subsequently, we will update our records accordingly.

Best wishes,

Paulann
Dr.Paulann Grech
Senior lecturer

Department of Mental Health
Faculty of Health Sciences
Room 51, Block A, Level 1
+356 2340 1180

Appendix E: Approval from CEO

21 st March 2022

Dr. Stephanie Xuereb

CEO

Mental Health Services

Mount Carmel Hospital

Dear Dr., Xuereb,

My name is Josephine Mifsud, I am a Charge Nurse working at Mount Carmel Hospital at Qormi MentalHealth Clinic. I am presently reading for a Master of Science Degree in Mental Health Nursing at the University of Malta and as part of its fulfilment requirements, I will be conducting a research study. The proposed title is “Caring for Patients on "Community Treatment Order '' in Malta – “Key Health Professionals’ experience". Through this research study, I intend to explore the lived experiences of nurses who are appointed as “Key Health Professionals” whilst caring for service users sectioned under the Seventh Schedule of the Mental Health Act (2012), also known as a “Community Treatment Order”. This will be carried out by conducting in-depth audio-recorded interviews with six to eight “Key Health Professionals” who work in a Mental Health Community setting. Participants will be recruited by Ms. Josephine Cassar (Community Nursing Manager), who has consented to act as an intermediary for this study (copy of letter attached). I will be providing an information letter explaining the nature of the study as well as a consent form to the participants. I can assure you that confidentiality will be maintained throughout the study and that the identity and personal information of the participants will not be revealed in any publications, reports, or presentations arising from this research. All data collected will be pseudonymized meaning that the transcripts will be assigned codes andthat this data will be stored securely and separately from any codes and personal data.

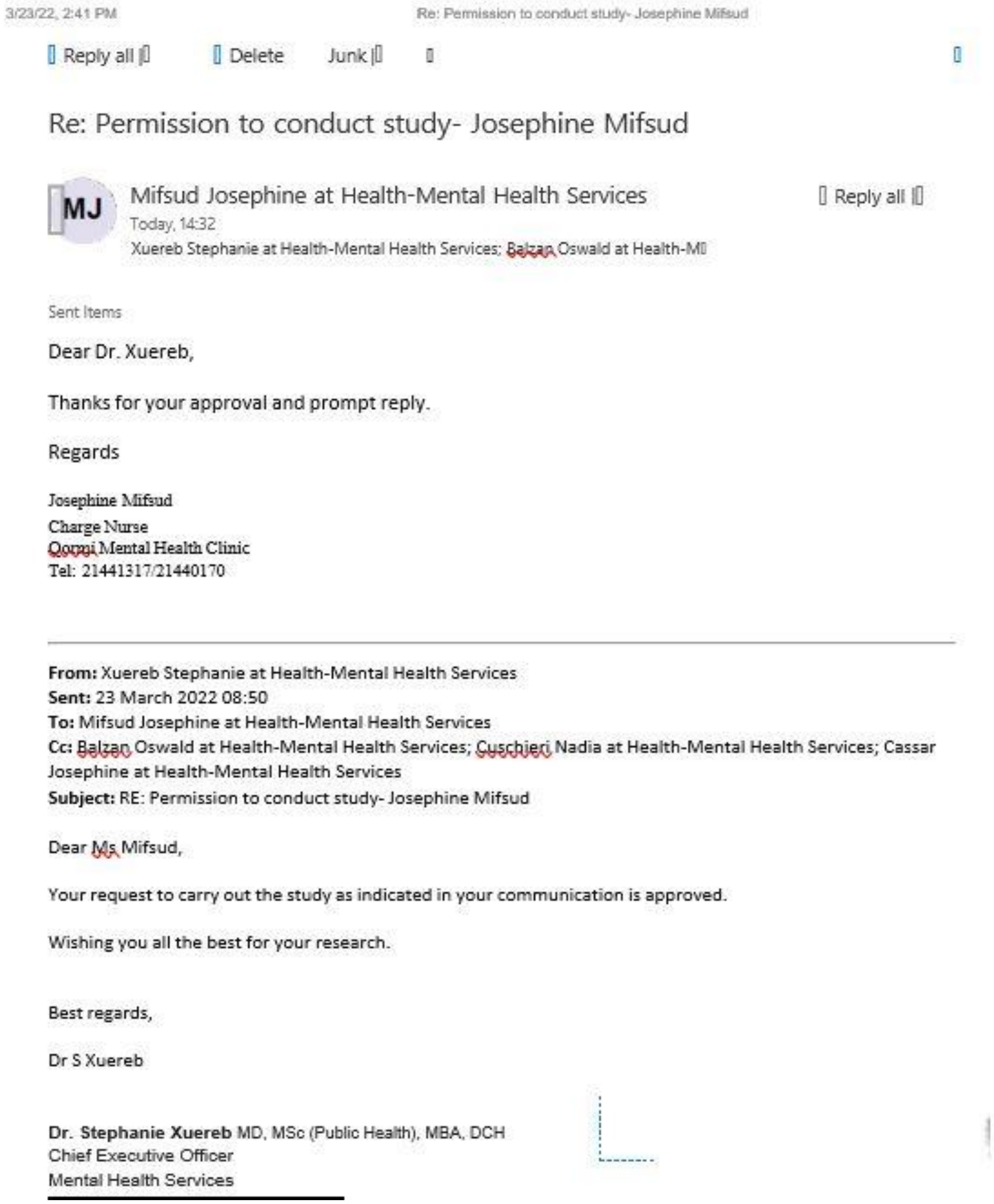
To fulfil research and ethical requisites, I would appreciate it if you gave your permission to conduct this study with members of your organization who work within a Mental Health Community team.

