

**Making sense of Community Treatment Orders:
the service-user experience**

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Since their introduction in 2008, Community Treatment Orders (CTOs) have become an increasingly common feature of mental health treatment. Although compulsory community treatment is used in many countries, there is a lack of consistent evidence of its clinical effectiveness and a dearth of methodically robust outcome studies. The international use of CTOs remains contentious based on the ethics of coercion and infringement of autonomy. Detailed understanding and interpretation of the experiential impact on service-users is necessary to inform the ongoing use and development of CTOs. Although some of the extant literature acknowledges the effect of historical and contextual influences on the implementation of CTOs, these influences have not been comprehensively evaluated. Existing exploratory studies reveal wide-ranging, often conflicting responses from service-users, describing mainly ambivalent reactions to a CTO. This indicates a need for rich detailed data and analysis of the service-users' experience of CTOs.

This study aimed to investigate how service-users make sense of their CTO experience. Ten active CTO service-users were purposefully recruited from an Assertive Outreach Team caseload in the north of England. Each participant undertook one or two semi-structured interviews facilitated with photo-journals and diaries. A total of 18 interviews were completed and the data subject to Interpretative Phenomenological Analysis. Themes were generated and organised into three clusters: *Pained and Powerless*; *Alignment and Reconnection*; and *Consolation and Compensation*. Some participants felt powerless to challenge the 'sentence' imposed as therapeutic intent. Many participants described feeling disadvantaged, different and labelled, but were also committed to recovery and reintegration into the community. Some participants perceived that small interactions could combine to leave them feeling more secure, less anxious and, paradoxically, more in control. The study proposes a theoretical framework that may unlock the therapeutic potential of CTOs, improving lived experience without compromising their social significance or effectiveness.

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Abbreviations

AMHP	Approved Mental Health Professional
AOT	Assertive Outreach Team
CTO	Community Treatment Order
IPA	Interpretative Phenomenological Analysis
LSD	Lysergic Acid Diethylamide
MHA	Mental Health Act
PICU	Psychiatric Intensive Care Unit
RC	Responsible Clinician
RCT	Randomised Controlled Trial
SOAD	Second Opinion Approved Doctor

Chapter 1

Introduction

1.1 Thesis overview

Community Treatment Orders (CTOs) were introduced, following much debate, by Section 32 of the Mental Health Act (MHA) 2007, which inserted new sections 17A-G into the MHA 1983 (Bartlett and Sandland 2014). According to Bartlett and Sandland (2014), the CTO is a legal mechanism that can exert considerable control over service-users in the community. The United Kingdom (UK) mental health charity Mind (2016), describes a CTO as an order made by a Responsible Clinician (RC), usually a consultant psychiatrist, to give an individual supervised treatment in the community. In England and Wales, a CTO can only be made if the person is already on a Section 3 of the MHA and fulfils the following criteria:

- The person is suffering from a mental disorder for which they need to receive medical treatment.
 - They need to receive this medical treatment for their health or safety or for the protection of others.
 - They can receive this treatment without needing to be detained in hospital.
 - The RC needs to be able to recall them to hospital if necessary, *and* (emphasis in original);
 - Appropriate medical treatment is available in the community.
- (Mind 2016)

An Approved Mental Health Professional (AMHP), usually a social worker, must agree in writing that these criteria are met, and they are appropriate to the individual (Jones 2013). A CTO usually lasts for six months from the date of the order, but it can be renewed at the decision of the RC and an AMHP (Jones 2013). In England and Wales, a CTO can come to an end in a number of different ways:

- The CTO expires before it is renewed.

- CTO is revoked following recall to hospital, the CTO ends and the individual is returned to the original Section 3 MHA as the RC considers the person now meets the criteria for detention in hospital.
- The RC discharges the person as the legal criteria for the CTO no longer apply.
- A Mental Health Tribunal discharges the person.
- A hospital managers' hearing discharges the person.
- The nearest relative discharges the person.

(Mind 2016)

The initial UK government predictions that CTOs would only be used for a small number of 'revolving-door patients' proved to be a major underestimation (Rawala and Gupta 2014 p13). According to Mustafa (2015), there has been a total of over 14,000 CTOs issued since their introduction in 2008, and are still used extensively by clinicians in England with a (latest total available at June 2017) total of 5426 service-users still subject to a CTO on the 31st March 2016 (Health and Social Care Information Centre 2016). During 2015/16 4361 CTOs were issued, a 4% decrease compared with 2014/15 (Health and Social Care Information Centre 2016). This compared with previous increases between the years 2010/11 (+10.1%), 2011/12 (+10.1%), then decreases between 2012/13 (-2.9%) and 2013/14 (-4.6%) before increasing again in 2014/15 (+2.9%) (Health and Social Care Information Centre 2016). A international review by Churchill, Owen *et al.* (2007) reported remarkable consistency in the characteristics of service-users on CTOs across very different cultural and geographical settings.

CTO service-users are typically males, around 40 years of age, with a long history of schizophrenia-like or serious affective illness, previous admissions, poor medication compliance, aftercare needs, the potential for violence and displaying psychotic symptoms, especially delusions, at the time of the CTO. (Churchill, Owen *et al.* 2007 p11)

However, this review also reported that 'limitations of the available evidence' prevented any reliable conclusions about specific groups being more likely to become subject to CTOs (Churchill, Owen *et al.* 2007 p11).

When an individual is subject to a CTO, they can be treated in the community for a mental health problem instead of going to hospital, but the RC can return the person to hospital to give immediate treatment if necessary (Mind 2016). The legislation has mandatory and variable conditions attached to the order, and if a person fails to follow the conditions or becomes unwell they can be recalled to hospital for enforced treatment if necessary. The mandatory conditions involve service-users in allowing access to the RC and a Second Opinion Approved Doctor (SOAD), both usually consultant psychiatrists, to undertake periodic reviews. The variable conditions are set by the RC according to circumstance and usually involve the service-user in accepting prescribed treatment and allowing access to the allocated care team at regular intervals.

Examples of other variable conditions include: having to live in a certain place; attending activities or therapy; being tested for alcohol or illegal drugs; and attending appointments for wider treatment (Mind 2016). A person can only be recalled to hospital, in England and Wales, if the RC considers that the individual requires medical treatment in hospital and there would be a risk of harm to their health or safety or to others if not recalled (Jones 2013). Individuals in England and Wales can apply for discharge from a CTO to the Mental Health Tribunal, who cannot look at the conditions, but can assess eligibility to the criteria for the CTO; help with this process is also available from independent mental health advocates (Mind 2016). Also, under certain circumstances, and if the RC does not object, a person's nearest relative can apply to the hospital managers for discharge from the CTO.

The first involuntary community treatment orders were employed in the United States (US) by North Carolina in 1979 and now over 40 states use the orders; Australia was next in 1986, followed by New Zealand in 1992, Israel in 1993, Canada in 1995 and Scotland in 2003; with CTOs now existing in more than 75 jurisdictions worldwide (Rugkasa 2016). Most of these jurisdictions use the term

'Community Treatment Order' to describe the legal instrument used, but certain jurisdictions use alternative terms including: mandatory outpatient treatment; involuntary outpatient treatment; outpatient commitment; involuntary commitment; and assisted outpatient treatment. All of these terms fall under the general descriptive phrase, used throughout this thesis, of 'compulsory community treatment' and wherever possible the use of the term 'Community Treatment Order' is also adopted. Similarly, different jurisdictions and differing disciplines use alternative terms for the subjects of the orders. Wherever possible, the term 'service-user' is used throughout this thesis, but alternative and equivalent terms are used such as: patient; consumer; customer; client; and user. These will be retained in direct quotations and direct references.

When CTOs were introduced to England and Wales in November 2008, I was working as a community mental health nurse in an Assertive Outreach Team (AOT). The referral criteria to AOT included a primary diagnosis of a psychotic illness and a history of disengagement, non-adherence to treatment and a history of repeated hospital admissions (Rawala and Gupta 2014). Many of the AOT service-users were subject to CTOs and their reaction to enforced community treatment was perplexing to me and my colleagues. Service-users found it difficult to describe their feelings towards the new legislation and their responses were sometimes unexpected and surprising. I and my colleagues anticipated a dualistic response from service-users. The more volatile and extrovert individuals were expected to exhibit a hostile backlash to the orders with overt refusals to comply with the conditions. A more ready acceptance was expected from the quieter more introverted people, welcoming a return to the community and discharge from hospital.

However, service-users appeared to display a diverse response that included more subtle and covert resistive approaches, together with some distress, frustration and hostility towards the orders, as well as some nuanced apparent agreement with the CTO. Some service-users described conflicting responses at different times, as well as other individuals expressing opposing views within the same narrative. It quickly became clear to me and my colleagues that clinicians did not understand the apparent complexities of the service-user lived experience

on a CTO. It was therefore difficult to determine how best to support these service-users or to develop a nursing intervention strategy that might improve the effectiveness of CTOs.

The service-user experience and perspective forms the basis of this study and therefore priority is given to this viewpoint throughout the research process. Chapter 2 places CTOs in historical and current context to critically explore how such background information can influence the development and use of CTOs. Chapter 3 reviews the extensive international literature on the use of CTOs which includes quantitative outcome studies and systematic reviews as well as the published qualitative studies that examine the service-user experience of CTOs. This chapter examines the numerous studies that describe the clinical effectiveness of CTOs, usually undertaken by researchers adopting a medical model approach. Other studies are also examined that aim to describe the factors that influence service-user CTO experience often identifying typologies and grouped responses.

Chapters 2 and 3 comprise a critique, appraisal and exploration of the body of knowledge surrounding CTOs which indicated a need for further qualitative investigation. In October 2013 the Secretary of State for Health published a post-legislative scrutiny of the Mental Health Act 2007, where the Department reviewed all aspects of the amended 1983 Act, which included the introduction of CTOs in November 2008 (Health 2013). This review recognised the need for a good practice guide and also recommended that the Ministers should 'keep CTOs under review' and 'should commission a fuller analysis of the value of a CTO in different clinical situations' (Health 2013 p2). Such analysis would aim to include an in-depth examination of the meaning and understanding of CTOs for service-users and the felt impact of CTOs on their daily lives. Chapters 4 and 5 detail the design, development and implementation of the study. These chapters describe the research theory, methodology and methods which have informed the research process. Options, selections and rationales are critically examined from initial design, through the recruitment process, data collection and analysis, to an evaluation of validity and quality. Chapter 5 also presents individual profiles of the ten participants involved in the study, summarised from clinical (medical)

case notes, together with brief biographical information and an indication of participants' previous use of mental health services. Participants were purposefully recruited from an Assertive Outreach Team and agreed to undertake one or two semi-structured interviews each. The study included 18 interviews in all, facilitated by timelines, diaries and photo-elicitation.

Chapter 6 reports the outcomes of the analysis with supporting extracts from participants' interview transcription which generated in-depth, rich, detailed and textured narrative. The analysis identified twelve themes which were organised into three clusters. The first cluster entitled *Pained and Powerless* represented a negative response to participants' CTO experience. This cluster included responses where participants felt powerless to challenge the 'sentence' imposed in the guise of therapeutic intent. In the second cluster, *Alignment and Reconnection*, some participants described feeling disadvantaged, different and labelled. However, they were also committed to recovery and reintegration into the community. Some participants in the third cluster, entitled *Consolation and Compensation*, perceived that small interactions with others could combine to leave them feeling more secure, less anxious and, paradoxically, more in control.

Chapter 7 further discusses the findings and analysis together with emergent constructs from the extant literature. By incorporating and combining data from the current study with themes, concepts and theory from the existing qualitative studies, new perspectives and alternative viewpoints can be explored. The discussion also acts as a sensitising interpretive lens to further the understanding of service-user CTO experience, as well as clarifying and extending the body of knowledge. Finally, Chapter 8 summarises the investigation and draws conclusions. The participants' negative feelings of coercion and control are balanced against more positive perceptions of therapeutic approaches. This section then proposes a way forward for the future use of CTOs with brief application examples. The chapter makes recommendations for future research, and provides a structured evaluation of the present study.

1.2 The research question

As yet, the research demonstrates no robust evidence that CTOs offer clear clinical benefit; yet their continued use is indicated. It is therefore important to attempt to establish how service-users understand the use of CTOs and how that use is experienced by individuals. The following research question, aims and objectives are proposed to further explore the phenomena of CTOs from the service-users' perspective.

**How do service-users make sense of their
Community Treatment Order experience?**

Capturing 'lived experience' is more than simple description, it captures the meaning and effect of the experience and the impact on daily life (Smith, Flowers *et al.* 2009). The participant and the researcher may uncover and reveal the detail of this lived experience through interaction and interpretation (Ponterotto 2005).

1.2.1 Aims

1. To explore, in-depth, the meaning, understanding and purpose of CTOs for service-users and the felt impact of CTOs on their daily lives.
2. To examine the service-user story, account and description of their mental health journey up to the implementation of the order as well as their current experience.
3. To assess the influence of historical and current social context on the development of CTOs.
4. To generate analytic outputs, through Interpretive Phenomenological Analysis (IPA), that may inform the way in which CTOs are understood and utilised.

1.2.2 Objectives

1. To progressively build a qualitative data set from ten service-users through the use of timeline interviews, photo-journals and diaries.
2. To review the wider literature in order to position CTOs in a contemporary socio-political context and current service provision.
3. To use IPA to engage in interpretation, analysis and reflexivity (Smith, Flowers *et al.* 2009)
4. To organise this material in a format that allows for analysed data to be traced and verified from initial comments on the transcript through thematic and clustering development into a final structure, discussion and conceptual model.
5. To use supervision and collaboration to test and develop the coherence and credibility of the interpretation and analysis.

Chapter 2

Historical and contextual development of CTOs

2.1 Introduction

According to Churchill, Owen *et al.* (2007), CTOs could be used to 'manage mentally-ill patients who failed to adapt to community life following the widespread closure of asylums' (p17). Rawala and Gupta (2014) reconceptualised this background to CTOs as stemming from the deinstitutionalisation of psychiatric services which led to improved community care provision. But this 'care in the community' also resulted in some service-users requiring frequent readmission in order to manage risk behaviours and offer more intensive treatment intervention (Rawala and Gupta 2014). Although many practitioners, academics and politicians have had serious concerns about failings in community care, these criticisms have usually connected with broader critical debates and past practices. Therefore, in order to fully understand the development and continued use of CTOs, it is necessary to further examine the contextual components and historical elements that have influenced the evolution of CTOs, specifically in England and Wales, but also in much of the Western world.

This chapter evaluates the contextual influence of the phenomenon of 'madness', where 'the mad' are distinguished from 'normal' and the regulation of the former is examined. The legacy of the asylum system and the former reliance on large mental hospitals will be examined. This is, potentially, an important influence of CTO service users and service providers alike as many will have had formative experience of these institutions. It follows that the closure of such establishments also had an effect on service-users and providers because of some of the problems associated with care in the community. The chapter then examines the origins of CTOs which stemmed from public reaction to high profile incidents involving people with mental illness in the community. These historical and contextual developments are critically linked to, and associated with the treatment of mental illness and the power of the pharmaceutical industry. Because CTOs operate in the community, the protection of society will also be

examined and critically evaluated in the light of mental health legislation and proposed service provision.

2.2 Madness

According to Morrall (2016), 'madness' induces both fear and fascination. Possibly, the phenomena cannot be ignored because it links with the primitive history of humanity, and possibly because the term puts boundaries on a comparative 'normality', and especially when 'mad' individuals are in with the rest of society (Morrall 2016). Leading scholars and pre-eminent historians of insanity such as Andrew Scull (2015) often refer to the 'massive and lasting disturbances of reason, intellect and emotions' as 'madness' (p11). According to Porter (2002), madness may be as old as mankind; is a term that few people have difficulty understanding (Scull 2015); and distinguished the 'normals' (Goffman 1959). Foucault (1961) referred to *l'aliénation mentale*, a stigmatised term responsible for what Morrall (2016) refers to as *la difference mentale*, a Foucauldian notion which signified a special and different variation from the norm. This term also provided a perceptual silo in which to place those identified by professionals, the laity, journalists, novelists and filmmakers (Morrall 2016).

'Madness' also extends beyond a medical gaze, offering a much broader salience involving social order and the cultures we form part (Scull 2015). For Scheff (1984) it is a label of last resort applied by the judiciary and psychiatry as well as a label applied for rule-breaking when all other labels have been ruled out. However, from Plato to the last decades of the twentieth century there has been a presumed need to segregate the mad from society (Porter 2002). Initially the family was assigned this responsibility but later, a new trade in lunacy developed, where private madhouses provided convenient places of confinement for removing mad relatives from families (Scull 2015). However, the horrors of the madhouses were soon exposed by enlightened individuals who initiated a moral fervour and enthusiasm for a supposedly more scientific and humanitarian approach (Scull 2015).

This advance in treatment of the mentally ill which contributed to the development of Foucault's (1961) 'great confinement' and the decision to construct an ever-

larger network of institutions that became, according to Scull (2015), the most notable feature of the Western response to mental disorder. Foucault (1961) maintained that this segregation amounted to more than physical separation but the debasement of madness itself, robbing madness of its force, fascination and empowerment previously enjoyed in the community. Porter (2002) argued that, although plausible, this perspective is simplistic as the 'great confinement' was slow to spread throughout jurisdictions. Institutionalisation was not the spectacular and automatic solution suggested by Foucault, although the rise of the asylum is contested, obscure and served many interests (Porter 2002).

According to Giddens (1991), asylums were first established with their curative properties in mind. However, the sequestration of the mentally-ill soon became synonymous with social control and the management of 'deviance' which arose from 'the inability, or unwillingness, to live the required type of life in the outside world' (Giddens 1991 p160) It could be argued that a similar form of legal sequestration is associated with the use of CTOs and some of the problems in 'dealing' with the supposed anti-social behaviours of 'madness' are now addressed by CTOs. For example, CTOs, rightly or wrongly, distinguish 'the mad' from 'normal', as well as attempting to [legally] segregate and regulate the two from each other (Bentall 2009). For CTO service-users with a diagnosis of 'serious' mental illness, such as schizophrenia and Bi-Polar Affective Disorder, often remain linked to dis-valued and distrusted groups, and are strongly associated with perceived and actual threat and nuisance (Rogers and Pilgrim 2014). As a consequence, this could subsequently influence their experience in the community as mental illness or 'madness' increasingly becomes a public matter (Rogers and Pilgrim 2014).

2.3 Asylums

Historians of madness all emphasise the significance of the rise of the asylumdom (Foucault 1961; Porter 2002; Scull 2015) and the associated legacy (Rogers and Pilgrim 2014). This segregation of 'the mad' into large institutions took place from the seventeenth century onwards across Europe, North America and Australasia, although there is wide disagreement on the precise timings of

this movement as well as comprehensive explanations for the shift (Rogers and Pilgrim 2014). Morrall and Hazelton (2000) describe asylumdom as social and/or physical apartheid, the response of the powerful to those perceived as *non-compos mentis* to contain them beyond the scrutiny of the 'normal' population. Although asylums varied in quality, reformers exposed many incidents of ill-treatment, cruelty and corruption (Porter 2002). This was not necessarily the intention of asylumdom and may have offered inmates refuge from far worse conditions living with relatives (Morrall and Hazelton 2000).

Most asylums were built as rural retreats on the outskirts of major cities and operated as self-sufficient communities with their own water supply, farms, laundries and workshops (Killaspy 2006). Isolation from one's everyday social environment was viewed as therapeutic even though this type of institutional apparatus was carceral rather than curative, where prompt removal from home or community was an important condition of recovery (Miller and Rose 1986). However, separation from the community also isolated practitioners from their colleagues in other developing medical specialities (Killaspy 2006). The asylum was not instituted for the practice of psychiatry, but psychiatric practice developed to manage the inmates with experience and innovation leading to 'moral treatment', with reformist ideals and an intent to standardise care and treatment (Porter 2002). Morrall and Hazelton (2000) maintained that moral management was based on a more benevolent approach where the mad could be returned to normality when subjected to more humane treatment. From the later part of the eighteenth century, psychiatrists established a power base in the asylums and moral management competed with stimulants, sedatives, emetics, purgatives, bloodletting, mechanical restraint and the electric shocks of progressive psychiatry (Morrall and Hazelton 2000).

According to Miller and Rose (1986), there were 'profound and fundamental challenges' (p16) to psychiatry's ability to cure insanity, and psychiatry's ambition to provide a curative machine in the shape of the asylum, was attacked at every opportunity. The fundamental critique still centred around the brutality of care and deprived conditions of incarceration as well as the organised monotony and asylum routine as a device for maintaining order rather than effecting cure (Miller

and Rose 1986). Another profound critique of asylumdom concerned psychiatry's theoretical framework and the shift towards today's dominant model where organic and genetic factors are viewed as underlying causes of mental 'illness'; and social, familial and environmental pressures function as 'triggers' (Miller and Rose 1986 p17). In the early decades of the nineteenth century the situation was different; a psychological/social model was dominant, and the notion of moral treatment held central. 'Moral' referred to concepts distinct from the physical nerves, fibres and ducts of the body and their contents; where emotions, daily routines and the enjoyment of luxury were prominent. However, in the latter part of the century these conceptual schemas were reversed (Miller and Rose 1986). Psychiatry's aspiration to align itself more closely with general medicine was established which demanded an aetiology based on hidden causal mechanisms that sought to identify a specific and constitutive lesion'; this was a move away from a 'social phenomenology of disorder toward general medicine' (Miller and Rose 1986 p18).