Whilst thanking you in advance, should you require further details regarding my study, pleasedo not hesitate to contact me on the mob. [redacted] by e-mail on [redacted] or my supervisor Dr. Alexei Sammut on [redacted]

Kind Regards,

Josephine Mifsud

M.Sc. Mental Health Nursing student



Re: Permission to conduct study- Josephine Mifsud

Mifsud Josephine at Health-Mental Health Services

Today, 14:32

Xuereb Stephanie at Health-Mental Health Services; Balzan Oswald at Health-M

Sent Items

Dear Dr. Xuereb,

Thanks for your approval and prompt reply.

Regards

Josephine Mifsud
Charge Nurse
Qormi Mental Health Clinic
Tel: 21441317/21440170

From: Xuereb Stephanie at Health-Mental Health Services
Sent: 23 March 2022 08:50
To: Mifsud Josephine at Health-Mental Health Services
Cc: Balzan Oswald at Health-Mental Health Services; Cuschieri Nadia at Health-Mental Health Services; Cassar Josephine at Health-Mental Health Services
Subject: RE: Permission to conduct study- Josephine Mifsud

Dear Ms Mifsud,

Your request to carry out the study as indicated in your communication is approved.

Wishing you all the best for your research.

Best regards,

Dr S Xuereb

Dr. Stephanie Xuereb MD, MSc (Public Health), MBA, DCH
Chief Executive Officer
Mental Health Services

Appendix F: Approval from Data Protection Officer

21st March 2022

Mr. Oswald Balzan
Data Protection Officer
Mental Health Services
Mount Carmel Hospital

Dear Mr. Balzan,

My name is Josephine Mifsud, I am a Charge Nurse working at Mount Carmel Hospital at Qormi MentalHealth Clinic. I am presently reading for a Master of Science Degree in Mental Health Nursing at the University of Malta and as part of its fulfilment requirements, I will be conducting a research study. The proposed title is “Caring for Patients on "Community Treatment Order '' in Malta – “Key Health Professionals' experience". Through this research study, I intend to explore the lived experiences of nurses who are appointed as “Key Health Professionals” whilst caring for service users sectioned under the Seventh Schedule of the Mental Health Act (2012), also known as a “Community Treatment Order”. This will be carried out by conducting in-depth audio-recorded interviews with six to eight “Key Health Professionals” who work in a Mental Health Community setting.

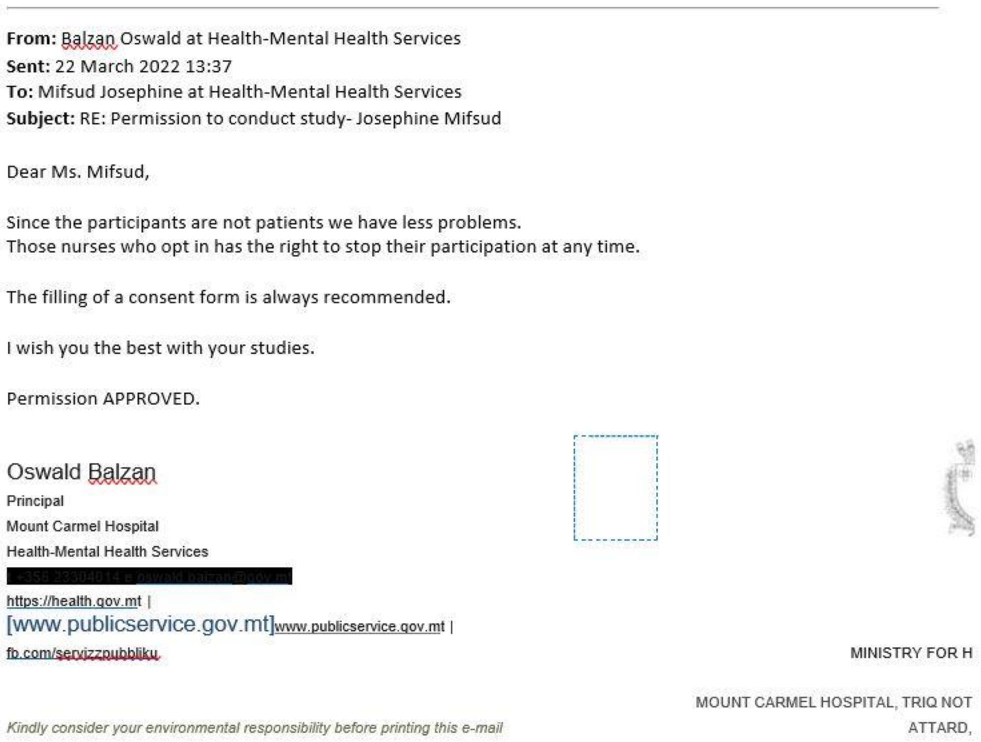
To fulfill research and ethical requisites, I would appreciate if you gave your permission to conduct this study with members of your organization who work within a Mental Health Community team. Participants will be recruited by Ms. Josephine Cassar (Community Nursing Manager), who has consented to act as an intermediary for this study. I will be providing an information letter explaining the nature of the study as well as a consent form. (copies of letters attached). Data will be stored anonymously and once the study is completed and the results are published, the data will be deleted by August/September 2023.

I can assure you that confidentiality will be maintained throughout the study. Identities and personal information will not be revealed in any publications, reports, or presentations arising from this research. All data collected will be pseudonymized meaning that the transcripts willbe assigned codes and that this data will be stored securely and separately from any codes and personal data. This data may only be accessed by the researcher. The academic supervisor/s and the examiners will typically have access to coded data only. There may be exceptional circumstances that allow the supervisor and examiners to have access to personal data too, for verification purposes. The coded audio-recordings and transcripts will be stored on the researcher`s personal computer which is password protected and in an encrypted format. Any material in hard-copy form will be placed in a locked cupboard.

Whilst thanking you in advance, should you require further details regarding my study, pleasebe welcome to contact me on mob. [redacted] by e-mail on [redacted] or my supervisor Dr. Alexei Sammut on [redacted]

Kind Regards,

Josephine Mifsud
M.Sc Mental Health Nursing student



From: Balzan Oswald at Health-Mental Health Services
Sent: 22 March 2022 13:37
To: Mifsud Josephine at Health-Mental Health Services
Subject: RE: Permission to conduct study- Josephine Mifsud

Dear Ms. Mifsud,

Since the participants are not patients we have less problems.
Those nurses who opt in has the right to stop their participation at any time.

The filling of a consent form is always recommended.

I wish you the best with your studies.

Permission APPROVED.

Oswald Balzan
Principal
Mount Carmel Hospital
Health-Mental Health Services
[redacted]
https://health.gov.mt |
[www.publicservice.gov.mt]www.publicservice.gov.mt |
fb.com/servizzpubbliku

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Appendix G: Approval from Director of Nursing