Further critique of the asylum system was generated from a landmark study by Erving Goffman (Goffman 1961) in four essays on the social situation of mental patients. This study examined: the characteristics of total institutions; the moral career of a mental patient; the under life of a public institution; the medical model and mental hospitalisation (Goffman 1961). Goffman (1961) described the stages of a process he termed 'mortification of the self' (p50) through a subtle system of rewards and punishments. This was combined with relief from economic and social responsibilities to foster an acceptance of the institutionalised view of the self where the inmate tried to act out the role of perfect inmate (Goffman 1961). This, in turn, reinforced the role of chronicity in mental illness which added to the mortification process and promoted further anxiety about being able to 'make it on the outside' (p69), according to Goffman (1961), a major reason why ex-inmates often do return. This introduced Goffman's notion of a moral career which is described as a series of betrayals where the individual is promised that successive deprivations of liberty and autonomy are in the inmates best interests and 'for their own good' (Suibhne 2011 p1). Suibhne (2011) argues that Goffman views mental illness as socially constructed, writing:

Mental hospitals are not found in our society because supervisors, psychiatrists and attendants want jobs; mental hospitals exist because there is a market for them. If all the mental hospitals in a given region were emptied and closed down today, tomorrow relatives, police and judges would raise a clamour for new ones; and these true clients of the mental hospital would demand an institution to satisfy their needs' Goffman cited in Suibhne, (2011)

Goffman (1961) argued that life in the total institution of the asylum was damaging and dehumanising to those confined. According to Scull (2015) this promoted a need for beneficent reform which was also initiated by funding and fiscal changes which necessitated the imperative to make substantial savings on state budgets. This proposed move from the asylum to the community was assisted by 'a barrage of scholarly and polemical criticism of the traditional mental hospitals that concluded that such institutions were, in fact, obstacles in the effective treatment of the mentally-ill' (Scull 2015). Much of this research was authorised by sociologists such as Goffman, but also renegade psychiatrists such as Thomas Szasz (1972) and R.D. Laing (1964). Szasz believed that mental illness was a myth and not a medical condition, a metaphorical sort of disease that was, in fact, a disparaging label that allowed the state and its agents in the form of psychiatrists 'to employ therapeutic rhetoric to confine troublesome people' (Scull 2015 p373). According to Szasz (2002), institutional psychiatry was an instrument of oppression, social correction and 'psychiatric slavery (p5).

Even though the era of massive institutions and grosser abuses reviewed by psychiatry and social scientists are recorded as institutions of the past, the dehumanising effect of any form of institutionalisation or any social system that reduces some individuals to a mere role still has resonance in the current climate (Suibhne 2011). Many service-users on CTOs will have experienced detention in mental hospitals and the 'asylum' system, and could re-live those experiences under the restrictions of a CTO. The idea of CTOs as virtual asylums resonates with many of the features of institutional asylums. For example, the power of

psychiatry is developed and maintained within their role as Responsible Clinicians in the CTO legal mechanisms; the subtle rewards and punishment systems of the asylum are replicated in the coercive nature of CTOs; and the notion of a moral career is still maintained by the CTO system within psychiatry.

2.4 Deinstitutionalisation

According to Scull (2015), asylums as 'instruments of treatment' were an enormous success, 'no matter how many asylums were built, more lunatics materialised to fill them' (p222). In order to address this ever-increasing asylum population, outpatient departments were established which assessed applicants to the asylums (Killaspy 2006). In 1925, there were 25 psychiatric outpatient departments in the UK, this increased to 162 over the next 10 years and, according to Killaspy (2006), formed the origins of community psychiatric care. This development began to transform the face of psychiatry in the decades following World War II with the psychiatric reforms promoted by The World Health Organisation (Novella 2010). An international consensus arose to overcome the old asylum-based system of care and establish new community-orientated therapeutic approaches with new policy strategies and systems (Novella 2010). Novella (2010) maintained that this involved moving away from the traditional institution of the mental hospital and resulted in considerable discharge of patients; the term deinstitutionalisation was coined to encapsulate this reform and is now often used in a problematic synonymous way.

Scull referred to this demise of the asylum as 'decarcerating the mad' (Scull 1977 p64), describing this transformation as 'astonishing', where changes of the [then] past two decades have run counter to the previous century-and-a-half-old trend of incarcerating vast numbers of inmates in mental hospitals. Running in parallel with these developments, a supposed shift towards the provision other community-based mental health services, such as supported housing, day services, community mental health nurses and social workers coupled with smaller inpatient and outpatient units based in and around district general hospitals (Killaspy 2006). However, there were also reported inadequacies in community service provision for people previously living in asylums and,

according to Killaspy (2006), this has provoked much debate over the last five or six decades.

As mentioned previously, early critics declared that community care had failed, citing concerns over the increased numbers of homeless secondary to the closure of the asylums. Scull (1977) argued that rhetoric associated with decarceration only served as 'ideological camouflage, allowing economy to masquerade as benevolence and neglect as tolerance' (p152). However, longer term studies indicated that the majority former inpatients had increased social networks, developed independent living skills and improved their quality of life without readmission to hospital (Leff and Trieman 2000; Thornicroft, Bebbington *et al.* 2005; Trieman and Leff 2002).

Yet there was also an acknowledgement that not all people adapted well to the policies of deinstitutionalisation; as the size and role of the old institutions reduced, much needed sanctuary was destroyed, particularly for those requiring the highest levels of support (Novella 2010). Many health care systems have been dramatically reduced to restricted acute hospital units and loose outpatient services with discharged service-users becoming dependent on under-funded public social services, families or informal carers (Novella 2010). Novella (2010) also introduced the critical parallel development of 'transinstitutionalisation' (p229) where former patients of mental hospitals have been transferred to alternative non-psychiatric, privately-run nursing and residential homes or care centres, which are often understaffed, provide little stimulation, which socially isolate service-users, and offer poor administration and little legal protection. Other chronic former hospital patients became homeless, were imprisoned or admitted to specific forensic institutions; many simply existed in loneliness, poverty, bad living conditions and with poor physical health (Novella 2010).

Yet because of the public's inherent fear and fascination with mental illness (Morrall 2016), societal attention has turned from charitable concern for this group's welfare into increasing rejection of them (Killaspy 2006). CTOs have been proposed as a solution to some of the problems associated with community care and the perceived care-gaps when compared with institutional care. The

legal framework surrounding CTOs also puts a responsibility on care providers to maintain adequate levels of support for those on CTOs. This would incorporate increased levels of monitoring for risks associated with relapse, unacceptable behaviours, housing problems and isolation (Churchill, Owen *et al.* 2007). The previously mentioned idea of CTOs as 'virtual asylums' could address some of the problems linked to deinstitutionalisation whilst minimising the economic and social costs involved (Novella 2010).

2.5 'Dubious origins' of CTOs

According to Snow and Austin (2009) CTOs have international 'dubious origins' (p179). This is because CTO legislation, particularly in the US and Canada, was frequently named after an individual who was killed by a person who had been diagnosed as mentally ill at the time of the incident. Brian Smith, a Canadian sports broadcaster, was shot dead by a mentally ill attacker leading to 'Brian's Law' being implemented in 2000 (CBC News 2000). In California 'Laura's Law' was passed in 2002 following the shooting of Laura Wilcox; she was working in a County Behavioural Health clinic where a client 'went on the rampage' and shot three people dead 'without warning or provocation' (Treatment Advocacy Center 2011). Also in the United States the New York law known as 'Kendra's Law' was implemented as a consequence of a 1999 incident where Kendra Webdale was pushed in front of a subway train by a person living in the community at the time and not receiving treatment for his mental illness (Office of Mental Health 2006). Kendra's family worked to change the law around outpatient commitment and had a significant role in getting the law passed.

In the Britain a similar incident occurred in 1992 at Finsbury Park station when Christopher Clunis fatally stabbed Jonathan Zito in the eye. The official report into the homicide identified a catalogue of errors and missed opportunities in the care of Clunis even though he had a diagnosis of schizophrenia, a long history of violence and known poor compliance with treatment (Bowcott 2009). As a direct consequence of this incident, Jonathan's wife, Jayne Zito set up the Zito Trust which was established to ensure that mental health service-users receive new treatments; to also provide support and advice to the wide range of people

contacting the trust with their problems and concerns; and to use their 'considerable influence' in proposing reforms to the Mental Health Act 1983 (Howlett 2000). The Trust 'wound itself up' in 2009 after years of supporting victims and lobbying for improvements in the delivery of community care services for the mentally ill; this coincided with the 2007 amendments to the Mental Health Act and the charity announcing that their 'work is done' (Bowcott 2009 p1). The Zito Trust represented the needs and concerns of the victims of community care failures and advocated that service-users with a history of violence should be subject to compulsory drug regimens and they felt that the introduction of CTOs under the amended act satisfied this demand (Bowcott 2009).

In 1998 the then UK Health Secretary Frank Dobson famously announced that 'Community care has failed' (BBC 1998). Dobson detailed a plan for a significant review of care in the community proposing an overhaul of mental health legislation, plans for crisis intervention and more support for the seriously ill, some of whom had slipped through the community care net. Dobson was reported as saying:

'Discharging people from institutions has brought benefits to some. But it has left many vulnerable patients to try to cope on their own. Others have been left to become a danger to themselves and a nuisance to others. Too many confused and sick people have been left wandering the streets and sleeping rough. A small but significant minority have become a danger to the public as well as to themselves.' (BBC 1998 p1).

Mr Dobson suggested that the government bring in community treatment orders to make sure patients get supervised care if they do not take their medication or if their condition worsens. However, Jayne Zito commented that resources and legislation were not the only problems and she believed that professionals had sometimes failed to detain people who were a risk to themselves and the community. She said:

There have been failures at a professional level to intervene and assess those patients who pose a risk'. (BBC 1998).

This situation mirrored incidents and developments in other countries resulting in a 'sort of expanding chain reaction' (p223) and within two decades all major Western countries were affected by a similar challenge in their mental health systems (Novella 2010). This was characterised by a crisis of the old institutional model, discussion of alternatives (often within the context of growing social and media interest), and political involvement with new legislation or national guidelines (Novella 2010).

Thus the legislation for compulsory community treatment started to emerge in the context of expanding community psychiatric services as more effective psychiatric treatments and legal reform heralded the process of deinstitutionalisation and decreased need for long and expensive hospital admissions (Snow and Austin 2009). However, Rees (2009) maintained that this movement of patients into the community and the closure of the large institutions was an 'administrative act' (p70) suggesting that these wide ranging changes away from building-based care were imposed on service-users more for the benefit of service providers. Snow and Austin (2009) examined the issue from an ethical perspective and suggested that the community was not ready to receive so many former hospital patients and that the stigmatising condition of mental illness was a major complicating factor in the community response. Successive governments remained committed to the principles behind the policy of closing long-stay psychiatric institutions but simultaneously acknowledged that the mental health system was, at times, failing in practice (Waterhouse 1994).

It could be argued that these powerful social, economic and political influences all combined towards the international development and implementation of CTOs. The public reaction to high profile incidents in the community and subsequent media reporting is as today as it was in the early 1990's and throughout modern history (Morrall 2016). This powerful public response, in turn, still motivates political lobbyists (Rose 2007); and is further driven by ever-increasing economic pressures in the current climate (BBC 2016). These contextual indicators suggest

that, despite the lack of clinical evidence, CTO use will probably continue for the foreseeable future in order to satisfy some of the socio-political and economic demands of the current healthcare climate. However, the more liberal view argues this socio-political response can deflect the emphasis away from treatment towards social control; however, a more widespread view suggests this re-corrects an imbalance towards unavoidable and necessary increases in social control.

2.6 Treatment of mental illness

This section offers a critical examination of the key debates around the treatment and medical approach to mental illness. According to Busfield (2011), the medical framework for understanding and treating mental illness has become dominant because of the professional activities of psychiatrists, but it has been widely contested both within and outside psychiatry. Although the precise character of challenge varied, the criticisms of psychiatric concepts and practice could be grouped into four main areas:

- The concept of mental illness is fundamentally flawed.
- Psychiatric practice is often inhumane, inappropriate and ineffective.
- The categorical model of mental diagnoses is defective.
- The concept of mental illness has been over-extended and applied too widely.

(Adapted from Busfield 2011)

The best-known critics have been grouped together under the 'anti-psychiatry movement', gaining their highest profile in the 1960's and 1970's (Porter 2002 p209). These critics included Thomas Szasz (1972) and Thomas Scheff (1984), who particularly attacked the concept of mental illness; Erving Goffman (Goffman 1961) and Michel Foucault (1961) were critical of psychiatric practice; and R.D. Laing (1964) was critical of both concept and practice; with all these individuals critical of the asylums (Porter 2002). Whilst medical historians present the story of psychiatry as one of ever-increasing psychiatric scientific investigation leading to more precise and effective interventions, the counter discourse of anti-

psychiatry argued that psychiatry was essentially an instrument of oppression (Bracken and Thomas 2005).

Szasz (1972) made the case that mental illness was a myth or, more specifically, that mental disorders were mere metaphors unless there was proven organic causation (Morrall 2016). Szasz's position was grounded in libertarian ideas which objected to the coercive, paternalistic control involved in compulsory detention, which he argued was incompatible with medical values (Busfield 2011). When psychiatrists choose to conflate coercion with care, they commit, according to Szasz (2002), psychiatry's 'original sin' (p31); where in fact psychiatry acts as a branch of the law, but in practice purports to be a branch of medicine, concerned with diagnosing and treating disease:

'In one of his roles, the psychiatrist is an agent of society ... One task requires coercing the 'patient'; the other task rendered impossible by the slightest threat of coercion, much less its actual exercise. Psychiatry's original sin is its refusal to acknowledge that the relationship between the psychiatrist and the involuntary mental patient is adversarial. In other words, the psychiatrist is a double agent, pretending to serve – impartially and 'scientifically' – the interests of both parties to a conflict: the mental patient and his psychiatric opponents, such as family members, employers, and courts. This is the source of virtually all of the problems that beset mental health legislation and mental health policy.' (Szasz 2002 p31).

He advocated a contractual, non-medical psychiatry, open to doctors and others, who could help and act in the patients' best interests, with separate 'prosecuting' psychiatrists acting for the state in criminal cases involving mental patients (Busfield 2011).

R. D. Laing gained notoriety for his book *The Divided Self* which was presented as a serious study of schizophrenia combining dense existential theorising with psychotherapeutic insights to provide a startling account of the inner world of a psychotic patient (Bentall 2009). Laing rejected the medical approach to mental

illness, claiming that psychosis was a logical reaction to victimisation within the nuclear family. This approach, understandably, was challenged by the families of children with psychosis, who often became increasingly sympathetic to medical models that redirected 'blame' towards genes, biochemistry and brain defects, rather than their dysfunctional relationships (Bentall 2009). Laing's views resonated with the liberal spirit of the times, and he was able to propose that the behaviour of a supposedly insane person could be rendered intelligible if it were placed in context and essential efforts made to understand the social norms and values used in judgment (Busfield 2011). The seemingly bizarre behaviour and incomprehensible speech of the mental patient, dismissed by many as meaningless, was in fact rich with meaning when viewed as an expression of distress they experienced from the dysfunction imposed by those closest to them (Scull 2015).

Thomas Scheff is often associated with anti-psychiatry with ideas presented in his classic study *Being Mentally Ill* (1984) which, according to Busfield (2011), located mental illness in the realm of deviance, drawing on symbolic interactionism and labelling theory. Scheff argued that symptoms of mental illness are better viewed as 'labelled violations of social norms' (p114) and chronic mental illness manifested as a social role (Busfield 2011). According to Morrall (2016), mental disorder for Scheff was a label applied for rule-breaking by the public and the media which also involved everyday rules of human performance such as respecting culturally appropriate interpersonal distances, culturally accepted speech in terms of situation and content. Once an individual's behaviour becomes labelled as rule-breaking they are likely to enter into a 'career' of a mentally-ill person, especially if marginalised and powerless and therefore less able to resist the application of the labelling process, which, in turn, leads to a cycle of further labelling and reinforcement (Busfield 2011). All these theorists within the anti-psychiatry movement represent a view 'from the other side' and elevate the notion of service-user subjectivity to highlight the deficiencies of psychiatric practice (Miller and Rose 1986 p28). They all emphasised the social character of human action and the need to put those actions (as symptoms of mental illness) within their social context. According to Busfield (2011), they also gave rise to the psychiatric survivors movement,

where the message of listening to, and consulting with, service-users is now more common within mental health provision and service development.

Psychiatric survivor groups shared some of the concerns expressed by critical professionals during the 1960's (Rogers and Pilgrim 2014) and in Britain the Mental Patients Union emerged in 1971 influenced by some of the radical ideas of the time (Busfield 2011). Around the same time similar groups were forming in Europe, the US and Canada and subsequent groups included British Survivors Speak out and the important Hearing Voices Network initiated in the Netherlands in 1987, which became increasingly influential across Europe and the US. According to Barker and Buchanan-Barker (2005), the Hearing Voices Network showed how formerly passive patients reclaimed their distress and applied their own labels within a philosophical framework that is personally and culturally meaningful. All such groups aim to reclaim their stories and experience of mental distress as well as challenging the 'territorialism and colonisation of madness' by the psychiatric establishment (Barker and Buchanan-Barker 2005 p5). The Psychiatric Survivor Movement was the result of the transformation of lone 'atomised voices' developing into a collective voice of shared resistance and demands for change which, in turn, connected to broader transformations in the social, economic and health arenas (Rogers and Pilgrim 2014 p213). Throughout this period the asylums in the UK continued to close with some patients and ex-patients supporting the programme of closure, but also expressing strong concern for the proposed post-closure provision of care in the community (Taylor 2015).

For all its failings, the asylum system fulfilled many treatment-related therapeutic functions including acute care and custody; physical assessment and treatment; occupational therapy and vocational rehabilitation; shelter; nutrition; basic income and clothing; provision of day and respite services; and much more (Thornicroft and Bebbington 1989). The development of alternative comprehensive services has been problematic, often leading to gaps in care due to the complexity of the network of ambulatory clinics, psychiatrists and/or psychotherapists, therapeutic communities, community clinics, day clinics, workshops, and the like, that are often poorly coordinated and autonomous in operation (Novella 2010). Whilst

Scull (1977) predicted this development as a consequence of capitalist influences, others maintain that the practice of psychiatry was able to adapt to occupy a central role in the 'therapeutic' management of severe and enduring mental illness which was made possible, in large part, to the parallel evolution of psychopharmacology – namely neuroleptic drugs (Bentall 2009; Moncrieff 2008; Trimble 1996). Szasz (2002) argues that antipsychotic drugs are 'founded on faith, not fact...they function as chemical straightjackets' (p151), because chemical restraint does not make others feel guilty, there is an inherent danger in their use:

'Being "on medication" becomes synonymous with being in control of one's self, or being properly controlled by competent experts, making patients and nonpatients alike feel that all is well with the world.' (Szasz 2002 p151-152)

Moncrieff (2008) maintained that the effect of this medication was a state of reduced physical and mental activity, including reduced emotional reactivity and indifference, which may suppress psychotic thought processes in low doses, but many patients find the effects of these drugs more unpleasant than their psychosis. Nevertheless, in most psychiatric services, medication is the first and sometimes the only kind of treatment offered and psychiatrists usually persist, even in the face of initial failure, to experiment with a series of different drugs, sometimes in combination and often at increasing doses (Bentall 2009).

According to Bentall (2009), many historians trace the modern psychopharmacological era of psychiatry to one single event, the accidental discovery of chlorpromazine's 'euphoric quietude' effect on the central nervous system, which rendered individuals 'tolerant of pain and indifferent to their surroundings' (p45). Others, such as Porter (2002), include the discovery of the psychotropic effects of lithium, which combined with phenothiazines (such as chlorpromazine) to replace the 'old black cartridges' (p205) of bromides and croton oil as well as the dangerous amphetamines widely used in the 1930's to treat mental illness. Many believe the development of these new drugs enabled patients to leave or avoid the psychiatric hospital, and maintain life, under

continuing medication, in the outside world. However, problems of side-effects, adherence and dependency were perennial, and major ethical and political questions arise when pharmaceutical products reshape personalities, especially when the development and marketing of such drugs are controlled by extremely powerful and influential monopolistic multinational drug companies (Porter 2002).

According to accepted theory, antipsychotic drugs are effective in treating the positive symptoms of psychosis because they block the effects of increased dopamine in the brain's limbic tract (Burton 2009). However, other brain tracts can also be affected, causing a number of unpleasant side-effects such as sedation, weight gain, involuntary muscle movement, loss of libido and sexual dysfunction, as well postural hypotension, dry mouth, blurred vision and constipation (Burton 2009). People taking the medication complain of 'zombification' and that psychiatrists do not listen to them (Taylor 2015). Taylor (2015) recognised that pushing remedies instead of listening is an old story, and if psychiatrists really listened to service-users there would only be a few patients on long-term medication:

"From eighteenth-century bloodletting and purging, to twentieth-century psychosurgery, ECT and neuroleptics, the preferred mode in mind-doctoring has been to deal with madness from a safe distance (...) One of the biggest problems with meds (...) is that they blunt the affect of doctors, allowing them to imagine themselves as dispassionate brain-fixers instead of what they really are – fellow human beings, with all their anxieties and vulnerabilities, caught up in the complex, highly charged relationships with their patients."
(Taylor 2015 p259)

Barbara Taylor (2015) maintained that madness touches us all in hidden places and the urge to push it away can be overwhelming; she cites examples of best practice involving 'up-close, sympathetic care relationships' (p259).