21 st March 2022

Dr. Victoria Sultana
Director for Nursing
Mount Carmel Services

Dear Dr. Sultana,

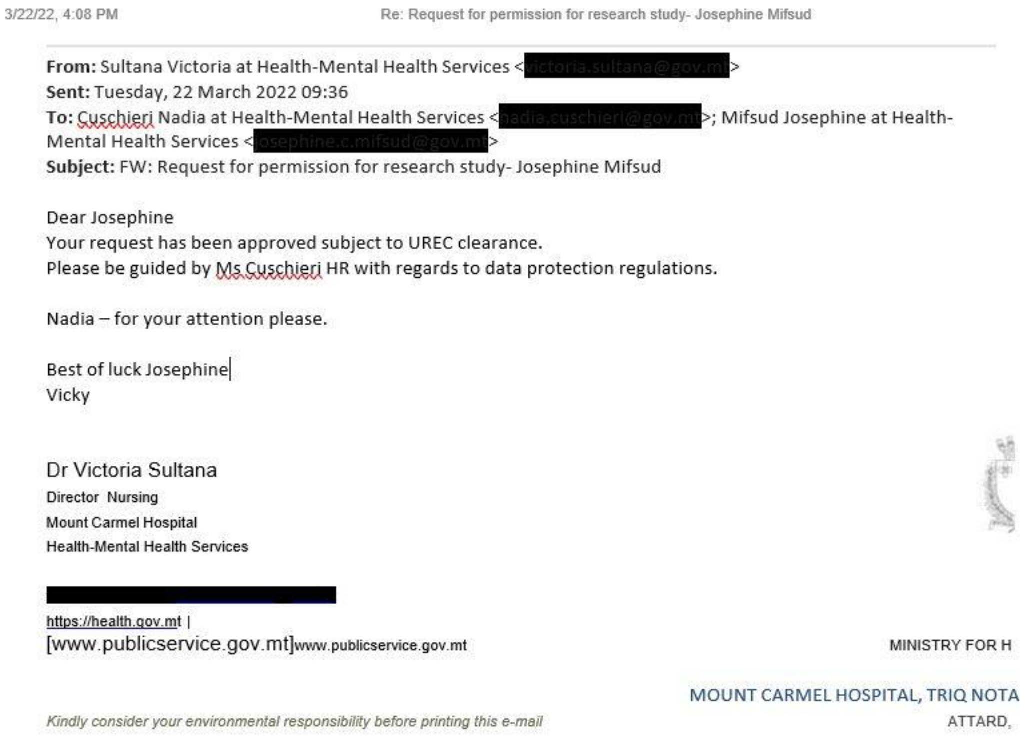
My name is Josephine Mifsud, I am a Charge Nurse working at Mount Carmel Hospital at Qormi MentalHealth Clinic. I am presently reading for a Master of Science Degree in Mental Health Nursing at the University of Malta and as part of its fulfilment requirements, I will be conducting a research study. The proposed title is "Caring for Patients on "Community Treatment Order '' in Malta – "Key Health Professionals' experience". Through this research study, I intend to explore the lived experiences of nurses who are appointed as "Key Health Professionals" whilst caring for service users sectioned under the Seventh Schedule of the Mental Health Act (2012), also known as a "Community Treatment Order". This will be carried out by conducting in-depth audio-recorded interviews with six to eight "Key Health Professionals", who work in a Mental Health Community setting. Participants will be recruited by Ms. Josephine Cassar (Community Nursing Manager), who has consented to act as an intermediary for this study (copy of letter attached). I will be providing an information letter explaining the nature of the study as well as a consent form to the participants. I can assure you that confidentiality will be maintained throughout the study and that the identity and personal information of the participants will not be revealed in any publications, reports, or presentations arising from this research. All data collected will be pseudonymized meaning that the transcripts will be assigned codes andthat this data will be stored securely and separately from any codes and personal data.

To fulfill research and ethical requisites, I would appreciate it if you gave your permission to conduct this study with nursing staff working within Mental Health Community teams

Whilst thanking you in advance, should you require further details regarding my study, pleasedo not hesitate to contact me on mob. [redacted] by e-mail on [redacted] or my supervisor Dr. Alexei Sammut on [redacted]

Kind Regards,

Josephine Mifsud
M.Sc. Mental Health Nursing student



3/22/22, 4:08 PM Re: Request for permission for research study- Josephine Mifsud

From: Sultana Victoria at Health-Mental Health Services <[redacted]>
Sent: Tuesday, 22 March 2022 09:36
To: Cuschieri Nadia at Health-Mental Health Services <[redacted]>; Mifsud Josephine at Health-Mental Health Services <[redacted]>
Subject: FW: Request for permission for research study- Josephine Mifsud

Dear Josephine
Your request has been approved subject to UREC clearance.
Please be guided by Ms Cuschieri HR with regards to data protection regulations.