However, biological psychiatry continues to be dominant and driven by the reductionist view that has been successful elsewhere in medicine; so much so that its supporters never question the reductionist application to psychiatry assuming its truth is self-evident (McLaren 2007). Sidley (2015) recognised that almost everybody with a diagnosis of schizophrenia will have been prescribed antipsychotic medication either as treatment for an acute episode or as maintenance even though they display few, if any, ongoing symptoms. Sidley (2015) offered a concise review of the empirical evidence evaluating the effectiveness of antipsychotics:

‘Given the research to date, it is reasonable to conclude that a drug’s success in reducing psychotic symptoms may chiefly reflect a broad tranquillising effect rather than any specific antipsychotic action.’ (Sidley 2015 p153)

Despite this lack of evidence and the persistence of unpleasant side effects, most people suffering from psychosis are instructed to continue taking antipsychotics indefinitely (Bentall 2009). Not surprisingly, according to Bentall (2009), some people become non-compliant with this medication and often the refusal to accept the medication is interpreted as a sign of relapse. Then the dose is, paradoxically, increased as well as long-lasting depot injections considered where the medication is slowly released from an oily or water-based medium over a period of weeks. However, attending for a painful injection adds to the already unpleasant experience of treatment and many service-users actively avoid such an intervention, which again is often interpreted as a sign of relapse or lack of insight (Bentall 2009).

As well as, or perhaps because of, these reported problems associated with biological treatments, service-users request ‘talking treatments’ (p134), complaining that such treatments are less frequently available than physical treatments (Rogers and Pilgrim 2014). These talking treatments generally rely on narrative as a resource for personal change; the service-user narrative is then used to generate an expert meta-narrative, which then informs the preferred model of the practitioner to develop a therapeutic approach (Rogers and Pilgrim

2014). The effectiveness and costs of such therapies are difficult to gauge, measure and evaluate as such confounding factors as client-practitioner interaction and practitioner competencies, good or inspirational practitioner variables and the service-user abilities for change. Such inter-subjective factors are difficult to audit as well as difficult to prescribe in guidelines and best practice instructions when compared with drug-prescribing practice (Rogers and Pilgrim 2014).

The individualistic treatment approaches featured in the foregoing section depend on 'an eclectic focus on a vague compound of social, psychological and biological factors' (Scull 2015 p379). However, the last decade has witnessed a shift from these individualistic level approaches to a wider set of factors defined at higher or lower levels (Allardyce and Boydell 2006). Examples of higher level factors include families, neighbourhoods, countries, or cultural contexts; and lower level factors usually concentrate on genetic or molecular properties in the brain (Allardyce and Boydell 2006), often referred to as neuropsychiatry (Rose and Abi-Rached 2013). Neuropsychiatry seeks to operate at a profoundly reductionist level where a neuromolecular vision of the brain emerges at a new scale. Under this neuromolecular gaze, the structure and processes of the brain and nervous system were made more understandable as the processes of interaction between molecules in neurons and the synapses between them are explained (Rose and Abi-Rached 2013). Genomic complexity can also be mapped onto the conceptual vision of the molecular brain in order to move beyond heritability in lineages and families to identify specific genomic variants and anomalies for susceptibility to disease or pathological conditions such as schizophrenia (Rose and Abi-Rached 2013):

'One now looks for the variations that increase or decrease the activity of an enzyme, the operation of an ion channel, or the sensitivity of a receptor site, and which, in all their multiple combinations, underpin all differences in human mental functioning, whether these be deemed normal variations or pathologies.' (Rose and Abi-Rached 2013 p11).

A parallel rapid growth has also taken place in higher level influences of the shared social environment on mental health (Allardyce and Boydell 2006). This is often referred to as the theory of social capital and attempts to identify and describe the forces that shape the quality and quantity of social interactions and social institutions (McKenzie, Whiteley *et al.* 2002). According to McKenzie *et al.* (2002), there are four main strands of social capital comprising collective efficacy, social trust/reciprocity, participation in voluntary organisations, and social integration for mutual benefit. The concept can also be divided into structural and cognitive social capital (De Siva, McKenzie *et al.* 2005). Structural components refer to roles, rules, precedents, behaviours, networks and institutions; these may bond individuals in groups to each other, bridge societal groups or vertically integrate groups with different levels of power and influence leading to social inclusion (McKenzie, Whiteley *et al.* 2002). Cognitive social capital describes values, attributes and beliefs that can produce cooperative behaviours, and the links between cognitive and structural capital are complex and multidirectional (McKenzie, Whiteley *et al.* 2002). Rogers and Pilgrim (2014) maintain that mental health service-users, because of their marginalisation and social class position in local communities, have limited access to social capital which may promote a sense of safe civility and neighbourliness in a locality. Paradoxically, individuals who are financially and psychologically robust in a community may be those who find it easier to contribute to, and benefit from, social capital in a local community (Rogers and Pilgrim 2014).

All these facets of mental illness' treatment are pertinent to the development and acceptance of CTOs in that they address many of the criticisms levelled at the previous era of enforced institutional treatment. For example, the accusation of the psychiatrist acting as 'double agent' still applies to the RC in the community; but this conflicting role is diluted by the aspiration to maintain and treat the service-user in the community, thus attempting to uphold the individual's rights and civil liberties. Although this attempt at cultural integration is closely supervised, it goes some way to appease the liberal spirit of the current era (Morrall 2016), psychiatric survivor groups (Rogers and Pilgrim 2014), as well as providing access to social capital (Bracken and Thomas 2005). Treatment of mental illness under a CTO is further supported by newer, more effective

treatment options such as a wide range of injectable antipsychotic depot preparations (Moncrieff 2008) and a developing network of additional treatment options such as psychological therapies (Bentall 2009). However, it must be acknowledged that depot preparations are a primary treatment option under a CTO as they ensure compliance and are enforceable whereas the additional treatments, by their nature, non-enforceable and therefore voluntary.

2.7 Pharmaceutical industry

With millions in each international currency spent annually on psychotropic drugs (Rogers and Pilgrim 2014), the pharmaceutical industry's ultimate purpose is to make money for its shareholders, to maximise profit and develop markets (Goldacre 2012). According to Mosher, Gosden *et al.* (2004), involuntary treatment is an essential part of the market for schizophrenia drugs. Without CTOs there would be a considerably smaller market because many people diagnosed with psychotic illness are now compelled to take neuroleptic drugs and it potentially offers an open-ended expansion of this market (Mosher, Gosden *et al.* 2004). To this end, the pharmaceutical industry runs coordinated public relations campaigns to set the mental health agenda in their favour by weakening service-user rights in mental health law and to increase the number of people eligible of involuntary treatment (Mosher, Gosden *et al.* 2004). This may involve funding campaign groups to undermine the civil liberties protection in mental health law and to stimulate the links between untreated schizophrenia and violent behaviour by submitting media stories and lobbying policy-makers (Mosher, Gosden *et al.* 2004).

'The system of representative democracy is being reshaped into a new kind of 'managed corporatocracy' in which public opinion and government policy are custom-made products that can be shaped, packaged and sold by skilled public relations experts. This example of a successful campaign to sell a very expensive product – the atypical antipsychotic drugs – is a chilling testimony to the power of Big Pharma [the pharmaceutical industries] to have its way with us.' (Mosher, Gosden *et al.* 2004 p127-8).

Western governments have, perhaps inadvertently, colluded with this treatment approach by supporting the medical management of madness and distress, which has stressed the similarity of general disease-specific medicine and psychiatry (Goldacre 2012). The drug companies have promoted the newer, more expensive, medications as particularly suited to community treatment and the control of symptoms through the chemical imbalance-dopamine theory of the nature of mental disorder (Moncrieff 2008). The combined intensity of publicity from the pharmaceutical industry and the psychiatric profession has moulded public attitudes to mirror and amplify the professional and commercial perspectives (Moncrieff 2008). It has been argued that in reality, many of the articles written in medical journals have been 'ghost' written by pharmaceutical companies, and 'much of what appears' in the lay press has been placed by pharmaceutical public relations companies (Moncrieff 2008 p71). According to Moncrieff (2008), these articles helped shape the popular conception that drugs are miracle cures, helping to transform them into exciting disease-specific treatments, responsible for quieting psychiatric service-users and confirming psychiatry's medication foundation.

'They [neuroleptic drugs] suited professional objectives to ally psychiatry closer to general medicine, and they facilitated political aims to run down the ageing and expensive asylums and find treatments that could be delivered in cheaper settings. They were also the perfect technical fix for the complex social problems posed by severe psychiatric disturbance' (Moncrieff 2008 p71).

Although the newer atypical antipsychotic preparations are costly, they are still cheaper to deliver than labour-intensive talking treatments, and can dampen down the agitation of psychotic individuals as a more cost effective alternative to crisis intervention, intensive family therapy and psychological programmes (Rogers and Pilgrim 2014). These drugs facilitated the economic and effective social control of disturbance and distress to be undertaken in the community as an unobtrusive relatively simple medico-legal activity and therefore act as ideal partners for compulsory treatment and CTOs (Moncrieff and Middleton 2015).

2.8 Protection of society

Psychiatry has, for many years, been sanctioned by society to use pharmacology as a form of social control in order to protect communities from mental disturbance (Miller and Rose 1986). Morrall (2000) maintains that violent madness is often misrepresented and amplified in the media, leading to scare-mongering and stereotyping. This is despite the fact that the majority of people diagnosed with mental disorders are not dangerous, and where there is danger this is more likely to be a danger to themselves rather than others, and more likely to be a victim of violence than a perpetrator (Morrall 2000). However, this picture is complicated by comorbid substance misuse and treatment non-compliance. Torrey (2015), using the United States as an example, argues that since 1970 there have been reported incidents of violent behaviour and homicides committed by individuals with untreated mental illness in the community. Existing studies suggest that at least 10% of all homicides and approximately 50% of mass killings were perpetrated by persons with untreated mental illness; studies also indicate that when these individuals are treated, these incidences reduce significantly (Torrey 2015).

In contrast, Bentall (2009) maintains that academic research does not demonstrate a close relationship between psychosis and violence, and that the gulf between perception and reality is explained by myths created by the mass media. The repeated suggestions of an association between mental illness and violence has led to inflated estimates of the public danger from psychotic individuals and policymakers use this association in order to justify 'therapeutic' coercion (Bentall 2009 p274). Rogers and Pilgrim (2014) state that public and political attitudes tend to assume that mental disorder predicts violence towards others even though the empirical evidence base is complex and variable. They summarise the evidence into three broad phases: the negative relationship phase suggesting that those with mental health problems were less violent than the general population; the small positive relationship phase where this relationship was reversed as increasing numbers were treated in the community; and the disaggregated phase where complex inter-relationships between clinical factors

revealed an increasingly complex picture which is difficult to predict (Rogers and Pilgrim 2014).

Wolff (2001) identified a fundamental difference between the expert and public concerns around risk from people with mental illness; this difference is dependent on the focus on *absolute* risk associated with small numbers, and the *relative* risk which increases with mental disorder (Wolff 2001 emphasis in original). When a high-profile incident is committed by a person with a mental illness, the media and public tend to focus on relative risk exposure whereas the expert opinion defends the absolute risk of a rare and isolated event (Wolff 2001). Relative risk reinforces the stereotypical perception of mental illness as unpredictable and a dangerous threat to public safety. Whereas experts can draw on some empirical evidence to support their views and confident predictions, the public lacks this information and sense of control:

‘Based on their limited and biased information about mental illness and violent behaviour, the public, often represented by a small vocal minority, assumes that any person with a mental illness is likely to commit a violent act and the likelihood of particular violent events occurring is unpredictable.’ (Wolff 2001 p806)

According to Slovic (2000), the greater the impact of the incident and the more these differences become polarised because such events amplify and heighten public safety fears and entrenched perceptions.

The media plays a major role in the perception of risk associated with mental illness (Morrall 2000; Morrall 2016; Philo 1996). Stories involving mentally disordered individuals promote and hold headlines by provoking the stereotypical view of the ‘mad as dangerous’ (Morrall 2016 p46) combining the three ingredients that generate public and media panic about mental illness and risk. These are:

1. The mad are unpredictable (the [incidents] could not have been foreseen).
2. The mad are irresponsible ([for example] prescribed medication was not taken).
3. Those with responsibility of overseeing the mad are incompetent (although [the incidents] were difficult to prevent, there is an insinuation that there was nevertheless a lack of monitoring). (Morrall 2016 p47)

Media, particularly social media, framing of complex issues tends to simplify selected elements of the issue then amplify and sensationalise those aspects which reinforces and further stereotypes these rare and shocking incidents (Wright 2014). Such an approach stimulates exclusionary public attitudes about future management of the problem, promoting segregation and institutionalised solutions to protect communities (Wolff 2001).

Nevertheless, according to Cockerham (2006), thousands of people are diagnosed as mentally-ill, detained and treated on a compulsory basis without their consent on the grounds that they are likely to be a danger to others, to self or to property. By linking the concept of dangerousness to mental disorder, society is then justified in enforcing preventive detention of the mentally-ill, a practice that would normally be illegal because the imprisonment of people presumed dangerous was without evidence of an overt act (Cockerham 2006). Dangerousness is the leading criteria for involuntary commitment and enforced treatment of the mentally-ill, and most people would agree that it is just cause for state intervention as well as being compatible with the popular stereotype of the unpredictable and potentially dangerous mental patient (Cockerham 2006). However, dangerousness is difficult to define and justify as well as problematic to predict (Bentall 2009; Cockerham 2006; Szasz 2002).

Szasz (2002) maintained that the notion of 'dangerousness to self and others' was essentially a medical concept which would normally prompt physicians to refuse to treat the person, even with consent; but in such circumstances a psychiatrist would insist on treating, even using compulsion. Most general

practitioners would remove a violent, threatening or abusive patient from their lists; whereas the psychiatrist would often use these behaviours as justification in adding such a person to their caseload (Szasz 2002). Bentall (2009) argued that it was unrealistic to expect that the greater use of compulsion would reduce the risk from dangerousness to the general public. Given that actual violence is such a rare event, many more non-dangerous individuals would be subjected to compulsion than dangerous ones, and although more vigorous psychiatric control might make everybody feel safer it was unlikely to increase public safety (Bentall 2009).

Psychiatrists are often called upon as experts to predict, testify and assess dangerousness, but Cockerham (2006) argued that clinical predictions of dangerousness based on insight, intuition and experience are possibly no more accurate than lay judgements. Psychiatrists are criticised most for non-prediction of dangerousness and they therefore tend to over-predict dangerousness to involuntarily detain a person than allow an individual to remain in the community free to possibly harm someone (Cockerham 2006). Scheff (1984) had previously argued that medical decision rules and norms were applied to psychiatry that it was always 'better safe than sorry' (p105); in most cases of mental disorder there was an element of danger, therefore it was safer to risk unnecessary detention rather than allowing potential danger to go uncontrolled. This medical norm combined with external pressures such as complaints and investigations into critical incidents can lead to high levels of defensive practice among practitioners (Passmore and Leung 2002). CTOs fit readily into this tendency towards defensive practice as they can be perceived as being less restrictive than inpatient detentions, but can still operate as safeguards against predicted dangerousness or other risks.

However, any person who is involuntarily detained, including under a CTO, has the right to a solicitor and the right to legal review; in the UK this takes the form of an independent Mental Health Review Tribunal (Health 2015). The Tribunal is comprised of a lawyer as chairperson, an independent doctor as a second opinion, and a lay person as knowledgeable other; they can examine the criteria of a detention under the Mental Health Act and have the power to discharge

people or approve their ongoing detention according to the evidence presented (Mind 2010). However, Nikolas Rose (1986) argued that Tribunals often served merely to legitimise the power and decisions of psychiatry rather than safeguard patient rights.

2.9 Mental health legislation and policy

The current emphasis in mental health policy is for treatment in the least restrictive environment, which is often cited to be in people's own home in the community (Jones 2013). However, it could be argued that this shift places more emphasis on monitoring, managing and predicting public protection, safety and risk (Rose 1999). Just as the decisions of psychiatry and Tribunals are often primarily influenced by safety concerns, so risk remains 'at the heart of mental health policy' (Wolff 2001 p803). Because of the demise of the asylums, psychiatric care was increasingly located and conducted 'in the community'. Such care became the shared ideal, and with it the intrinsic dilemmas and hazards of psychiatric policy also transferred into the communal constitution of society (Gordon 1986).

According to Moncrieff (2003), modern psychiatric legislation combined two strands of law that originated in 18th century England. The first involved the power of the state to incarcerate the mad, empowering local magistrates to confine those considered dangerous; the second strand was concerned with protecting patients' interests (Moncrieff 2003). These two stands were enshrined in the Act for the Regulation of Private Madhouses 1774, which first included the role of a doctor in certifying madness, and later extended in the Lunacy Act of 1890 as a means of regulating the 'mad-doctoring trade' (Scull 2015 p135). The first decades of the 20th century marked the Government's change in policy, where state intervention and social welfare became increasingly accepted and health policy was driven by an enthusiasm for prevention and early treatment (Moncrieff 2003). The 1930 Mental Treatment Act allowed hospitals to treat mentally ill patients without certification (Turner, Hayward *et al.* 2015), endorsing the medical model of mental disorder and abolishing the role of the magistrate in commitment proceedings (Moncrieff 2003).

By eliminating the legal proceedings associated with the involvement of magistrates, the Mental Health Act 1959 transferred responsibility for detaining the mad entirely over to medical professionals (Moncrieff 2003). The 1959 Act repealed the 1890 act and abolished the Board of Control, an inspection system that had been operating since the 19th century, thus reducing its role in regulating psychiatric activities (Turner, Hayward *et al.* 2015). However, the 1959 Act did establish the Tribunal system as some recognition that protection of patients' interests was necessary (Moncrieff 2003). The Mental Health Act 1983 renewed concerns for protecting patients' interests and reintroduced an inspectorate in the form of the Mental Health Act Commission, influenced by the civil rights movements of the 1960s and 1970s (Moncrieff 2003).

However, having professionalised the process of 'dealing with the mad' (p9) in 1959, the government, in recent reforms, is increasingly clawing back power to itself in the belief that psychiatrists are not controlling and detaining enough people (Moncrieff 2003)¹. This has been fuelled by the debate about whether community care works for the community, and a 'community care backlash in many countries' (Wolff 2001 p802) can be traced back to a small number of violent acts committed by persons with mental illness (Snow and Austin 2009), which were then sensationalised by the media (Morrall 2016), leading to moral panic in public opinion and the need for political response to safety concerns (Wolff 2001). Cohen (1972) described this general process as moral panic triggered by a labelled person which is then described by the media in sensational terms that excite and entrench stereotypes and fears. Then, through repetition, the incident gains momentum and snowballs into a major social problem where eventually the public demands protection from policy makers (Wolff 2001). This media framing of these rare violent incidents reinforces fearful stereotypes to the extent that policy makers are compelled by public pressure to

¹ More recently, the government has indicated a further change of policy in the Conservative election manifesto, where psychiatric care 'too often leads to detention, disproportionate effects and the forced treatment of vulnerable people' Brown, M. (2017). Teresa May wants to scrap the Mental Health Act. The Guardian. London.

respond in ways that potentially distort public spending and influence the approach to solutions (Wolff 2001).

Policy makers tend to approach solutions in terms of political consequences, thus any adverse event arising from policies that can be traced back to ignorance, inaction or neglect of the state can be damaging to the government (Wolff 2001). Policy-makers tend to spread the political risk among responsible parties by adopting a 'shotgun approach' (Wolff 2001 p810). For example, in the UK successive governments have introduced new services aimed at addressing issues of risk such as crisis intervention teams and early intervention services; new powers such as CTOs; better detection in risk assessments; increased funding; and wider availability of treatments such as newer antipsychotic medications and access to psychological services. This shotgun approach also included devolving the management of risk away from policy-makers towards professionals and practitioners. Policy-makers imply that the goal of policy is a zero level of risk which is unrealistic and destined to fail (Wolff 2001). When incidents occur responsible clinicians are identified and blamed along with their respective organisations through the operation of independent Tribunals and the Coroners Court. Wolff (2001) emphasised that the professional and personal costs associated with being identified as an irresponsible practitioner can be extremely high. In this way the public assignment of blame serves to transfer the policy-makers risk aversion to the community in ways that distort the principles of best practice and transmits a contagion of defensive practice from policy-makers to practitioners (Wolff 2001). Such an approach is counter-productive resulting in short-term chaos as frontline workers become overwhelmed by a raft of new directives and governance, poor staff retention, public disillusionment and, in turn, an increased demand for security focused treatment and social control (Wolff 2001). Grove (1994) argued that the forces of reaction from the fears of a badly informed populace served to recreate the old institutions in new forms.

According to Rogers and Pilgrim (2014), recent reviews of spending on mental health services indicate a strong inertia about resources being allocated to hospital-based activity and there is a strong socio-political emphasis on social control in the community. At the same time, although overall spending on mental

health has increased year-on-year, the proportional funding increase for mental health has been much smaller than for physical healthcare. In 2016, the Health and Social Care Bill became law in the UK which included a demand for parity of esteem, meaning mental and physical health services should be treated equally, yet the funding levels for NHS mental health care in England continues to fall (Bloch 2016). The Department of Health attempted to offset the political risk with a spokesperson stating:

‘These figures do not show the full picture for mental health spend – councils, third-sector organisations and NHS England all play a role in providing services, and all receive government funding.’
(Bloch 2016)

The introduction of this new legal requirement for parity has also generated significant activity at policy level and has led to a number of specific measures being introduced, but questions have been raised whether the rhetoric can be matched by reality (Naylor 2015). Rogers and Pilgrim (2014) maintain that a major part of this reality involved the solution for the social problems associated with mental abnormality – how to deal with a group of non-conformist, troublesome, worrisome and economically inefficient people who were previously physically segregated from others. The old asylums offered a total solution, providing three main functions; semi-permanent accommodation, treatment and social control; concurrently in one institution. The policy-makers challenge was to retain these functions in revised forms of institutional medical care with new legal measures that ensured coercive control for community-based service-users (Rogers and Pilgrim 2014). The widespread use of CTOs throughout the Western world indicates that CTOs provided this coercive control, offering an effective solution to this policy-makers challenge.

2.10 Proposed service provision

According to Berks (2005) this seemingly contradictory challenge of therapeutic treatment and social control was a consequence of psychiatric history having roots in medical history. On the one hand psychiatric history depicts asylums created primarily for social control and that psychiatric illness is largely a social

construct. On the other hand 'Philippe Pinel freed his patients from their chains', Freud discovered the unconscious, medical science and pharmacology made progress against the 'scourge' of mental illness (Berks 2005 p1). Traditional medical and psychiatric history progressed through scientific discovery and technological innovation until the academic and social climate changed during the twentieth century (Berks 2005).

Intellectuals such as Goffman (1961), Foucault (1961) and Szasz (1972) criticised and challenged medicine and psychiatry. Moncrieff and Middleton (2015) maintain that modern societies now rely on a medical model to manage irrational and disturbing behaviour. They suggest that the political agendas and policy implications associated with the social control of madness should be openly debated rather than 'hidden away behind the language of medicine and treatment' (Moncrieff and Middleton 2015 p267). Service-users subject to a CTO are now legally linked to the political system of health and the profession of psychiatry (Dept of Health 2015). This linkage was initially encapsulated in the National Service Framework (Dept of Health 1999) that stated that crisis should be anticipated or prevented by clinicians, risk should be eliminated or reduced, and that a delay in the use of medication could lead to poorer outcomes.

Around the same time the government affirmed the public's view setting safety and public protection as a priority, the phrase adopted for building public confidence was 'safe, sound and supportive services' with 'safe' always appearing first and frequently related to the terms of danger and violence (Wolff 2001). However, in the latest review of the current state of mental health and the government's *The five year forward view of mental health* (Taskforce 2016) this emphasis appears to be shifting from an illness and control model towards a disability and inclusion model (Repper and Perkins 2003):

'A social disability model entails a change in thinking, i.e. a change in focus from symptoms and cures to people's lives outside their illness - when we think about people's interests, aspirations and achievements. Whereas an "illness" perspective focuses on changing people (making them "fit in" by decreasing their symptoms), within a social model of disability, changing the

world becomes a primary consideration. It prioritises enabling people to do things they want to do and to live the lives they wish to live (with the adaptations, supports and aids, as well as the social and policy changes, that they need in order to do so).’ (Repper and Perkins 2003 p27)

The latest government publication has not the same emphasis on safety, instead focusing on the recent ‘transformation’ in mental health, linking the development of new antipsychotic drugs with ‘greater emphasis on human rights, leading to the growth of community based services’ (Taskforce 2016 p4). The Taskforce places headline significance on an approach:

‘to reduce the long term impact for people experiencing mental health problems (...) and to reduce the costs for the NHS’. (Taskforce 2016 p4).

The main areas of proposed improvement in this ‘fresh mind-set’ for people with severe and enduring mental health problems are: greater access to physical treatments; access to stable employment and housing; a seven day crisis response service; creating mentally healthy communities; and the development and application of new mental health research (Taskforce 2016). The Taskforce (2016) maintains that there should be even greater emphasis placed on people’s experience and valuing ‘experts-by-experience’ (p18) as real assets in the design and development of services. However, this fresh mind-set appears to be at odds with the use of CTOs, which form part of an illness and control model (Wolff 2001) that is employed in many jurisdictions.

Wolff (2001) argued that an illness and control model is likely to fail as a result of public disillusionment because episodes of violence will continue to arise and the public can expect to be disappointed with the value of security focused community care policies. This disillusionment has been confirmed in studies indicating little change in public attitudes towards social acceptance of severe mental illness over the last decade despite advances in mental health literacy, understanding, biological and genetic modelling (Schnittker 2008; Schomerus, Holzinger *et al.*

2012), although Time to Change (2015) report more favourable attitudes towards mental illness generally between 2008 and 2014. According to Wolff (2001) future mental health policy can only succeed if expectations are set appropriately and sensibly, with the government acknowledging that it can only reduce risk of violence associated with persons with mental illness, not eliminate that risk.

The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (NCISH 2014) produced a UK average of 75 homicides per year with 56 victims per year in England and Wales. Because the vast majority of those diagnosed with mental disorders are not dangerous (Morrall 2016), finding those 75 individuals before they commit a violent act is highly unlikely even with legal frameworks such as CTOs encroaching on the civil liberties of all persons diagnosed with severe and enduring mental illness (Wolff 2001). Wolff (2001) also recommended that there needs to be a denunciation of the 'blame culture (p825), arguing that elite leadership is required in the face of conflicting opinions about the nature and size of social problems as well as their depiction and management. Progressive policy in a democracy requires effective coordination and appropriate responsiveness to public opinion, discerning proactive leadership rather than reactive obedience (Wolff 2001).

However, according to John Turner and colleagues (Turner, Hayward *et al.* 2015), recent history indicates that proactive leadership and policy development needs to incorporate, as well as the risk agenda, a number of common preoccupations which, they argue, should be central to future considerations. These include the rise of the service-user, the allocation of resources, changing and contested definitions of mental health and psychiatric need, and the impact of changing professional values on the delivery of services (Turner, Hayward *et al.* 2015). There is a consensus in the literature (Rogers and Pilgrim 2014) that one of the most important changes in the recent history of British health care has been the rise of the service-user movement. Experts-by-experience and psychiatric survivors have highlighted inadequacies of resources and lack of treatment needs in many areas (Repper and Perkins 2003). But have also introduced a more positive and optimistic view whilst successfully engaging professionals in collaboration with service-users in the design and delivery of services, which has

constituted a relatively unusual and advanced aspect of British practice (Turner, Hayward *et al.* 2015). However, the future design of services will incorporate a preoccupation with cost and resource constraints exacerbated by the lack of meaningful statistics (Turner, Hayward *et al.* 2015). With care spread across the NHS, local authorities, third sector and private providers, meaningful comparisons are difficult, prompting passionate controversy about the principles of funding for mental health care as fragmentation of provision has led to fragmentation of evidence (Turner, Hayward *et al.* 2015).

Although psychiatry and psychopharmacology remains pre-eminent in current mental health care, there is constant challenge to this position, with the continuing relevance of the anti-psychiatry movement to contemporary debate (Bentall 2009; Bracken and Thomas 2005; Bracken, Thomas *et al.* 2012). Links have been made between the service-user movement and critical psychiatry that have challenged the previous uncontested diagnoses and involuntary treatment forced on people with severe mental health problems. This has led to the development of a more enlightened approach of 'postpsychiatry' which moved beyond reductionism towards medical practice based on hermeneutics (Bracken and Thomas 2005 p2). This conceptual shift has been echoed by other professionals such as Moncrieff (2008) in her critique of the scientific basis of drug treatment, and Richard Bentall's (2009) deconstruction of the basis of diagnosis.

This suggests that the mental health professions appear notably tribal, even identifying specific positions within clinical and academic debates to remain loyal to their specific professional communities (Turner, Hayward *et al.* 2015). However, the more recent legislation, which incorporates CTOs, allows for alternative professional groups to undertake professional responsibilities previously the exclusive domain of psychiatrists, for example, nurse prescribing regulations and the role of Responsible Clinician available to social work, psychology and nursing practitioners (Jones 2013). Each of these professional communities have developed their own value systems which inform the changing patterns of interactions between professional groups, the social distances between practitioners and patients, the patterns of recruitment into different roles, and the

structures supporting professional identities, which all impact differently on the provision of mental health care (Turner, Hayward *et al.* 2015).

2.11 Conclusion

This chapter examined some of the important contextual elements that influence the development and implementation of CTOs. It is important to understand how the various influences outlined in this chapter can influence the continued, and potentially increasing, use and of CTOs despite the lack of supporting clinical evidence. However, the historical and contextual influences can also shape the experience of CTO service-users in the community. For example, negative perceptions of 'madness' have increasingly become a public matter with the closure of the larger mental hospitals. As certain service-users become products of deinstitutionalisation, they can feel rejected and lonely in the community, more as a consequence of high profile past incidents in the community. The 'dubious origins' of CTOs are a primary indicator of the public demand for protection from 'the mad' in society. CTOs can offer legal segregation and confinement, previously one of the functions of the asylum system. In an era of deinstitutionalisation, particularly in combination with pharmaceutical developments, CTOs offer effective treatment in the community, together with access to alternative therapies and social capital. Past, present and, potentially, future mental health policy and service provision tends towards primarily addressing the problems of protecting society whilst also attempting to maintain the therapeutic intent of effective treatment. There are numerous contextual indicators that suggest CTOs may be able to fulfil that role for the foreseeable future.

Chapter 3

Literature review

3.1 Introduction

Over the last three decades the evidence of the effectiveness of compulsory community treatment has been examined closely, debated, sifted and contested (Morrissey 2016). Although CTOs are established in many jurisdictions worldwide (Rugkasa 2016), the extensive body of literature and practice evidence has remained inconclusive and conflicting (Maughan, Molodynski *et al.* 2014). According to Rugkasa (2016), reviews of CTO legislation are often preceded by debates around clinical benefit justifying restriction of service-user liberty and rights. This chapter will therefore examine much of this literature organised into two broad sections: quantitative studies examining clinical and social outcomes; and qualitative studies investigating stakeholder perspectives, with particular emphasis on service-user experiences of CTOs. There have been three systematic reviews undertaken including studies published during the period up to May 2015. Studies published after that date were reviewed by myself and included in this chapter. The reviewed body of literature includes descriptive and case controlled studies as well as Randomised Controlled Trials (RCTs). All of the qualitative stakeholder studies, which featured a service-user focus are reviewed in detail in this chapter together with a summary discussion and conclusions drawn from the extant literature.

3.2 The pursuit of clinical evidence

The main focus of the existing evidence base for CTOs has been on service-user clinical and social outcomes, often undertaken from a medical model perspective and economic drivers in reducing hospitalisation. Most published studies and relevant papers have been examined in one of three systematic reviews. The studies and articles published prior to 2006 were reviewed by Churchill *et al.* (2007); those published from 2006 to 2013 were reviewed by Maughan *et al.* (2014); and those published from 2013 to May 2015 were reviewed by Rugkasa (2016). A further search was undertaken by me, using the original search terms and using updated databases – Embase 1996 to 2017 week 28; Ovid MEDLINE

1996 to June week 5 2017; and PsychINFO 2002 to July Week 1 2017 – to update the review and also to include all major articles, papers and studies from the period 31st May 2015 to 7th July 2017. The original search terms were repeated by myself and each of the systematic reviewers using PyscINFO, MEDLINE and EMBASE and consisted of:

- Community treatment orders
- CTO
- Mandatory outpatient
- Involuntary outpatient
- Outpatient commitment
- Involuntary commitment
- Assisted outpatient treatment

Churchill *et al.* (2007) reported in their executive summary that it was not possible to state whether CTOs were beneficial or harmful to patients. Overall, although some stakeholder views were positive, there was no robust evidence about either the positive or negative effects of CTOs on key outcomes. These including hospital readmission, length of hospital stay, improved medication compliance, or patients' quality of life. Maughan *et al.* (2014) concluded that there was still no robust evidence that CTOs had a significant effect on hospitalisation rates and other service use outcomes, stating that non-randomised studies continued to report conflicting results. Jorun Rugkasa's (2016) review acknowledged that the systematic reviews had all come to the same conclusion, finding conflicting results of patient benefit in CTO outcome studies; she cast doubt over the usefulness and ethics of CTOs and recommended that future research utilise RCTs.

However, after reviewing the three RCTs undertaken to date (see section 3.2.3), Kisely and Campbell (2014) reported that compulsory community treatment resulted in no significant difference in service use, social functioning or quality of life compared with standard voluntary care. A significant difference was found in terms of crime; people receiving compulsory community treatment, compared to

those receiving voluntary treatment, were less likely to be victims of violent and non-violent crime, although it was unclear if this was due to intensity of treatment or its compulsory nature (Kisely, Campbell *et al.* 2017). The review undertaken by O'Brien *et al.* (2009) maintained that RCTs produced equivocal results and presented numerous methodological challenges. Where improved outcomes were demonstrated in comparative cohort studies it was, again, unclear whether the outcomes were associated with legal compulsion or enhanced service provision, and a divergence of views were demonstrated across and within stakeholder groups (O'Brien, McKenna *et al.* 2009). All reviewers argued the need for further research into compulsory community treatment and possible alternative approaches such as descriptive studies and comparative cohort studies.

3.2.1 Descriptive studies

A substantial body of work exists comprising local, small scale studies aiming to describe the nature of CTO populations as well as stakeholder views (Rugkasa and Dawson 2013). These studies were conducted in the United Kingdom, Europe, Canada, United States and Australasia revealing a very similar pattern of service use and service-user profiles across jurisdictions (Rugkasa 2016). Service-users on CTOs tend to be middle-aged males, diagnosed with a schizophrenic illness with a history of non-compliance as well as repeated admissions (Rugkasa and Dawson 2013). Many of these service-users misused substances, were self-neglecting, isolated, with a history of aggression and violence (Churchill, Owen *et al.* 2007). Interestingly, 190 mental health professionals surveyed in the UK were in favour of CTOs (Coyle, Macpherson *et al.* 2013). Clinicians in New Zealand tended to prefer CTOs as a treatment option (Romans, Dawson *et al.* 2004) with many psychiatrists internationally reporting reductions in admission rates, improved stability and treatment adherence (Mullen, Dawson *et al.* 2006). According to clinicians, this prevented service-user repeated relapse and readmission, thus breaking the distressing 'revolving door cycle' (Rugkasa 2016 p16); which, significantly, was cited as a prime justification for the introduction and use of CTOs (Jones 2013). Clinicians also reported that

the stability associated with CTOs reduced risks to service-users themselves and to others in the community (Churchill, Owen *et al.* 2007).

The views of family members were also included in some descriptive studies, who were also generally in favour of CTOs. Family members perceived the orders as a positive influence on their relative, on themselves, on family relationships and on relations with the clinical team (Mullen, Gibbs *et al.* 2006). Swartz *et al.* (2003) indicated that clinicians, family members and members of the general public held similar views about the use of CTOs, preferring to avoid hospital admission, interpersonal violence and maintain good interpersonal relationships by the use of compulsory community treatment. However, limitations of descriptive study design mean that any observed improvements could not confidently be attributed to the CTO. Also any reported advantages of the CTO were often compared with the alternative of hospital admission rather than with voluntary community treatment (Rugkasa 2016).

3.2.2 Case control studies

These types of studies included uncontrolled cohort studies and controlled matched sample before-and-after studies where the outcomes of service-users subject to a CTO are compared with those of a control group (O'Brien, McKenna *et al.* 2009). A number of studies utilised a large Australian data set, recording 16,216 CTOs (Burgess, Bindman *et al.* 2006; Kisely, Smith *et al.* 2005; Kisely, Xiao *et al.* 2004). These Australian studies reported increased readmission rates for those discharged on a CTO over a ten year period but the treatment provided and the nature of the control groups were not described. A four year study in Toronto compared CTO discharged service-users with a non-matched comparison group over a 12 month period (Hunt, da Silva *et al.* 2007). The CTO group showed a reduction in readmission, particularly in the last 6 months post discharge. The authors concluded that service-users who had historically refused treatment, engaged better with treatment on a CTO. O'Brien, McKenna *et al.* (2009) reviewed several smaller comparison studies which showed reductions in readmission rates and/or bed day reduction. These outcomes were reported in North Carolina (Geller, Grudzinskas *et al.* 1998; Hiday and Scheid-Cook 1987),

Massachusetts (Geller, Grudzinskas *et al.* 1998) and New South Wales (Vaughan, McConaghy *et al.* 2000). However, Churchill *et al.* (2007) reported finding no reliable evidence from case control studies that CTOs kept service-users out of hospital. Similarly, none of these large database case control studies found differences in length of stay, service contact, compliance with treatment, social functioning or violence (Churchill, Owen *et al.* 2007).

Gonzales, Nesi *et al.* (2015) examined eligibility criteria for service-users subject to compulsory community treatment and those treated on a voluntary basis. The specific criteria examined was predicting risk of suicide and risk of future violence (Gonzales, Nesi *et al.* 2015). The study found no significant difference between the CTO and voluntary treatment groups and questioned why some individuals and not others are subjected to compulsory community treatment; this is despite CTOs being 'celebrated' in the media as reducing incidents of violence from 'dangerous' people with mental illness (Gonzales, Nesi *et al.* 2015 p1376). O'Brien, McKenna *et al.* (2009) argued that comparison studies show mixed results as a consequence of the methodological weaknesses. Although Rugkasa (2016) maintained that well-designed, non-randomised studies could produce valuable insights about associations between CTOs and outcomes, she also recognised that there were potential limitations regarding generalisability, vulnerability to service changes, and were confounded by inadequate matching and regression to the mean. Further, the epidemiological design of such studies mean that none could generate findings for causation (O'Brien, McKenna *et al.* 2009). However, Maughan, Molodynski *et al.* (2014) summarised the collective case control study findings as a 'strong level of evidence' that CTOs have no significant effect on key outcomes.

3.2.3 'Gold standard' evidence

According to Robson (Robson 2002) the RCT is viewed as the 'gold standard' (p116) and method of choice in quality healthcare research. RCTs provide the most rigorous test of treatment effect, reduce the potential effects of sample bias and regression to the mean, and can identify in advance both the hypothesis and outcome measures to be used (Rugkasa and Dawson 2013). However, Mustafa

(2016) argues that RCTs cannot evaluate complex interventions such as CTOs, and this type of research can become overvalued, misleading and potentially harmful to individual service-users. In CTO research, three RCTs have been conducted, two in America (New York and North Carolina) in 2001 (Steadman, Gounis *et al.* 2001; Swartz, Swanson *et al.* 2001) and a third (the Oxford Community Treatment Order Evaluation Trial, OCTET) conducted twelve years later in England (Burns, Rugkasa *et al.* 2013).

RCTs have potential limitations including participation refusal, attrition and protocol violations and these aspects of each trial may have affected their generalisability (Rugkasa and Dawson 2013). The New York trial had a smaller than expected sample size ($n=142$), high attrition rate (29.6%) with lack of adherence to protocol; the North Carolina trial ($n=264$) had a refusal rate of 12% and attrition rate of 18.2% (Kisely and Campbell 2014). The OCTET study ($n=336$) had a refusal rate of 20% and, interestingly, the treatment of around a quarter of participants did not follow the protocol for the randomised condition (Rugkasa and Dawson 2013).

During 2015, a further subgroup analysis of the OCTET study data was published to test the effect of CTOs on wider clinical and social outcomes, including service-users' experiences of services and the use of treatment pressure as well as exploring differential effects in different groups of service-users (Rugkasa, Molodynski *et al.* 2015). Quantitative data was collected on service-user-rated outcomes, symptoms and social functioning conducted at baseline and repeated at six and twelve months. The effects of CTOs on the following outcomes were tested:

- Symptom severity
- Insight
- Substance abuse
- Social functioning
- Employment
- Overall social outcomes

- Type of medication
- Attitude and adherence to medication
- Therapeutic relationships
- Preference for joint decision-making
- Satisfaction with services
- Experience of leverage
- Perceived coercion
- Perception of the fairness and effectiveness of pressure

Various subgroup analyses were performed basing the analyses on clinical characteristics associated with outcomes in psychosis. These included testing associations between outcomes and: diagnosis; duration of illness; gender; age; symptomatology; levels of functioning; social inclusion/isolation; ethnicity; and educational achievement. Rugkasa *et al.* (2015) found that there was no significant difference between the randomised and control arms of the study in any of the reported outcomes, Rugkasa *et al.* (2015) therefore concluded that CTOs did not have any benefit on any of the tested outcomes and that their continued use should be carefully reconsidered. However, the OCTET cohort was further followed-up and analysed by Puntis, Rugkasa *et al.* (2017) who found some evidence of an association between CTO use and better engagement with community teams and fewer breaks in care.

A commentary by Szmukler (2014) questioned if there was a place for community treatment orders after the OCTET study. George Szmukler (2014) argued that the findings of the above study were consistent with the essentially negative findings of the other American RCTs. He further maintained that the results were largely consistent with the argument that outcome difference in previous non-randomised studies, as well as in the comparative studies can be explained by better service provision for individuals when subject to a CTO rather than due solely to the order itself (Szmukler 2014). Two interpretations were proposed: the first is to conclude that CTOs should not be used; the second involved construing the basic principles of compulsory community treatment in a very different way. Szmukler (2014) suggested that treatment for mental illness should be viewed in

the same way as physical treatment in that a capacitous individual has the right to reject treatment even if the consequences could be grave. In most jurisdictions, such a refusal can only be overridden if the individual lacks 'decision-making capacity' and the treatment is judged to be in the 'best interests' of the person (Szmukler 2014 p331). A CTO would only be used during a period of impaired decision-making and could be linked to some form of advance statement formulated when the person had decision-making capacity. Such a statement may express a preference for future anticipated treatment, such as taking medication on a self-regulated intermittent basis because of undesired side-effects; or preferring a longer period subject to a CTO rather than hospital admission, with the order recognising previous non-compliance and then acting as a control or incentive to continue treatment until decision-making capacity was restored (Szmukler 2014). Szmukler (2014) acknowledged that clinicians may resist this approach as it requires a major shift in the accepted thinking around community compulsion.