Nadia – for your attention please.

Best of luck Josephine
Vicky

Dr Victoria Sultana
Director Nursing
Mount Carmel Hospital
Health-Mental Health Services

[redacted]

https://health.gov.mt |
[www.publicservice.gov.mt]www.publicservice.gov.mt

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MOUNT CARMEL HOSPITAL, TRIQ NOTA
ATTARD,

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Appendix H: Psychologist Letter

14th March 2022

Ms. Tania Farrugia

Clinical Psychologist

Psychology Department

Mount Carmel Hospital

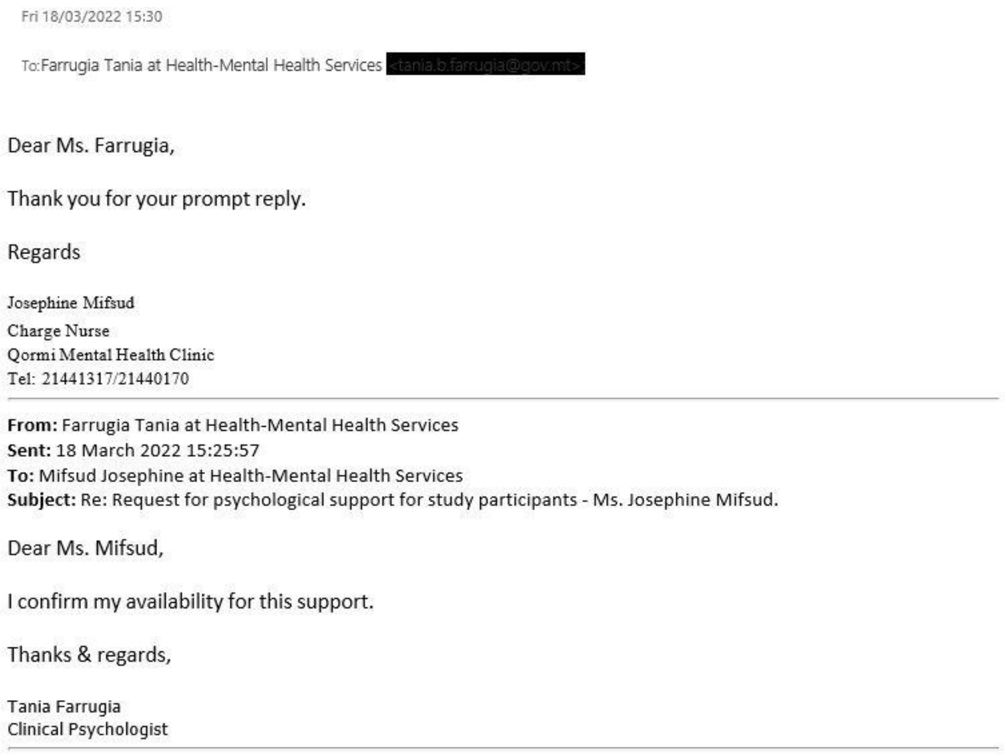
Dear Ms. Farrugia,

In the coming weeks, I will be submitting my application to FREC regarding the research project I will be doing as part of my MSc in mental health nursing. The study will explore the lived experience of “Key Health Professionals” whilst caring for patients detained under a “Community Treatment Order”.I will be conducting six to eight interviews with nurses who are appointed as “Key Health Professionals” who will be referred by Ms. Josephine Cassar who is a Community Nursing Manager who already agreed to act as an intermediary. I am asking for your professional assistance in case anyof the interviewees would feel disturbed and might need the support of a psychologist.

Thanks in advance

Josephine Mifsud

MSc Mental Health Nursing student



Fri 18/03/2022 15:30

To: Farrugia Tania at Health-Mental Health Services [redacted]

Dear Ms. Farrugia,

Thank you for your prompt reply.

Regards

Josephine Mifsud
Charge Nurse
Qormi Mental Health Clinic
Tel: 21441317/21440170

From: Farrugia Tania at Health-Mental Health Services
Sent: 18 March 2022 15:25:57
To: Mifsud Josephine at Health-Mental Health Services
Subject: Re: Request for psychological support for study participants - Ms. Josephine Mifsud.

Dear Ms. Mifsud,

I confirm my availability for this support.

Thanks & regards,

Tania Farrugia
Clinical Psychologist