For all reviewed RCTs, outcomes for the compulsory community treatment group and the control group did not differ significantly (Kisely, Campbell *et al.* 2017). The OCTET study failed to discern any benefit from CTOs in terms of readmissions, time in hospital, in global clinical outcomes (as assessed by the Brief Psychiatric Rating Scale and Global Assessment of Functioning) or any wider range of clinical or social outcomes (Szmukler 2014). The internal validity of the OCTET study was also questioned by Mustafa (2015) which left the study with only a 35.2% chance of proving the effectiveness of CTOs. Curtis (2014) argued that the OCTET study did not study service-users who might have benefited from a CTO and that the psychiatrists involved were unlikely to have used the provisions of a CTO assertively. He argued that the results should not be taken to provide evidence of effectiveness or otherwise. In reviewing the three RCTs together, Kisley and Campbell (2015) concluded that compulsory community treatment results in:

'no significant difference in service use, social functioning or quality of life compared with standard voluntary care' (p543)

It is interesting to note that Jeffrey Swanson and Marvin Swartz argue both in the American literature (Swanson and Swartz 2014) and in British publications (Swartz and Swanson 2015) that the search for a definitive and generalizable RCT may be a 'quixotic quest' (Swanson and Swartz 2014 p808) and other carefully managed designs such as case control and descriptive studies may be 'definitive enough' (Swartz and Swanson 2015 p810)

3.2.4 'Expert' opinion and comment

The body of literature on expert opinion and comment is extensive and diverse and is therefore not reviewed in its entirety here. Rather, representative samples are presented to illustrate the range and scope of opinion and comment. When compared to the effectiveness studies, expert opinion has largely served to critique CTOs based on ethical and human rights issues (Light 2014). The continuing debate, which examines the justification of CTOs based on clinical benefit compared with criticism of CTOs based on the erosion of service-users' civil liberties, has also been subject to ethical analysis. An example of this analysis examined the shifts in philosophy from rights-focused principles, where the infringement of individual service-user freedoms is examined. Towards a more utilitarian or outcome-focused principles, where the proportionate benefit for the greatest number of people is considered. Significantly, in practice this meant that the value of the service-users' right to freedom was overridden by the value of public safety (Lepping 2007).

However, because of the difficulties in predicting dangerousness, the pursuit of public safety resulted in psychiatric defensive practice towards service-users (Snow and Austin 2009) and 'net-widening' in the use of compulsory community treatment (Geller, Fisher *et al.* 2006). Ethical justification needed to be based on the premise that CTOs will improve outcomes for the service-user and the public; this premise was not evidenced (Lepping 2007). However, Maden (2007) argued that the ethical concern associating violence with mental illness was minimised and was a rare case of medical treatment presenting a potential risk to a third party. Because the general public may be exposed to risk without their consent, it is appropriate for the Government to persist with risk-based legislation (Maden

2007). Dale (2010) maintained that coercion had been implicitly accepted as part of everyday life in contemporary society in terms of criminal justice and taxation, and for a relatively small group of service-users, presenting a potential risk to themselves and others, CTOs were therefore ethically justified.

The justification to restrict the liberty of adults with decision-making capacity who have not broken any law will always be subject to contentious ethical debate (Rugkasa 2016). The views of clinicians are often divided with opponents focusing on patient's rights to maintain autonomy rather than receive paternalistic care. Most interestingly, O'Reilly *et al.* (2016) report that patients themselves are ambivalent about CTOs, describing them as coercive whilst simultaneously reporting benefits. It is therefore unsurprising that the debate has always shifted towards evidence of effectiveness (Rugkasa and Dawson 2013). But over the last four decades, CTOs have become the internationally preferred clinical and policy solution for addressing non-compliance with treatment, thus breaking the revolving door cycle, helping to stabilise patients while also reducing risks to them and their community (Rugkasa 2016). Sharon Lawn and colleagues (2016) argue that CTOs are inherently complicated and there is limited research or theory that examines the complexity of CTOs and how service-users and clinicians make sense of their experiences.

The accepted thinking and current opinion of UK psychiatrists was surveyed by DeRidder *et al.* (2016). This was a repeat of a survey originally undertaken in 2010 by the same authors to establish clinicians' experiences and opinions of using CTOs. The latest study found that the opinion of clinicians had not changed since 2010 with the need for service-user treatment adherence, engagement and improved insight remaining the most important consideration in implementing and discharging a CTO. The main support for the use of CTOs was to complement existing legislation and provide greater choice of treatment options; that the increase of compulsory powers was appropriate for clinical and social benefits; there was sufficient clinical guidance to feel confident about CTO use; and that clinicians could observe benefits from CTO use. The main disagreements with CTO use were a feeling CTOs would have no long-term benefit; that well-resourced community services could provide the same benefits; there was

insufficient clinical evidence to feel comfortable placing service-users on CTOs; and that the introduction of CTOs was a retrograde step for mental health services. However, the survey did acknowledge that CTOs will continue to be used in large numbers and new evidence² had not affected opinion significantly, but also that it was crucial that clinicians continue to evaluate practice in this area (DeRidder, Molodynski *et al.* 2016)

An Australian qualitative study aimed to derive a conceptualised model of risk in compulsory community treatment (Light, Robertson *et al.* 2015), in which 38 participants including service-users, caregivers, clinicians and legal decision-makers were interviewed. A model of risk was proposed incorporating domains of risk of harm to self or others, risk of social adversity, risk of excess distress, and risk of compromised treatment (Light, Robertson *et al.* 2015). The findings were consistent with the literature about the multidimensional nature of risk, particularly in mental health settings where a 'rich stew' of risk meanings were recognised, weighed and balanced by clinicians (Light, Robertson *et al.* 2015 p651).

A focus group study of staff experiences of CTOs was also undertaken in Norway by Stensrud, Hoyer *et al.* (2016). The study involved three focus group interviews with 22 participants; all were health professionals responsible for CTO care provision and/or CTO decision makers. Data were analysed using content analysis. The health professionals reported difficulty combining control with therapeutic care, but gave greater emphasis to patients' need for treatment and continuity of care than to their autonomy (Stensrud, Hoyer *et al.* 2016). This promoted a discussion whether increased attention to service-user autonomy rather than a focus on gaining insight into the nature and cause of people's illness would improve treatment concordance and reduce the use of coercion (Stensrud, Hoyer *et al.* 2016).

² Referring to the OCTET study, Burns, T., J. Rugkasa, *et al.* (2013). "Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial." The Lancet **381**.

A literature review of coercion by Francombe Pridham, Berntson *et al.* (2016) examined the relationship between CTOs and service-users' perceptions of coercion, reporting on 14 studies from seven countries. The review acknowledged that CTOs were a clear target for ethical debate on coercion in mental health practice and that coercive elements may be reduced by increased service-user information, better therapeutic relationships, and fairer processes. CTOs were viewed as an extension of the daily pressures and leverage applied generally in mental health community treatment (Francombe Pridham, Berntson *et al.* 2016). However, in the most recent discussion on the pros and cons of CTOs by Heun *et al.* (2016), they reported that scientific evidence that CTOs work was 'weak at best' (p117) and that the use of coercion without, or even against, scientific evidence may be seen as unethical, possibly violating the service-users' human rights. The authors argued that:

'... the time, money and resources spent on administration ... within the current CTO legislative framework would be better spent working with patients on developing more collaborative approaches to the ongoing management of their condition.'
(Heun, Dave *et al.* 2016 p117)

Heun, Dave *et al.* (2016) argued that whilst it was impossible to disprove that CTOs do not work at an individual level with some service-users, the likelihood that three independent RCTs have produced false negative results is low, and under those circumstances clinical support of CTOs was questionable (Heun, Dave *et al.* 2016).

The final section of this expert opinion and comment incorporated three quantitative studies that examined alternative outcomes. These outcomes included violent behaviours, offending rates, serious violence perpetration and suicide risk for individuals subject to compulsory community and comparative groups. Swanson *et al.* (2000) aimed to test whether compulsory community treatment may help reduce the incidence of violence among people diagnosed with serious mental illness and a history of hospital recidivism. This RCT was undertaken in North Carolina with 262 participants randomly assigned to a control

group released with no compulsory treatment or court-ordered treatment after discharge. Four-monthly follow-up interviews with participants and case managers were conducted along with service record analysis. The results indicated a significantly lower incidence of violent behaviour in people with more than six months compulsory treatment. This appeared to be due to improving adherence to prescribed medications and diminishing substance misuse (Swanson, Swartz *et al.* 2000). However, limitations included non-randomisation of duration of court orders and that some participants with a history of serious violent behaviour could not be assigned to the control group and could have led to a potentially biased conclusion (Swanson, Swartz *et al.* 2000).

Hough and O'Brien (2005) tested the hypothesis that recipients of a CTO should have demonstrated a decrease in dangerousness including criminal offending. The criminal records of all 1841 recipients of CTOs in South Australia over a three year period were compared one year prior to the CTO, one year during the CTO, and one year post CTO. Although the majority of recipients did not re-offend, there was a significant reduction in the rate of offending and violent offending between the pre- and post-CTO periods. This suggested that a CTO had significant benefits for the period of implementation and the twelve month period following, endorsing the view that judicious use of CTOs may significantly reduce the offending rate in those with serious mental disorder (Hough and O'Brien 2005).

Phelan *et al.* (2010) followed 76 individuals mandated to compulsory community treatment and 108 people in a comparison group for a one year period. Among other outcomes, the groups were compared in regard to serious violence perpetration and suicide risk; these two outcomes were found to be lower in the compulsory treatment group than in the comparison group (Phelan, Sinkewicz *et al.* 2010). However, the authors acknowledged that because compulsory treatment included other service enhancements, the results should be interpreted in terms of the overall impact of compulsory community treatment rather than treatment content or 'legal coercion per se' (Phelan, Sinkewicz *et al.* 2010 p137).

The critiques of CTOs reflect philosophical concerns about the relative values of what matters as an outcome, and also what and who counts as evidence (Light 2014). Even if the study design and empirical questions could be resolved, philosophical ambivalence about the use of compulsory community treatment would continue due to the presence of other conceptual and evaluative difficulties that could not be resolved through research or empirical means (Dawson, Romans *et al.* 2003). For example, Mulvey *et al.* (1987) highlighted the potential danger of unfulfilled promises of treatment and the probable erosion of civil liberties that would be difficult to identify, examine and measure. As a consequence Molodynski *et al.* (2010) recognised the need for qualitative studies especially exploring service-user views and experience of how compulsory community treatment affects their lives.

3.3 Qualitative service-user studies

Despite the fact that compulsory community treatment has been in force globally for over three decades, there have been relatively few qualitative studies examining the service-user perspective despite their potential to give important insights (O'Reilly 2001). In all, 22 qualitative studies involving service-user interviews and focus groups were identified from the period 1993 to 7th July 2017 (see Table 3.1). These studies have been comprehensively reviewed and their relevance to the present study examined. The studies were undertaken in England, Scotland, Australia, USA, New Zealand, Canada and Norway. Sample sizes ranged from $n=5$ to $n=68$ (mean $n=22$); ages ranged from 16 to 85 years (mean 38 years) with a mean gender split of 68% male and 32% female. Not all were subject to treatment orders at the time of interview, but most had been subject to compulsory community treatment during the two years prior to participation. Some study participants were described as sharing the characteristics of those likely to be on a CTO at a later date (Gault 2009).

Table 3.1 : Summary of reviewed qualitative studies

Authors	Country	Sample size	Methodology	Summary of findings
Atkinson, Garner <i>et al.</i> 2002	Scotland	65	Interviews. Thematic analysis.	Most did not understand changes in the law. Difficulty negotiating with psychiatrists. Problems with side-effects not taken seriously.
Brophy & Ring 2004	Australia	30 in groups. 18 Individual.	Focus groups. Interviews. Qualitative.	Participants generally dissatisfied with CTOs. Viewed CTOs as stigmatising and disempowering.
Canvin, Bartlett <i>et al.</i> 2002	England	20	Interviews. Auto-coding.	Contradictory responses both accepting and resisting orders. Typologies of fatalism & resignation, dependency, ownership, bargaining, cooperation, resistance & rejection.
Canvin, Rugkasa <i>et al.</i> 2014	England & Wales	26	Interviews. Constant comparative analysis.	Perceived chief purpose of CTO as medication adherence. Participants expressed uncertainty about enforcing conditions and recall. No single definitive view or experience of CTOs.
Corring <i>et al.</i> 2010	England	8	Interviews. Phenomenological approach	Major themes: lack of knowledge regarding illness; need for symptom management; discontent with social relationships; lack of daily activities and meaningful occupation; insufficient awareness of personal strengths; a desire to help others; satisfaction from increased stability.
Fahy <i>et al.</i> 2013	England	17	Structured survey tool + open-ended interviews.	Majority felt CTOs facilitated early hospital discharge but were not involved in the process. Large proportion of service-users lack motivation to understand information given. All felt they must abide by conditions although they lacked knowledge about recall criteria.
Gault 2009	England	11	Interviews. Grounded theory.	Themes emerged as: loss of credible identity, playing the game, medicalisation, therapeutic competence and incompetence, increased control. Initial reluctance to comply but eventually accept the need for treatment. Significance of relationships with professionals and

				importance of communication.
Gibbs, Dawson <i>et al.</i> 2005	New Zealand	42	Interviews. Thematic analysis & global attitude scoring.	Majority generally supportive of CTOs valuing access to services, sense of security, treatment and health improvement and a helpful step towards community stability. Minority strongly opposed to the order.
Gjesfjeld & Kennedy 2011	USA	9	Interviews. Thematic analysis.	Ambiguous sense of personal control. Inconsistent understandings of the order. All reported an improvement in their life.
Lawn, Delany <i>et al.</i> 2015 Lawn, Delany <i>et al.</i> 2016	Australia	8 (+10 workers)	Interviews. Thematic analysis. In-depth interviews. Critical discourse analysis.	Moral framing was used by service-users to identify themes of: punished for being bad; being seen as untrustworthy; having faults to be corrected; resisting engagement in the recovery process. The same sample were also analysed with interpretive attention to the use of metaphor to describe how participants construct and experience CTOs.
Light, Robertson <i>et al.</i> 2014	Australia	5	Interviews. Grounded theory.	Lived experience characterised by typologies of: access concerns, isolation, loss and trauma, resistance and resignation, vulnerability and distress. Complex experience with distress caused by illness, communication gaps, difficulty accessing care and services. Also ambivalence caused by coercion and constraint which also can be beneficial.
McDonnell & Bartholomew 1997	Australia	7 Qual. (+130 Quan.)	Interviews. + Mixed method.	Participants preferred community to hospital. Would prefer wider treatment options. Experienced coercion and ambiguity around timescales of the orders with discharge criteria unclear.
Mfoafo-M'Carthy 2014	Canada	24	Interviews. Phenomenological approach.	Participants perceived positive impacts as: affirmation of experience within the system; improved rapport with clinical team; increased compliance; and feelings of empowerment. Perceived negative impacts: feelings of coercion and associated stigma.
O'Reilly, Keegan <i>et al.</i> 2006	Canada	14	Interviews. Constant comparative	Participants had contradictory feelings about CTOs. Most experienced some degree of

			analysis.	coercion, many believed the orders provided necessary structure to their lives.
Rawala & Gupta 2014	England	6	Focus group	Service-user views were mixed and ambivalent with CTOs considered restrictive.
Ridley & Hunter 2013	Scotland	49	Interviews. Thematic analysis.	Participants felt their voice was heard but had little influence over treatment decisions. Legislation has not modified the dominant psychiatric paradigm. Shifts in practice recommended to improve therapeutic relationships and include a more holistic approach with recovery perspectives.
Riley & Hoyer 2014	Norway	11	Interviews. Thematic narrative analysis.	Participants generally complied with CTO because of clear and secure framework and alternative hospitalisation. No physical force reported but coercion experienced through excessive control and little collaboration in treatment.
Scheid-Cook 1993	USA	68	Interviews. Thematic analysis.	Participants experienced greater social control but 'better than being in hospital'. Some participants gained insight into mental illness as deviant behaviour requiring control.
Schwartz, O'Brien <i>et al.</i> 2010	Canada	6	Interviews. Thematic analysis.	Participants reported feelings of coercion and powerlessness but recognised some positive aspects. CTOs add to problematic feelings of stigma associated with mental illness with specific issues around labels, control and discrimination.
Stensrud <i>et al.</i> 2015	Norway	16	Interviews. Grounded theory.	Main finding that participants felt their lives were on hold. Being seen as patients prevented them from taking responsibility. Medical context seen as an obstacle to recovery. Lives dominated by healthcare agenda and control that reduced quality of life. Participants felt safe and secure with easy access to staff and services.
Stroud, Banks <i>et al.</i> 2015	England	21	Interviews. Thematic analysis.	CTOs were perceived as helpful in certain circumstances for the 'right' service-users. Factors influencing effectiveness

				included recognition of CTO containing elements, respect for legal authority and accepting conditions.
Stuen, Rugkasa <i>et al.</i> 2015	Norway	15	Interviews	CTOs were experienced as a security net, a social control mechanism, and as a violation of autonomy.

A systematic review of the views and experiences of subjects of CTOs has very recently been undertaken by Corring, O'Reilly *et al.* (2017) who also identified the same papers. The systematic review particularly highlighted three themes from studies of service-user experience; the first was a negative theme where service-users felt coerced and controlled; the second theme highlighted medication as the perceived main reason for a CTO; and a third theme of CTOs as a safety net. These findings are interesting as they represent a range of responses including negative, ambivalent and positive reactions; as well as the use of metaphor in the perceived safety net. Authors of the reviewed qualitative studies have usually organised their data into themes, groups or processes. These typologies have been listed and broadly arranged into groups of positive, negative and ambivalent responses in Table 3.2 below. This demonstrates the diverse and conflicting nature of responses. The studies included in the previous table will be reviewed in the following section with particular emphasis on how they examined and analysed these broad arrangements of positive, negative and ambivalent responses. The following review will also include, where possible, some indication of how these categories of responses were perceived and include descriptions of the felt impact on participants subject to compulsory community treatment.

Table 3.2 : Grouped typologies of qualitative study responses

Positive responses	Negative responses	Ambivalent responses
Better than hospital. Preferred community. Ownership. Cooperation. Access to services. Health improvements. Provides structure. Accepting the need for treatment over time.	Lack of treatment options. Resistance. Rejection. Dependency. Stigmatising. Disempowering. Enforced treatment. Use of injections. Reduced medication	Experienced coercion. Ambiguity of duration. Discharge criteria unclear. Fatalism. Resignation. Bargaining. No undue hindrance. Affects only 'mental' part of life.

<p>Increased stability. Desire to help others. Increased support. Increased employment opportunity. Interaction with professionals, family and friends. Improved quality of life. Facilitates early discharge. Facilitates treatment. Fosters engagement. Improved rapport. Increased compliance. Feelings of empowerment. Offers organisation, structure and routine. Support and protection. Clear and secure framework. Alternative to hospitalisation. Access to staff. Security net.</p>	<p>choices. Restrictions on residence. Restrictions on travel. Increased coercion. Loss of credible identity. Medicalisation. Increased control. Lack of illness knowledge. Lack of symptom management. Discontented social relationships. Lack of daily activity. Lack of meaningful occupation. Restrictive. Feeling controlled. Labelled as mentally-ill. Stigmatisation. Powerlessness. Not involved in discharge process. Inconsequential service-user voice. Maintains dominant medical paradigm. Isolation and marginalisation. Loss of identity. Loss, trauma and grief. Loss of relationships. Distress caused by illness. Treated differently. Feeling a second-class citizen. Excessive control. Minimal collaboration. Punished for being bad. Having faults to be corrected. Lives on hold. Preventing self-responsibility. Domination by services. Dependent on professionals' decisions. Social control mechanism. Violation of autonomy.</p>	<p>Effect on therapeutic relationships. Playing the game. Varying relationships with staff. Varying staff competencies. Varying levels of communication. Varying awareness of personal strengths. Ambiguous sense of personal control. Inconsistent understandings. Lack of knowledge of discharge criteria. Reduced motivation. Misunderstand legal rights. Enforced adherence to conditions. Enforced medication adherence. Misunderstanding conditions. Misunderstanding criteria for recall. Compromised autonomy. Submission and acceptance. Resisting engagement in recovery. Paradox of care and control. Helpful for 'right' service-users.</p>
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For example, McDonnell and Bartholomew (1997) reported positive responses from participants who preferred being in the community to hospital, but negative

responses where they experienced a lack of treatment options and ambivalent responses around their experiences of coercion, timescales of the order, as well as unclear discharge criteria. The authors recommended that all stakeholders should work together to better balance the individual's desire for autonomy with the state's regulatory obligations (McDonnell and Bartholomew 1997). This was one of the earliest studies using interview data from CTO participants, but the emphasis was on the service provision of CTOs rather than the participants' experience of CTOs. Participant data was used to confirm suspected deficiencies in service provision rather than participant experience driving the study to reveal problems with clinical practice or with mental health services. This early tendency to view participant responses through the lens of clinical or administrative practice rather than attempting to understand responses from a service-user perspective may have been indicative of low priority afforded to this perspective and the subordinate position of qualitative research at the time.

However, five years later, Canvin *et al.* (2002) described contradictory responses both accepting and resisting compulsory community treatment. The authors maintained that the diverse responses were similar to Valimaki's (1998) self-determination continuum, which could be understood in terms of individuals moving across a continuum from active involvement in their self-determination to passive involvement to no self-determination at any time. Interestingly, the authors identified and described typologies of experiences and also movement and changes in behaviours along a self-determination continuum indicating that change is possible between the diverse positions of resisting and accepting compulsory treatment. This was also a brief attempt to explain why participants responded in different ways as well as describing how participants responded to a CTO. Canvin *et al.* (2002) identified and conceptualised three broad approaches to compliance – imposed, chosen and active compliance - which also corresponded to positive, negative and ambivalent responses. Imposed compliance was argued to be represented by the negative fatalism and resignation responses; chosen compliance was represented by ambivalent bargaining and cooperation responses; and active compliance was represented by the positive ownership response. The negative responses were described as accepting the inevitable, when compliance seems unavoidable. Ambivalent

responses were described by a service-user as complying 'because I want to and because I have to' (p365). Positive responses were where service-users recognised the beneficial aspects of the CTO and had a wish to maximise these benefits. There was potential reported for therapeutic 'manipulation' of service-user responses by clinicians in order to improve outcomes. This was dependent on collaboration and the development of an important therapeutic alliance between professionals and service-users (Canvin, Bartlett *et al.* 2002).

Gibbs *et al.* (2005) found that the majority of participants were positive about, and supportive of the CTO, valuing access to, and alliance with professionals and services; and attributing health improvements to treatment under the order. Negative responses included reduced choice about medication and restrictions on residence and travel, with a minority of service-users strongly opposed to the order (Gibbs, Dawson *et al.* 2005). The authors identified an ambivalent group who found that the restrictions did not unduly hinder them in their day-to-day life (Gibbs, Dawson *et al.* 2005). This study also made a separate attempt to score service-users' global attitude to the CTO ($n=42$) with two researchers independently reviewing each transcript and rating each interviewee as either: wholly favourable 19% ($n=8$), generally favourable but noted disadvantages 46% ($n=19$), equally for and against 21% ($n=9$), generally opposed but noted advantages 7% ($n=3$), and totally opposed 7% ($n=3$).

Gibbs *et al.* (2005) maintained that service-users separated their lives into a mental health and non-mental health life where they had more control. They viewed the CTO as affecting only the mental health part of their life thus limiting its perceived impact. Once again, the authors suggested that movement and change was possible in that CTOs were flexible instruments and there was room for exercising considerable discretion and negotiation in balancing autonomy, health and social functioning (Gibbs, Dawson *et al.* 2005). This study attempted to balance participant perspectives within a clinical context and was able to translate participant responses into professional language whilst retaining some of the feelings expressed by many of the participants.

Movement and change for participants was a theme in Gault's (2009) study where CTOs were viewed as a process, with a range of responses which included positive responses of accepting the need for treatment; negative responses of loss of credible identity, medicalisation and increased control; ambivalent responses of playing the game, relationships with staff, varying therapeutic competencies and levels of communication. Gault (2009) suggested that when service-users are first subjected to a CTO they lose their credible identity. In order to regain some control, individuals appear compliant (playing the game), but eventually they accept the fact of their illness (medicalisation) and accept treatment. However, they may experience acceptable treatment, thus promoting concordance; or they may experience unacceptable treatment resulting in non-compliance and increased control. This acceptance of treatment, according to Gault (2009), depends on the therapeutic competence or incompetence of the practitioners involved. Gault (2009) also argued that as society becomes more concerned with risk, seeking systems to control and predict behaviour, mental health services tend then to see risk rather than people. Participants in the study expressed a desire to be cared for by clinicians who aim for a position of mutual understanding around acceptable treatment rather than risk management (Gault, 2009).

The attitudes of clinicians was an important feature in a study by Corring *et al.* (2010), which examined the quality of life for individuals on a CTO and also identified all three broad typologies of positive, negative and ambivalent themes. Major positive themes included satisfaction from increased stability and a desire to help others; negative themes were a lack of knowledge around illness, lack of symptom management, discontent with social relationships, lack of daily activity and meaningful occupation; and an ambivalent theme was identified around varying awareness of personal strengths (Corring, Anders *et al.* 2010). The general perception for participants was an experience of loss of control and freedom, as well as a reduction in overall wellbeing. The study suggested that clinicians could and should facilitate and encourage service-users to establish and maintain control over their daily activities as an integral part of treatment planning. This study demonstrated that multiple factors influenced quality of life on CTOs, with the imperative that opportunity is given to service-users for

discussion on the most profound factors that could reduce symptoms of illness and levels of anxiety (Corring, Anders *et al.* 2010).

Rawala and Gupta (2014) identified that service-users in their study perceived a wide range of complex responses, including some positive and negative themes, but an overall ambivalent service-user reaction to CTOs. Light *et al.* (2014) also acknowledged that the lived experience of participants on a CTO was complex with, again, the general categories of positive and beneficial themes, negative and distressing themes, as well as themes of significant ambivalence. Positive descriptions were characterised by CTOs facilitating access to treatment and acting as a safety net within the health system; the CTO was also an opportunity to foster agency and engagement. Negative descriptions were characterised by feelings of isolation, stigma, being marginalised, loneliness, being ignored, and loss of identity. Participants also voiced negative feelings of loss and trauma, shock and grief associated with detention, the loss of relationships and social roles, as well as feelings of vulnerability and distress associated with illness in the community.

Ambivalence was generated from an acknowledgement that CTOs, although coercive and compromising autonomy, may also be beneficial through a process of submission and acceptance of the instrumental value of a CTO (Light, Robertson *et al.* 2014). From their analysis of the data, the authors distilled the lived experience for participants 'as one of distress and profound ambivalence' (p348). The distress emerged from the mental illness *per se*, and from the sense of isolation and disempowerment that arises from the order. Communication gaps and difficulty accessing optimal care appeared to compound these feelings. The ambivalence arose from a view that CTOs are coercive, constraining autonomy and agency but may also be beneficial. This ambivalence is not a simple dichotomy between paternalism and autonomy; but an experience of intense practical, moral, existential complexity and uncertainty (Light, Robertson *et al.* 2014). It is interesting that the authors attempted to examine the phenomenon of ambivalence in more depth which, in turn, tended to give more emphasis to this category, identifying a deeper meaning and significance for participants.

However, many of the studies simply identified a clear dichotomy and organised responses into more discrete positive and negative themes. For example, O'Reilly *et al.* (2006) found that many participants were positive about the CTO believing it provided necessary structure to their lives, but most participants were negative in their response as they experienced some degree of coercion. The study also reported that whilst most service-users perceived little or no disruption of therapeutic relationships, a few remained very angry with clinicians (O'Reilly, Keegan *et al.* 2006). Schwartz *et al.* (2010) also reported positive and negative feelings regarding CTOs. The positive statements included increased support, employment potential, perceived improved mental health, and positive interactions with professionals, family and friends. The dominant negative themes involved feelings of being controlled and labelled as mentally-ill, as well as problematic feelings of stigma and powerlessness. The authors identified a connection between disagreement with diagnosis and negative statements regarding the conditions of their CTO, particularly the condition of mandatory psychotropic medication (Schwartz, O'Brien *et al.* 2010). It was notable that although the authors reported positive and negative feelings about the CTO, the only feeling they identified was one of anger on the part of participants, all the other 'feelings' were non-specific and were expressed in professional language such as 'employment potential' and 'stigma'.

Similar professional language featured in a study by Mfoafa-M'Carthy (2014), which examined the experiences of ethnic minority individuals on CTOs where participants perceived both positive and negative impacts of the order. Positive experiences included a feeling of support and protection that enabled them to stay grounded and responsive to treatment; participants also felt the CTO offered organisation, structure and routine which had a stabilising effect. Participants felt positive about the rapport that developed between them and the clinical team which helped them 'feel good about themselves' (Mfoafa-M'Carthy 2014 p17). Negative experiences of CTOs included the negative effects of racism that restricted their treatment options; the negative perceptions also featured stigmatisation, feelings of being a second-class citizen and being treated differently; also participants expressed feelings of being coerced into accepting

the CTO with hospital discharge dependent on consenting to the conditions of the CTO (Mfoafa-M'Carthy 2014).

The ambivalence associated with the theme of early hospital discharge featured in other recent studies. For example, Fahy *et al.* (2013) found that the majority of service-users believed that CTOs facilitated earlier discharge from hospital but that participants were not involved in the process. Many participants lacked motivation or the ability to understand the information provided about their legal rights and all felt they must strictly adhere to conditions and medication compliance in order to remain in the community. Canvin *et al.* (2014) found there was no single definitive experience or view of CTOs from participants; however, all participants perceived the main purpose of CTOs also to be medication adherence using legal enforcement. There was mixed evidence of how the mechanisms of CTOs were understood especially around the associated conditions and the criteria for recall. This focus on medication and lack of understanding may have implications for the broader goal in service-user care and involvement under CTOs (Canvin, Rugkasa *et al.* 2014). According to Riley *et al.* (2014), participants in their study generally complied with compulsory community treatment because of a 'clear and secure framework' (p506) and because the alternative would be hospitalisation. Coercion was experienced as a limitation of freedom through excessive control with little service-user participation. The authors recommended that such limits on freedom should be considered when imposing compulsion in the community as participants reported that when treatment and care take place in the community it feels like 'coercion moves into your home' (Riley, Hoyer *et al.* 2014 p511)

This emphasis on, and reporting of mainly negative themes were replicated in such diverse jurisdictions as Scotland, Australia and Norway. Atkinson *et al.* (2002) found that few of their Scottish participants were clear about their rights and legal status under compulsory community treatment. Service-users reported difficulty in communicating with practitioners as well as problems negotiating medication with professionals, feeling that the debilitating side-effects were not taken seriously (Atkinson, Garner *et al.* 2002). Brophy and Ring (2004) estimated that in 2004 in the Australian state of Victoria, 3000 people were placed on CTOs

annually. Service-users were generally dissatisfied with the use of CTOs, viewing them as stigmatising and disempowering. A constant theme was the 'intense dislike' (p166) for enforced treatment, particularly the use of injections, and a lack of alternative therapies (Brophy and Ring 2004). The results of this study suggested there was 'significant room for improvement in both development and implementation' to ensure that the basic founding principles of CTOs are translated into practice (Brophy and Ring 2004 p171). Ridley and Hunter (2013) found that the introduction of CTOs in Scotland, according to service-users' experiences, did little to change the dominance of the medical paradigm. Although the legislation provided a foundation for improving the process of compulsion, fundamental changes in clinical practice were needed to incorporate improved therapeutic relationships, which included a more holistic and recovery-orientated approach (Ridley and Hunter 2013).

However, the traditional and dominant medical paradigm featuring non-therapeutic alliances were identified in negative themes from two of the latest qualitative studies. Lawn, Delany *et al.* (2015) examined the presence and consequences of moral framings in service-users' experiences of CTOs. They found that participants often used a moral framework where they were invariably:

'punished for being bad, seen as untrustworthy, and having faults to be corrected via coercive mental health service practices that worked against their full engagement in the recovery process' (p287).

According to Lawn, Delany *et al.* (2015), experiences of CTOs were multi-layered and depended critically on practitioner empathy and reflection in order to resolve the paradox and moral 'grey zone' (p274) between caring and controlling. The same authors, using the same sample, further analysed in-depth interviews with particular interpretive attention to participants' extensive use of metaphor. According to Lawn, Delany *et al.* (2016), participants used metaphor to help explain their experience and their feelings, and to express their suffering. This attention to metaphor revealed additional insights into participant experience of CTOs as coercive, where they described feelings of punishment, control and

scrutiny. The authors argue that the interpretation of metaphor was useful in engaging participants in meaningful dialogue 'as an alternative to practice predominately focused on risk' (p14). The importance of metaphor use lies in the potential for researchers to access the experience of service-users on CTOs, promoting trust and rapport with participants, and enabling better understanding of experience through the examination of the language used (Lawn, Delany *et al.* 2016).

Stensrud, Hoyer *et al.* (2015), as authors, used metaphor to describe how service-users in Norway felt when their daily lives were dominated by the agenda set by health professionals which subjected them to controlling measures resulting in reduced quality of life. The main finding of this study was that service-users on CTOs experienced their lives being 'on hold' (p209), felt that the CTO kept them in the role of patients, and made them hesitant and dependent on professionals' decisions; all of which was perceived as preventing recovery and a transition to a more normal life (Stensrud, Hoyer *et al.* 2015). All of the participants reported a high level of perceived coercion that 'coloured their whole world' (p215); they felt they had a poor understanding of the boundary between personal autonomy and clinical decisions so that service-users felt a lack of control over their own lives (Stensrud, Hoyer *et al.* 2015). These authors recommended that clinicians needed to be aware of this phenomenon in order to enhance the autonomy of service-users on CTOs, where 'mere adaptation to treatment' (p215) was replaced by therapeutic collaboration on alternatives and options (Stensrud, Hoyer *et al.* 2015). Stuen, Rugkasa *et al.* (2015) also used metaphor to describe a positive theme of a 'security net' (p9), as well as identifying more negative service-user experiences of CTOs as a social control mechanism and a violation of autonomy.

By contrast, the final group of qualitative studies reported largely ambivalent and positive themes or wholly positive responses. For example, Gjesfjeld and Kennedy (2011) found that participants voiced an ambiguous sense of personal control over the process and general confusion about what was being asked of them while on these orders. This had the potential to establish a troubling pattern of passivity for post-CTO care and required an early commitment to collaboration

on the part of practitioners. However, whether individuals liked or disliked the orders, participants all reported an improvement in their life or a personal benefit from this coercive treatment (Gjesfjeld and Kennedy 2011).

In one of the earliest studies, Teresa Scheid-Cook (1993) reported that clients were cognisant of the greater liberty that compulsory community treatment afforded and 'was better than being in hospital' (p186). For the majority of participants the main objective of their lives was to remain out of hospital, and compulsory community treatment was perceived as definitely better than hospital (Scheid-Cook 1993). Over two decades later, Julia Stroud and colleagues (2015) found that compulsory community treatment was perceived as helpful in certain circumstances for the 'right service user' (p91). They reported that service-users found the structure and support offered by CTOs reassuring, particularly for those who respected the authority of the legal framework, and accepted and understood that the associated conditions were in their best interests (Stroud, Banks *et al.* 2015). However, although the authors of these studies recommended that CTOs should be carefully planned interventions, and that assessments should involve the service-users' perceptions as an important indicator of the value and potential effectiveness of compulsory community treatment, they remained vague about the detail of participant perceptions of CTOs.

The extant qualitative studies indicate that compulsory community treatment is perceived positively, negatively and with ambivalence across all jurisdictions in varying combinations. Service-users experience these categories with a mixture of qualified acceptance of some potential benefit. There were varying levels of hostility and distress vis-a-vis the negative experiences of coercion, together with loss of control and autonomy. Also, a wide ranging experience of ambivalence was characterised by feelings of uncertainty, inconsistency and confusion. The studies give the impression that participants' views are not finite or fixed but are subject to change and influence by practitioners, professionals and processes. Many participants perceived that mental health services are often focused on predicting and managing risk rather than developing a collaborative, therapeutic approach to individualised care. However, the studies demonstrated a general

consensus around 'profound' ambivalence associated with CTOs and the need for deeper understanding of service-user responses, associated feelings and theoretical principles involved.

3.4 Summary of the literature

Despite the availability of nearly four decades of evidence and the experience of CTOs in over 75 jurisdictions worldwide, the extensive body of literature is unable to fully inform decisions about the continued use of CTOs. The most comprehensive and thorough of three systematic reviews maintained that it was not possible to state whether CTOs were beneficial or harmful to service-users. The range of research designs used in the quantitative studies were beset by conceptual, practical and methodological problems, so that, overall, there was a lack of robust evidence for positive or negative clinical outcomes. These outcomes included: hospital readmission; length of hospital stay; improved medication compliance; or patient quality of life. Qualitative studies examining service-user experience identify and describe three broad typologies of response to CTOs – positive, negative and ambivalent categories. Profound ambivalence has been identified as indicative of potential for positive change and a therapeutic opportunity for clinicians to enhance the service-user experience on a CTO.

Some qualitative studies have described lived experience under a CTO as a process and have identified potential for flexibility and movement between conflicting positions as CTOs progress. One study used interpretive techniques to examine understandings, feelings and associated principles that revealed additional insights into service-user experience of CTOs. However, psychiatrists, as the main decision-makers' generally consider CTOs necessary for maintaining treatment adherence, engagement and improved insight. The literature consensus suggests that widespread CTO use will continue despite this lack of evidence. Several authors have suggested that the pursuit of definitive clinical evidence may be beyond the scope of current research paradigms and that the extant qualitative evidence may not have revealed the full extent of service-user experience under a CTO. This review indicates that in-depth interpretive techniques may be a potential method for examining the service-user experience

of CTOs as well as offering understanding why service-users describe experiential diversity, ambivalence and apparent contradiction in response to CTOs.

Chapter 4

Research theory

4.1 Introduction

The research question is concerned with capturing and understanding experience. The study of human experience is complicated because of the complex nature of social phenomena (Bowling 2002). Attempting to get as close as possible to service-users' experience of a CTO involves obtaining 'knowledge of the quality and texture of the experience itself' (Willig 2013 p16). This requires the researcher to enter participants' experiential world and capture some of their feelings, thoughts and perceptions which constitute experience. This chapter examines the potential ontological, epistemological, philosophical and methodological opportunities and challenges to researching such experience. The section also explores the role of reflexivity in the research process when positioning participants' description within wider social and cultural contexts. This 'second-order account' can provide commentary on participants 'sense-making' activity where metaphor use is often also considered (Larkin, Watts *et al.* 2006 p104). The participant descriptions generated will therefore involve a certain amount of interpretation to capture and comprehend service-users' experience of CTOs.

4.2 Paradigm selection

This section justifies the choice of paradigm selected from a range offering a 'scientific' positivist approach, through a critical realist perspective, towards a socially constructed 'reality'. In order to explore this range, the advantages and disadvantages of each paradigm are examined, and the section explores the potential benefits of co-constructed research data. Paradigms encapsulate the basic foundational beliefs that set limits to legitimate inquiry (Guba and Lincoln 1994). Guba and Lincoln (1994) maintained that these fundamental beliefs remain interconnected and direct investigators in conceptualising and classifying their research (Ponterotto 2005). However, Guba and Lincoln (1994) noted that paradigms are not open to proof in the conventional sense; they cannot be elevated in a hierarchical criteria. They are informed and sophisticated

constructions as a response to three defining questions focusing on ontology, epistemology and methodology (Guba and Lincoln 1994).

A constructivism paradigm denotes the basic tenet of this approach, which proposes that reality is socially constructed (Berger and Luckmann 1971). In practice this means that research participants are viewed as helping to construct 'reality' with the researcher (Robson 2002 p27). Robson (2002) maintained that constructivists work in the relativist tradition, where researchers have grave difficulties with the notion of an objective reality which can be known. They instead consider the task of the researcher to understand the multiple social constructions of meaning and knowledge and because there are multiple realities, research questions cannot be fully established in advance of this process. Researchers within this paradigm tend to use methods such as interviews and observation as well as other, more creative, approaches to data generation which allow them to acquire multiple perspectives (Robson 2002). Essentially, constructivists embrace reality as constructed in the mind of the individual, rather than a singular external entity (Ponterotto 2005). According to Ponterotto (2005), this paradigm espouses a hermeneutical approach, which maintains that meaning is hidden, but can be brought to the surface through interpretation and deep reflection, stimulated by interactive researcher-participant dialogue.

The centrality of this interaction between investigator and the object of investigation is a distinguishing characteristic of the constructivist paradigm, and only through this interaction can deeper meaning be revealed (Ponterotto 2005). There are few examples of this paradigm in the extant CTO literature although the ethnographic work of Hannah Jobling (2014) embraces this approach. She immersed herself in service settings in order to explore the questions of 'who might CTOs work for, in what circumstances and why?' (p49). Ponterotto (2005) argued that proponents of constructivism emphasise the goal of understanding 'lived experiences' (p129) from the viewpoint of those who live it day by day, and that lived experience occurs within a social historical reality. Such lived experience may be outside the immediate awareness of the individual, but it is

argued that it can be partially brought to prominence by interaction, co-construction and interpretation (Ponterotto 2005).

By contrast, positivism, essentially, looks for the existence of a constant relationship between events, or, in the language of experimentation, between two variables and considerable ingenuity is employed to control the conditions of the experiment (Robson 2002). However, when people are the focus of the study, particularly when this is taking place in a real world context, 'constant conjunction' is virtually impossible (Robson 2002). In the research attempting to link CTOs to clinical outcomes using RCTs, attempts were made to establish causation between CTO use and reduced hospital admissions, carefully controlling variables using randomisation. A comprehensive review argued that RCTs of CTOs were beset by practical, legal and clinical complexities that made them extremely difficult to conduct (Churchill, Owen *et al.* 2007). However, rather than reject this positivist perspective totally, it could be reconceptualised into a more promising basis for social science and a postpositive view developed (Ponterotto 2005). Postpositivism, for example, acknowledges that objective reality can only be imperfectly apprehended, and that human intellectual mechanisms are flawed with intractable life phenomena, such that 'true' (p129) reality cannot be fully captured (Ponterotto 2005). Postpositivism has been judged akin to critical realism (Bhaskar 1989) and social realism (Rogers and Pilgrim 2014). Within the CTO body of research, many of the quantitative case control, before-and-after, non-randomised comparative studies and descriptive studies are rooted within the postpositivist paradigm. However, the quality of the postpositivist evidence in this field limited the strength of any conclusions about the effects of CTOs (Churchill, Owen *et al.* 2007).

Critical theory or critical realist paradigms advocate a reality that is constructed within a social-historical context with reality often conceptualised within power relations (Ponterotto 2005). Critical realist reality is complex, multi-layered and a multi causal web of interacting forces, where all phenomena can be explained in part by, but not reduced to, their underlying generative mechanisms (Oliver 2012). According to Oliver (2012), critical realists seek vertical explanations which link events and experiences to underlying mechanisms rather than

antecedent events to 'allow theorising to go beyond what is immediately knowable' whilst maintaining an obligation to test that theorising 'in the crucible of real-world experience and against competing theories' (p375). Critical realism has an explicit emancipatory goal and provides a framework where surface appearances may be challenged by an examination of the structures that generate them (Robson 2002). In this way, critical theorists support a programme of action that can go beyond 'surface tinkering to tackle the deeper roots of needs and false beliefs' (Oliver 2012 p376). In the CTO literature, some of the modified grounded theory approaches and thematic analyses described in the qualitative studies have been undertaken from a critical realist perspective. For example, Ridley and Hunter (2013) examined the legislation within the structure of the dominant psychiatric paradigm; Schwartz, O'Brien *et al.* (2010) investigated participant feelings of coercion and powerlessness; and Stenstrud *et al.* (2015) identified the dominance and control associated with the healthcare agenda. A critical realist approach could be adopted to examine the underlying structures potentially influencing the historical and wider contextual development of CTOs.

However, in a commitment to exploring how service-users make sense of CTOs, the current study acknowledges a commitment to the benefits of a constructivist paradigm. At the same time, the usefulness of other paradigms is also acknowledged within the extant CTO literature. However, the constructivist approach allows for an examination and exploration of a complex and multi-faceted reality which may be co-constructed through participatory and reflective research methods where findings are co-created. This paradigm allows for in-depth, detailed investigation of the felt impact and lived experience of service-users subject to CTOs – that is, knowledge of the quality and texture of the experience itself. These findings can then be combined and compared with existing studies using other approaches, which may not be able to investigate to such depth and detail, in order to extend, expand and deepen the body of knowledge and understanding associated with CTOs. Other distinctions and definitions are also relevant to paradigm perspectives and CTO research, for example, distinguishing between idiographic and nomothetic approaches.

4.3 Idiographic and nomothetic

Idiographic means applying to the individual as opposed to nomothetic which refers to application to people generally, general patterns or universal statements (Ponterotto 2005). Idiographic research concentrates on understanding the individual as a complex, unique entity described in rich detail; by contrast, nomothetic research aims to uncover general patterns of behaviour with a normative foundation described in objective and impersonal terms featuring generalizable findings averaging out individual variation (Willig 2013). The positivist and postpositivist studies in the CTO literature are all nomothetic in focus, and many of the critical theory studies attempt to broaden their findings and typologies in order to enable a degree of generalisation. However, these studies tend to overlook fine data detail and richness in the pursuit of generalisation (Bowling 2002). CTO studies that fall within the constructivist paradigm are idiographic and are concerned with the particular rather than the general. Idiography does not deliberately avoid generalisations, rather establishing them differently, locating them in the particular and, hence, developing them more cautiously (Smith, Flowers *et al.* 2009). For the current study this means that 'intensive and detailed engagement' can be undertaken with an individual case to produce insights 'that are integrated only in the later stages of the research' (Willig 2013 p87). This will enable each individual participant's experience to be explored in-depth, in its peculiarity.

4.4 Ontological positioning

According to Carter and Little (2007), textbooks often present ontology as a foundational element of qualitative research. Ontology considers the nature of existence (Abercrombe, Hill *et al.* 1994), the science or study of being (Blaikie 2007), or the features of social reality (Layder 2003). Elder-Vass (2012) maintained that positivism and constructionism are often regarded as opposing traditions in social theory, and indeed even mutually contradictory. Positivism assumes that the truth or 'facts' (p20) are gained from direct experience or observation, invisible or theoretical entities are rejected (Robson 2002). Anthony Giddens (1997) maintained that Émile Durkheim (1858-1917), a founder of sociology, argued that social life must be studied with the same objectivity as

scientists study the natural world by analysing objects or events rigorously. By contrast, constructionist approaches maintain that there is no reality independent of human consciousness (Robson 2002). Reality is not 'self-evident, stable and waiting to be discovered'(p11), there are other ways of knowing about the world other than direct observation, these involve human activity, perceptions and interpretations (Rogers and Pilgrim 2014).

However, Madill, Jordan *et al.* (2000) introduce additional positions within this positivism-constructionism dichotomy, suggesting there is a ontological continuum between polarised and conflicting positions. When authors move beyond the polarised view towards a more differentiation, additional terminology is introduced such as differing forms of naïve realism towards the positivism end of the continuum and more extreme forms of radical constructionism at the other. Researchers generally consider social concepts as real enough to be named, investigated and analysed (Carter and Little 2007). Rogers and Pilgrim (2014) hold the central perspective of critical realism which accepts that reality does exist, but also considers that human action is 'neither mechanistically determined by social reality nor does intentionality (voluntary human action) simply construct social reality', thus material reality constrains action, but does not simply determine such action (Rogers and Pilgrim 2014 p13). This contrasts with the more naïve realism where a rigorous scientific approach is adopted and a more radical constructionism ontology, where the notions of any absolute foundations for knowledge, are challenged and considered a discursive construction.

Ontological emphasis determines position on the continuum which then informs epistemology and methodology (Madill, Jordan *et al.* 2000). The position held for the current study is one of contextual constructionism. This means that, according to Guba and Lincoln (1994), multiple and sometimes conflicting realities exist for participant and researcher, but they may change as their constructors become more informed and sophisticated. Thus the realities of CTOs are different for the various stakeholders and those realities may change over time. This contrasts with the positivist ontology which pursues a definitive reality, in the form of measurable outcomes. It also differs from the post positivist and critical realist ontology that assumes that the reality of CTOs can only be

captured imperfectly, but is always situated in the wider social, political and economic frameworks such as the public responses to homicides and the monetary pressures on capitalist budgetary controls. The aim of the inquiry is to enable increased in-depth understanding from a 'more informed and sophisticated multi-voiced reconstruction from passionate participants' (Guba and Lincoln 1994 p112)

4.5 Epistemological positioning

According to Ponterotto (2005), epistemology is 'concerned with the relationship between the knower, as research participant, and the would-be knower, as researcher' (p131). Positivists promote dualism where the researcher, participant and phenomena are assumed to be independent of one another, and by following rigorous standardised procedures the participant and phenomena can be studied objectively without bias (Ponterotto 2005). Within such paradigms, the researcher should not influence the participants or vice versa, otherwise flaws are introduced into the study. The positivist paradigm in CTO research literature places great emphasis on 'the true experiment' of the RCT (Bowling 2002 p225) and places definitive importance of the results of such studies, even suggesting that the latest RCT indicates that use of CTOs be discontinued (Burns, Rugkasa *et al.* 2013). Postpositivist approaches include other comparative quantitative studies that also question continuing the use of CTOs based on evidence that is *probably* true. For critical realists, such as the CTO studies undertaken using modified grounded theory, the relationship between the researcher and participant is transactional and subjective. But the relationship is also structured and dialectic in nature, with the intention of using contrasting logic to highlight the influences on under-represented groups such as those service-users subject to CTOs (Fahy, Javaid *et al.* 2013; Gault 2009; Gibbs, Dawson *et al.* 2005).

The characteristics of these more 'scientific' and more rigid paradigms tend to limit the potential for exploration, discovery and understanding necessary for the investigation of the sense-making process. A constructivist paradigm advocates a more expansive and fluid transactional subjective stance where reality is a socially constructed, dynamic interaction between researcher and participant

(Ponterotto 2005). The aim of the current study is to capture the 'lived experience' of the participant, which is not simply the participant's description of the experience, but the meaning and effect behind that experience and the impact on the participant's day-to-day living (Smith, Flowers *et al.* 2009 p1). These lived experiences may be outside the immediate awareness of individuals but may be 'brought to consciousness' by interaction with the researcher (Ponterotto 2005 p129). In this way understanding can be created between investigator and respondents as the investigation proceeds (Guba and Lincoln 1994). In the current study, this constructivist paradigm was adopted and positioned outcomes as co-created by me and CTO service-users during interviews. In this way, the understandings and meanings associated with CTOs could be explored along with the impact on the daily lives of service users as they attempted to make sense of compulsory community treatment.

4.6 Philosophical positioning

In order to investigate beyond established knowledge and to explore lived experience at greater depth, an alternative approach must be adopted to move away from familiar approaches to research and the 'natural attitude' to remain open to new understandings (Finlay 2014 p122). The current study aimed to examine the phenomenon of CTOs by exploring service-users' experience of CTOs in participants' own terms as they 'engage with the world' around them (Willig 2013 p84). In order to fulfil these aims, philosophical positioning within the broad disciplines of phenomenology and hermeneutics were employed.

4.6.1 Phenomenology

Phenomenology is rooted in a relatively new philosophy initiated by Edmund Husserl (1859-1938) and it has grown and expanded since that time (Giorgi 2010). The core of this perspective is the emphasis on the experiential claims and concerns of the participant, hence the researcher must approach data with the aim of understanding the participants' world and describe 'what it is like' (Larkin, Watts *et al.* 2006 p104). However, access to this experience is both partial and complex and cannot ever achieve a first-person account as the account is always constructed by the participant and the researcher (Larkin,

Watts *et al.* 2006). Husserl maintained that in adopting the phenomenological attitude, habitual, taken-for-granted understandings have to be bracketed whereby the researcher puts aside the everyday world and any past knowledge, scientific or theoretical understandings are held in abeyance in order to let the phenomenon show itself 'in its essence' (Finlay 2014 p122).

Finlay (2014) maintained that the researcher must attempt to stay open to receiving what is presented, and strive to be as present as possible to the phenomenon described through participants' narrative or transcript. This requires that a genuinely empathic and curious stance is adopted whilst remaining reflexive, being critically self-aware and mindful of the investigator's own particular personal, cultural and historical position and perspective (Finlay 2014). Phenomenological research basically starts with concrete descriptions of lived experiences as first person accounts set down in common language and free of abstract generalisations (Finlay 2009). Researchers then proceed by 'reflectively analysing' these accounts, perhaps on a case-by-case basis initially, then by combining case analyses to offer a synthesised account, identifying general themes about the essence of the phenomenon (Finlay 2009 p10).

There has been criticism of phenomenological philosophy and research stemming from the diversity of central issues, developments and applications (Finlay 2009; Giorgi 2010; Ratcliffe 2011). According to 'good science' (p3) where all methods are fully described, prescriptive and intersubjective so as to allow evaluation and replication. Although this problem is sometimes associated with descriptive phenomenology, it is more often a characteristic of the more interpretative forms of hermeneutic phenomenology distinguished by some scholars (Finlay 2009). Whilst all phenomenology is attempting to describe rather than explain, with descriptive phenomenology, researchers aim to discover essential general meaning structures of a phenomenon, staying close only to what is revealed in all its richness and complexity (Finlay 2009). The researcher then extracts the essence of the experiential quality of the experience without attributing any meanings which are imported from outside the description itself (Willig 2013).

Interpretative phenomenology, according to (Smith, Flowers *et al.* 2009), was influenced by the work of Heidegger (1889-1976), Merleau-Ponty (1908-1961) and Sartre (1905-1980). Each of these philosophers contributed and extended the view of phenomenology to include a focus on the person as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns (Smith, Flowers *et al.* 2009). These philosophers position interpretative phenomenology in the real world, but allowing deeper exploration than simple description allows, and a greater connection with daily living than grander, more abstract approaches would encourage.

[These philosophers] move us away from the descriptive commitments and transcendental interests of Husserl, towards a more interpretative and worldly position with a focus on understanding the perspectival directedness of our involvement in the lived world – something which is personal to each of us, but which is a property of our relationships to the world and others, rather than to us as creatures in isolation (Smith, Flowers *et al.* 2009 p21).

Such an approach is important in really listening to mental health service users as they are 'experts by experience and that experience is multi-layered, requiring investigation by interpretation (Barker and Buchanan-Barker 2005 p225). Phenomenological researchers generally agree that the central concern is to 'return to embodied, experiential meanings, aiming for fresh, complex, rich descriptions of a phenomena as it is concretely lived' (Finlay 2009 p6).

Willig (2013) maintained that all phenomenological research should incorporate three basic Husserlian principles of epoché, phenomenological reduction, and imaginative variation. Epoché requires the suspension of presuppositions and assumptions to allow an awareness of the phenomena presented; reduction encapsulates and describes the phenomena in its totality; and variation accesses the structural aspects of the phenomena (Willig 2013). Therefore reduction concerns the texture of 'what' is experienced and variation explores 'how' this

experience is structurally made possible (Willig 2013 p84). Finlay (2009) argued that phenomenological research is phenomenological when:

‘(...) it involves both rich description of the lifeworld or lived experience, and where the researcher has adopted a special, open phenomenological attitude which, at least initially, refrains from importing external frameworks and sets aside judgements about the realness of the phenomenon. (p8).

Again, this is important in the analysis of service-user experience as their descriptions may invite judgements and interpretation from differing, more rational and systematic perspectives such as the medical or socially normative viewpoint. Phenomenological method is sound if it links to phenomenological philosophy and that its methodological claims are justified and consistent; researchers also need to establish whether they seek normative or idiographic understandings, how to manage researcher subjectivity, and whether phenomenology should be pursued as a science, an art, or combination of both (Finlay 2009).

It is useful to consider the philosophical positioning applied to the extant qualitative literature, as well as the current study, exploring service-users experience of CTOs. As previously discussed in Chapter 3.3, most of the qualitative studies present broad typologies which are nomothetic in nature and tend to lack richness and detail as a consequence (for example, Canvin, Bartlett *et al.* 2002; Gault 2009; Light, Robertson *et al.* 2014). Some even pursue a scientific approach with multiple investigators assessing global attitudes towards CTOs as part of the study (Gibbs, Dawson *et al.* 2005). There is little evidence in this body of literature if researchers have engaged in attempt to recognise their potential subjective influences on the study, or any clearly stated links to any philosophical perspective. As a direct consequence of these limitations, the current study committed to idiography, especially in the early stages of analysis, thus the focus is on the particular rather than a search for a general or universal truth. However, there was also a requirement to move beyond the particular and individual analysis to examine the dataset as a whole to identify trends, patterns and themes. The current study therefore, could be classed as more of an

explorative pursuit, with the art of interpretation at its core. Although typologies are also developed in the current study, they have been developed more cautiously, where the main emphasis primarily focused on each individual complex experience before combining and synthesising these experiences and moving towards more general claims.

4.6.2 Hermeneutics

Smith, Flowers *et al.* (2009) described hermeneutics as the theory of interpretation that has been mainly influenced by Heidegger (as previously noted, also influential in phenomenology) and Gadamer (1900-2002). Both these philosophers argued that hermeneutics or interpretation aimed to find meaning in written or spoken accounts (Willig 2012). For Heidegger, this was a concern with something which may be latent, or disguised, and which may be brought to light, into appearance, and interpretation could make sense of that appearing (Smith, Flowers *et al.* 2009). Gadamer was not concerned with the intention of the participant, when bringing phenomenon to light, but with the meaning content of the material itself (Smith 2007). Gadamer was sceptical of recreating the intention of the participant because of the historical gap, insisting that interpretation was a dialogue between past and present and the aim should be not to relive the past, but to learn from it in the light of the present (Smith 2007).

The challenge, therefore, at the heart of interpretation, is to ask questions about it in order to make sense of something, and in order to understand that something, we need to adopt a viewpoint towards it and relationship with it (Willig 2012). However, several authors maintained that these inherent layers of subjectivity shape how a phenomenon is perceived and what can be known about it and, paradoxically, this eliminates the possibility of a neutral or objective view (Smith 2007; Smith, Flowers *et al.* 2009; Willig 2012). The same authors argued that this paradoxical dynamic is reflected in the hermeneutic cycle, where the parts of a whole can only be understood by understanding the whole, while the whole itself can only be grasped on the basis of an understanding of the parts (Willig 2012). According to Smith (2007), the hermeneutic cycle is perhaps the most resonant idea in hermeneutic theory and is potent in describing the analytical process in a

non-linear style with the possibility of constantly 'digging' deeper with the interpretation (Smith 2007 p5) .

The forgoing literature review and contextual examination of CTOs has indicated some areas for further investigation and interpretation. These identified deficits resonate with the anticipated outcomes of an in-depth interpretation. For example, Willig (2012) maintained that depending on the focus of attention, an interpretation could generate any, or all, of the following:

- A better understanding of the participant's intended meaning, i.e. a clearer sense of what the participant was trying to express through the narrative.
- A better understanding of the participant's unconscious or unintended communication, i.e. what may have motivated the participant to say what was said even though the participant may not have been aware of this motivation.
- A better understanding of the social, political, historical, cultural and/or economic context behind the expressed narrative.
- A better understanding of what the narrative may inform about the nature and quality of a more general concept such as human existence, social progress or human psyche. (adapted from Willig 2012 p8-9).

Willig (2012) also differentiated between 'suspicious' interpretation and 'empathic' interpretation (p11). Suspicious interpretation aims to get at the truth of the matter and is like detective work where clues are interpreted to find what really happened. Appearances are not taken at face value and instead used a clues that indicate a more significant, important latent meaning (Willig 2012). This type of interpretation tends to be theory-driven and in order to extract deeper meaning from a narrative it is necessary to have access to a theoretical formulation which informs the interrogation and provides a lens to view the transcript (Willig 2012). Empathic interpretation is an approach which seeks to elaborate and amplify the meaning contained within the presented narrative; the

interpreter remains with, rather than examines below, what is presented and focuses on what is explicit rather than what is hidden (Willig 2012). The interpreter attempts to make connections between features and qualities, noticing patterns and relationships, examining the material from different angles, 'zooming in and out' (p13) and engaging in the hermeneutic cycle to increase understanding and obtain a more complete picture (Willig 2012). However, Willig (2012) maintained that neither of the two approaches to interpretation can generate satisfactory insight in isolation and a combination of the two is required.

These approaches resonate with Linda Finlay's (2009) concept of a descriptive-interpretative continuum where specific work may be more or less interpretative. This continuum may range from simple description at one end through the hermeneutics of empathy, to examine the complete surface picture, towards the hermeneutics of suspicion, which examines below the surface in search of hidden meanings. Both suspicion and empathy can be combined with hermeneutic cycling in order to contextually grasp parts within larger wholes, provided that the interpretation remains descriptively grounded (Wertz 2005). Frederick Wertz (2005) also maintained that hermeneutic phenomenology is hospitable, accepting and receptive of 'the things themselves'; it does not form theories, operationalise variables, deduce or test hypotheses, or use 'probabilistic calculations to establish confidence as do positivist and neopositivist approaches' (p175). Reality, with its many meanings and subjective processes, can be faithfully discovered, and have essential features that can be described and interpreted by the research scientist (Wertz 2005). In order to fully analyse the experience of service-users subject to CTOs, all these interpretative techniques should be employed. The current study should allow for these approaches to be fully utilised exploring the lived experience of participants.

4.7 Reflexivity

According to Willig (2013), phenomenology and interpretation is always a joint venture in that the interpretation will always contain something that belongs to the researcher and something that belongs to the participant. In order to interpret an account, the researcher must contribute some ideas, some expectations, some

conceptual tools used in approaching the narrative (Willig 2013). Thus researcher subjectivity is inevitably implicated in the research, the questions arises to what extent, and how, researcher subjectivity should be 'marshalled' (Finlay 2009 p12). The researcher cannot be detached from the data, cannot be a neutral observer who is affectively and politically removed, but rather an instrument in the research process whilst comprehensively taking account of the reflexive and self-reflexive processes (Medico and Santiago-Delefosse 2014). Woolgar (1988) distinguishes between reflexivity and reflection on a continuum between 'radical constitutive reflexivity' through to 'benign introspection' (p20) or reflection.

According to Woolgar (1988), reflection maintains the positivist distinction between object and representation and aims to present an 'accurate' representation of participants' accounts. Reflexivity, on the other hand, adopts a constructivist approach where reality is constructed contemporaneously and researcher or participant's accounts are valued equally. Reflection often aims to achieve the positivist goal of accuracy in reporting, whereas reflexivity is an explicit evaluation of the self (Shaw 2010). Finlay (2008) argued that researchers need to cultivate a special attentive attitude of openness and wonder that requires discipline, practice and patience:

'... between bracketing pre-understandings and exploiting them as a source of insight, the researcher experiences contradictory and paradoxical pulls. They must simultaneously embody detachment from lived experience and involvement with it. Naïve openness and self-aware[ness] criticality become intertwined - a dialectical dance indeed. The challenge for the researcher is to remain focused on the phenomenon being studied while both reining-in and reflexively interrogating their own understandings. The aim, always, is to see through fresh eyes, to understand through embracing new modes of being.' (Finlay 2008 p29).

This subjectivity should therefore be foregrounded in order to separate what belongs to the researcher and what belongs to the participant (Finlay 2009).

Rachel Shaw (2010) maintained that some acknowledgement or reflexive account should be included in written reports and journal articles; this will often take the form of a declaration of the authors' position in relation to the research question and/or participants. This was sometimes the case in the extant CTO qualitative literature with two papers including a more detailed contribution and notes section (Lawn, Delany *et al.* 2015; Scheid-Cook 1993). Sharon Lawn (2015) declared herself a 'consumer and carer advocate' (p15) and one of her co-authors a service-user who had been 'subject to CTOs many times in the past'; therefore their input to the research was invaluable. Of the 22 qualitative studies reviewed, eight were authored by researchers within a psychiatry discipline; seven from a social work background; four from legal departments; and one from an occupational therapy specialism. These differing perspectives would all have an influence on the interpretative emphasis. For example, many of the extant qualitative studies potentially favour their professional mandate in order to promote a therapeutic function. This may result in an over-estimation of the beneficial potential of CTOs, especially when confronted with ambivalent responses from service-users. Equally, from a service-user advocacy perspective such ambivalence could be subject to under-estimating the same potential.

However, reflexivity considers more than potential biases and has much in common with psychotherapists' use of countertransference and, therefore, the researchers reactions to participants' responses (Willig 2013). According to (Smith, Flowers *et al.* 2009), when attempting to understand 'lived experience' (p34), a holistic approach should ideally be adopted which considers differing viewpoints such as emotional, cognitive, existential and practical domains. For example, when CTO service-users reflect cognitively on the effects of the order on their daily lives; they may have existential concerns about where they fit into the community under the order, and they consider the practical limitations that the associated conditions could place on their activities. The psychiatric perspective, within the extant CTO literature, could focus on the cognitive domain of the service-user; the social work viewpoint could concentrate more on the existential concerns of the service-user; and the lawyers and occupational therapists could attend more to the practical implications associated with conditions attached to the orders. When individuals are facing major issues and experiences, the

multidimensional aspects of their responses are equally important and therefore a holistic phenomenological analysis is necessary (Smith, Flowers *et al.* 2009).

4.7.1 Reflexive statement

Reflexivity is used throughout this thesis where, according to Robson (2002), 'an awareness of the ways in which the researcher, as an individual with a particular social identity and background, has an impact on the research process' (p172). Reflexive sections of the thesis are clearly identified and provide transparency in details that would have otherwise been concealed from the reader.

4.7.2 Reflexive account

As researcher in the current study, I am from a nursing background, and as such, bring both a clinical and service-user (advocacy) perspective. However, it must be acknowledged that mental health nursing is closely allied to psychiatry and influenced by the medical model of care with a strong mandate to 'do good', apply therapeutics and become powerful 'experts' in care (Benner 1984). Nursing in general is associated with therapeutic endeavour and could possibly emphasise the consequences of that endeavour in favour of the potential benefits of CTOs. Reflexivity is employed throughout this thesis in an effort to maintain a critical self-awareness by being mindful of my own personal, cultural and historical position and perspective. According to Shaw (2010) this can be best achieved in practice by the following statement:

'to proactively manage myself in my interactions with my participants and the world and to actively explore how these encounters impact my pre-existing beliefs and knowledge – my fore-understandings – in order to understand afresh the phenomenon I am studying'. (p241)

With specific reference to this study of the service-user experience of CTOs, I have asked myself three fundamental questions:

1. What did I think of CTOs?
2. What did I imagine the experience was like?

3. What agenda was behind the research?

In answer to the first question, I thought that CTOs were less restrictive than remaining in hospital, but gave little thought to the alternative least restrictive option of voluntary care (i.e. without any compulsion at all). I assumed that CTOs were inherently therapeutic, but was also aware that this may be rejected by certain service-users as a matter of choice, but also to their ultimate cost. The second question brought to mind imaginations of additional freedoms for service-users compared to continued detention in hospital. I imagined individual's being able to engage with day-to-day living, but I never considered the 'threatening' unconscious presence of a CTO (and potential recall to hospital) in the background. The answer to the final question involved an acknowledgement of some denial on my part. I was aware that my positive expectations of CTOs could be both naïve and misinformed with recognition that the reality for service-users may be very different to my somewhat idealised imaginings.

However, Mauthner and Doucet (2003) argue that there may be limits to reflexivity and that no matter how aware and reflexive we try to be, it may be impossible to grasp the unconscious filters through which we interpret experiences. The extent to which we can be aware of our influences on the research may increase over time from conducting the study and the months that follow. According to Mauthner and Doucet (2003), it may be more useful to think in terms of 'degrees of reflexivity' (p425) with some influences being easier to identify and articulate at the time of the research, while others take time, distance and detachment. In order to maximise the degree of reflexivity, reflexive boxes have been added to the following chapters in order to highlight the reflexive process in practice.

4.7.3 Reflexive boxes

Reflexive boxes are used where reflexive considerations are appropriate to specific sections of the thesis and brief discussions are summarised in these separate boxes.

4.8 Methodological approaches

In considering how best to capture service-users' lived experience of CTOs, several methodological approaches were considered. It was essential for the methodology selected for the current study to incorporate phenomenological and hermeneutical theoretical perspectives together with a flexible idiographic approach. Phenomenological research examining the service-user experience of CTOs should be undertaken to obtain a better understanding of the quality, meaning and significance of that experience for the individual concerned (Willig 2012). It is important, according to Willig (2012), to recognise that the enquiry is concerned with the phenomena of CTOs rather than the people who are describing them and is concerned more with how CTOs are experienced rather than why CTOs are being experienced.

4.8.1 Interpretative Phenomenological Analysis (IPA)

IPA aims to explore the participants' experiences from their own perspective whilst recognising that such exploration must necessarily implicate the researcher's own view of the world and also the nature of the interaction between researcher and researched (Willig 2013). IPA shares the aims of more descriptive phenomenological methods in attempting to capture the quality and texture of individual experience and also shares some of the features of alternative qualitative methodologies to form an effective amalgam of methods that enable the researcher to engage in a double hermeneutic where the researcher is trying to make sense of the participant trying to make sense of what is happening to them (Smith, Flowers *et al.* 2009).

According to Willig (2013), IPA usually works with transcripts from semi-structured interviews, drawing on some of the features of narrative analysis, generating data suitable for phenomenological analysis. Although interviews are the most common form of data collection, other methods can be employed such as diaries, journals and other meaningful symbols (Willig 2013). IPA takes an idiographic approach, analysing texts generated by participants one-by-one, insights are produced as a result of intensive and detailed engagement, these cases are then integrated in the later stages of the research (Willig 2013). The

systematic nature of the analytic procedure and the provision of ever more detailed descriptions of the analytic process have meant that IPA has become increasingly attractive to researchers over the last few years (Smith, Flowers *et al.* 2009).

Drawing on the principles of thematic analysis, the IPA data-set requires the researcher to identify and label emergent themes that characterise each section of the text (Willig 2013). The researcher then introduces structure to the analysis where some of the themes will be structured into clusters that share conceptual meanings or references, whereas the relationships between other themes may be better represented by hierarchical relationships with one another. These clusters of themes then need to be given labels that capture their experiential essence, and a summary table produced that presents the structured themes together with quotations that illustrate each theme (Willig 2013). Smith (2004) argued that IPA is constantly developing as a methodology and can be flexible enough to incorporate some of the principles of other phenomenologically informed approaches; for example, in subsequent discussion, IPA analysis can inform emergent theoretical developments and conceptual modelling as is often the case in grounded theory studies. IPA's founder, Jonathan Smith, has always proposed that IPA can develop and incorporate the distinctive features of other approaches to enable the collection and interpretation of participants' verbal reports to make a valuable research contribution to other dominant qualitative traditions (Smith 1996).

According to Smith, Flowers *et al.* (2009), IPA is increasingly being used to examine the experience and context of psychological distress and conditions such as schizophrenia. Current approaches to psychotic illness view such episodes as understandable experiences, rather than meaningless, pointless and beyond the scope of detailed study (Bentall 2009). These newer approaches strongly resonate with phenomenological-hermeneutic research (Smith, Flowers *et al.* 2009). The aim of IPA in the current study was to explore the participants' world view on a CTO in order to access the participants' perspective as closely as possible, and to examine the chain of connection between describing, thinking and feeling (Smith 1996). IPA emphasises exploration of the subjective

perceptual processes involved when a person searches for meaning and attempts to make sense of experience (Smith, Jarman *et al.* 1999). IPA allows for the exploration of the phenomenon, the participants' perception and experience, and is flexible enough to study individuals' lived experiences as well as examining the impact of CTOs on a peoples' daily life.

4.9 Sense-making

According to Chater and Loewenstein (2016), this is an under-appreciated drive and a powerful human motive that seeks to make sense of an individual's immediate experience, life and world. Sense-making is closely linked to the maintenance of meaning (Moser and Schroder 2012) and the need for simplification (Chater and Loewenstein 2016), sense-making narratives (Cardano 2010) and relationships with others (Barker, Lavender *et al.* 2001). Sense-making strategies can often be disrupted by the development of chronic conditions such as schizophrenia (Barker, Lavender *et al.* 2001) and associated treatment regimens such as CTOs (Cardano 2010). Barker, Lavender *et al.* (2001) suggest that service-users need continued support in their journey towards developing their understanding and sense of self within mental health services that have 'traditionally dismissed these narratives as madness' (p211).

Chater and Loewenstein (2016) maintained that sense-making is pleasurable, there is satisfaction in being able to relate a coherent chronicle about periods of our lives, especially important periods. Equally there are pains associated with an inability to make sense of situations, and these pleasures and pains are not symmetric with the pains of failure being stronger and more aversive (Chater and Loewenstein 2016). Therefore, a service-user believing they had made sense of a CTO and then found they had not tends to be an overall negative experience, despite the fact they are left in the same situation in which they began (Chater and Loewenstein 2016). It is important, therefore, that the sense-making process is allowed to develop and conclude through the 'human affinity for narrative – for telling stories about things that help to make sense of them' (Chater and Loewenstein 2016 p151).

Schizophrenia and psychotic illness is a highly complex condition and multitudes of perspectives are necessary to understand and assist those affected (Barker and Buchanan-Barker 2005). The distress associated with such conditions can be compounded by the trauma of enforced treatment both as an inpatient and in the community (Bentall 2009). According to Barker and Buchanan-Barker (2005), individuals who find themselves in mental health services experience a 'crisis of the self' as a 'threat to their selfhood' (p57) and should be allowed to re-tell their story in a safe relationship in order to recover and reconnect with the self (Herman 1992). Cardano (2010) argued that individuals cope better with illness when allowed to engage with this, often laborious, sense-making activity through the composition of narratives intended to 'create new links between past, present and future' (p253). As a consequence people should be allowed to tell, explore and develop their stories and description of experience in their own words, using the language and communication that makes sense for them (Barker and Buchanan-Barker 2005).

4.10 Metaphor

Service-users with psychosis often have difficulties communicating their experiences (Saavedra, Cubero *et al.* 2009) and are sometimes unable or unwilling to directly express painful experiences (Whigham 2006). Individuals often use metaphor as a bridge to describe phenomena, which can then be used as a catalyst for further investigation and interpretation (Shinebourne and Smith 2010). The current study, therefore, was attentive to metaphor. Lawn, Delany *et al.* (2016) maintained that metaphors are a way that mental health patients articulate the nature of CTOs, and by acknowledging the role of metaphor in these patients' lives researchers can enhance opportunities to engage participants in more meaningful dialogue about their personal experiences.

4.10.1 Metaphor in mental illness

According to Frow (2001) 'normal' language is supposed to work 'transparently, economically, truthfully and to the point' (p285). Yet Lakoff and Johnson (1980) suggested that metaphors are pervasive in everyday life providing linguistic coherence in our understanding of the world, helping us to describe the abstract (e.g. fear) in physical terms (e.g. eating away). Kangas,

Warren *et al.* (1998), maintained that metaphors add more than facts or empirical truth to a description in that they can add richness and depth of meaning to a phenomenon. In a wide ranging literature review of schizophrenic language since the 19th century, Covington, He *et al.* (2005) argued that individuals with psychosis often display unusual language impairments and Berrios (1991) warns that those in the grip of psychosis can express 'empty speech acts, whose informational content refers to neither world nor self.' (p12). However, Mould, Oades *et al.* (2010) completed a systematic review of 28 studies where metaphor was used by people with a psychotic illness. These authors concluded that the extensive use of metaphor as a strategy was a potentially valuable way for people with a psychotic illness to express their experience, maintaining that metaphors compactly convey what might otherwise be too difficult to articulate. This would suggest that the unusual and traumatic experiences of people with a psychotic illness are not easily described using conventional language. Rather, such individuals tend to use metaphorical expression or, more commonly, avoid describing experience at all (Mould, Oades *et al.* 2010).

In professional mental health contexts, the accuracy of 'talk' of service-users with a psychotic illness is often questioned or challenged (Rogers and Pilgrim 2010). Indeed, Richard Bentall (2009) maintained that service-users have been systematically ignored on the grounds that their mental illness disqualifies them from reasoned expression and response; he maintained that even those individuals diagnosed with a severe mental illness are capable of expressing their experiences. It could be argued that these challenging and negative responses from professionals and practitioners are compounded over time resulting in very guarded interactions and interview responses from service-users (Bracken and Thomas 2005).

Several authors maintained that those listening to people with experience of psychosis should hear figurative language as they would from other people, neither over- or undervaluing it, and should assume that these individuals, although initially difficult to understand, have the ability to use expressive language appropriately and communicate successfully (Billow, Rossman *et al.* 1997; Kuperberg 2010; Roberts 2000). Southall (2012), argued that the use of

metaphor is a major way in which service-users communicate complex experience, allowing sensitive subjects to be described and offering a bridge to understanding what might be a superficially confusing narrative to the listener. Even when service-users are in the midst of trauma, metaphors offer the listener a valuable route to understanding (Redden, Tracy *et al.* 2013).

Listening to participants' use of metaphor, therefore has the potential to deepen understanding, generate new insights and challenge old perceptions of mental illness, yet they are often overlooked (Carpenter 2008). According to Shulman (1996), mental health professionals and practitioners seem to have been coerced into an inherent blindness towards the camouflaged communication and rational meaning in 'madness'. Szasz (1976) maintained that the only thing 'wrong' with such 'madness' is the inability or unwillingness of the professional audience to accept and seek to understand service-user metaphor use. However, accessing the meaning in service-users' use of metaphor is not always straightforward, for example, Sontag (1989) maintained that metaphorical expressions may be idiosyncratic and particularly important to the participant and, therefore, a potentially rich source of data, but those same idiosyncrasies may conceal meaning and confound the analyst.

4.10.2 Metaphor in narrative based research

Within qualitative approaches it has been argued that attending to a participant's use of metaphor can enrich the understanding of their narrative and move the analysis to a deeper interpretive or conceptual level (Larkin, Watts *et al.* 2006; Smith, Flowers *et al.* 2009). Smith (2011) described these important expressions as 'gems' (p6). He proposed that individual metaphors used by speakers can illuminate, and become integrally related to the analysis of their narrative. Metaphors, he argued, often stand out and demand analytical attention, offering insight into experience as it can 'shine light' (p7) on the phenomenon, a section of the narrative, the complete interview or even the corpus as a whole (Smith 2011). Smith, Flowers and Larkin (2009) emphasised this dynamic, hermeneutic cycle relationship as a method of exploring the deeper meaning of a metaphor, which may only become clear when seen in the context of the whole interview. Simultaneously the meaning of the whole interview may depend on the meaning

of the metaphor. Therefore, Smith, Flowers and Larkin (2009) suggested that the search for meaning may involve consistently moving back and forth within the data in order to explore the 'part-whole coherence' (p28) of the narrative.

4.11 Conclusion

Research theory involves the researcher adopting positions within paradigms, approaches, ontology, epistemology and philosophies that promote the service-user perspective and viewpoint in order to fully explore lived experience. Thus a position within a constructivist paradigm can be linked with an idiographic approach. An ontological position towards contextual constructionism allows an epistemology that generates outcomes that are co-created between participant and researcher. Such outcomes are the result of a phenomenological approach that attempts to understand the service-users' world on a CTO, using hermeneutics to find meaning in an individual's account. Reflexivity is then employed to marshal the researcher's subjectivity, and IPA used as the methodology for the current study, which explores the participants' world view on a CTO. The research attempts to make sense of the service-user making sense of CTOs and attends to metaphor through the analysis, which is often used as a bridge in describing the phenomena.

Chapter 5

Research method

5.1 Introduction

IPA has now secured a valuable (Mjosund, Eriksson *et al.* 2016) and, some argue, a dominant position in qualitative research (Hefferon and Gil-Rodriguez 2011; Pietkiewicz and Smith 2012; Smith 2011). However, rather than being influenced by the intuitive appeal of this method for health related research, this chapter explains and justifies the decisions made around the conduct of the study as a result of theoretical, methodological and philosophical underpinnings outlined in the previous chapter. Careful and structured considerations enabled the adoption of a bolder design which focuses on day-to-day experiential detail of service-user life on a CTO. This close attention to the underlying thoughts, feelings and understanding of participants' experience through the use of IPA has not been attempted before in the study of CTOs. A small sample was recruited from specialist areas of practice, with participants agreeing to multiple data collection methods. Rigorous data analysis techniques were employed with attention to validity and quality throughout the research process. Finally, I was given access to psychiatric reports prepared by medical staff for Mental Health Review Tribunals which oversee renewals of CTOs. In order to inform methods selection and subsequent analysis, brief profiles of the participants are presented from these medical reports.

5.2 Design

The aim of this study was to explore the experience of service-users subject to a CTO. This was an exploratory interview based study, with two interviews per participant planned, supported by timelines, diaries and photo-elicitation.

5.3 Ethical considerations

NHS Health Research Authority ethical approval was granted for the current study (REC Reference No.12/NE/0060) and R&I permission given by the NHS Foundation Trust involved (see *Appendix 1*. for formal approval evidence). At the heart of ethical consideration was the duty to protect participants from harm or

loss, promoting psychological wellbeing and dignity throughout the research process (Willig 2013). However, the intention for the current study was to go beyond these basic ethical principles, aiming to deliver positive benefits to service-users by way of improved practice guidelines which attempt to enhance the CTO experience for service-users through the development of a research-informed conceptual model. The sections below outline areas of special ethical consideration.

5.3.1 Risks, burdens and benefits

There were a number of anticipated benefits to participants of this research, including being able to ventilate their thoughts and feelings to an interested and independent person (Larkin, Watts *et al.* 2006) and being heard and understood above the existing professional knowledge (Roesch, Vaughn *et al.* 2009). Risks included the encountering of sensitive or even distressing issues for service-users and assurances were given that they could pause, suspend or cancel the interview or further participation at any stage without needing to give a reason. The clinical care team were made aware of when the interviews were taking place and were available to offer support to the service-user if necessary. If the research generated any significant clinical issues the duty of care of the investigator's capacity as a mental health nurse became paramount. In such circumstances, the plan was that the research process would stop and a nursing process implemented.

Reflexive Box Potential role conflict was acknowledged as some participants may have known that the interviewer/researcher was also a mental health nurse. Therefore the role of the interviewer was emphasised as one of a researcher, bound by impartiality, confidentiality and independence. Primacy was given to developing an open, honest and safe interaction for both participant and researcher.

The agreed protocol was to immediately report any concerns to the care coordinator and/or the care team for follow-up with the service-user. It was

necessary to implement this protocol in one of the interviews when a participant became increasingly thought disordered and confused; therefore, with the participant's agreement, the interview was stopped to avoid any further distress. With the participant's permission, the care team were immediately informed and the person was given additional support by the AOT. Guidelines were followed that support nurse-researchers to reflect on potential role conflict in qualitative interviewing (Jack 2008).

Risk assessments for home interviews were agreed with the care coordinator prior to the interviews and prearranged safety phone calls made to the care coordinator before and after the interview to confirm safe completion. Participants were also invited to make diary entries and undertake a photographic exercise which could be considered a burden; however, the literature reports that participants usually describe this experience positively (Pink and Afonso 2004). Participating in interviews may involve emotional labour, but interview participation was often reported in a positive manner (Frith and Harcourt 2007), participants were compensated for their time and effort with a voucher scheme specifically suggested and approved by the Trust service-user research advisory group.

Reflexive Box I consulted with a research advisory group composed of service-users and ex-users. They thought that remuneration was appropriate and suggested the use of vouchers as payment for participation but not ones that could be exchanged for alcohol or solvent use. It was agreed that this system encouraged participation and would not adversely affect the quality of the data.

5.3.2 Confidentiality and anonymity

Anonymity was ensured at the earliest opportunity by removing any person-identifiable information at the interview transcription stage with anonymity further assured using pseudonyms previously agreed with the service-user. The researcher transcribed all responses and the names changed and any identifying details omitted at this stage to ensure anonymity of the transcribed material. The

Participant Information Sheet (see *Appendix 2.*) outlined potential situations where confidentiality may have to be broken and information shared with the Responsible Clinician, care coordinator or clinical team. However, the need for this breach did not occur at any point in the research process.

5.3.3 Security

Storage of all personal data was limited to the researcher's personal computer at his home address, a University of Leeds secure server and a USB removable drive held at the University of Leeds by a supervisor. All were password protected and encrypted to University of Leeds standards. All electronic storage and encryption was undertaken in consultation with University of Leeds IT services and the researcher adhered to the University's policy for 'Safeguarding Data – Storage, Back-up and Encryption'. Interview recordings and photo images were stored on password protected servers and USB drives all encrypted to University standards. Data from the digital recording devices was transferred to a password protected hard drive within 24 hours of each recording; the original digital recording was then erased.

5.3.4 Ethical use of visual images

Although increasingly used in healthcare as a form of ethnography by proxy (Pink and Afonso 2004), it is recognised that the use of photography can be an intrusive activity. Therefore anonymity and confidentiality, especially photographs of people, were dealt with in four ways. First, short training sessions were given at the end of interview 1 and before the photo-journals were commenced concerning the ethics and mechanics of photographs to ensure that service-users understood the implications of visual images in research. Second, the protocol was that signed consent slips would be required from any individual who was photographed in order to ensure that they understood why the images were being collected and how they would be handled. Third, it was explained that copies of any original images would only be available for viewing by the participant, the researcher, supervisors and examiners. Finally, any images intended for use in any thesis, report or publication required a specific photograph release consent form. Any such images would have all facial features blurred and other identifying details digitally removed using specialist software.

5.3.5 Ethics of interpretation

The interpreter has the power to shape what comes to be known about the research participants' experience. Willig (2012) argued that interpreting another person's experience means moving beyond the surface of the participant's description where the interpreter 'processes what he or she hears and/or reads, digests it, metabolises it, and generates something new' (p19). Interpretation can be misused to control, oppress or manipulate vulnerable groups, particularly where researchers are generating suspicious interpretations that participants would not always recognise or endorse (Willig 2012). Willig (2012) proposes three strategies to help ensure an ethical approach to interpretation:

1. Keeping the research question in mind and being modest about what the research can reveal. No one interpretation can provide all the answers about a phenomenon; research claims are always limited.
 2. Ensuring that the participant's voice is not lost. Any sense-making and meaning-making come both from the participant and the researcher; the analysis is always a synthesis of the participant's and the interpreter's perspective. The integrity of the original account must be respected and valued in its own right.
 3. Remaining open to alternative interpretations. Analysis should open-up, rather than close-down meaning where researchers 'contextualize and narratize' (p59) the data within the wider picture to achieve fuller understanding. This means considering the relationship with the various social, political, economic and cultural interests that exist within the society where the research takes place.
- (Adapted from Willig 2012 p56-60)

Avoiding the negative impact of interpretation was a priority for this study where a vulnerable group of service-users were describing difficult experiences, using metaphor and agreeing to their responses being recorded. There was obvious potential for researcher misrepresentation and distortions, the silencing of voices, and the infringement of rights was eliminated or minimised.

Reflexive Box Discussions with supervisors helped to maintain restraint in some of the research claims and also encouraged discussions around participant voice, meaning-making and alternative interpretations of the data. This was particularly useful in the interpretation of metaphor.

5.4 Recruitment

Although there is often pressure on researchers to recruit a large sample (Hefferon and Gil-Rodriguez 2011), with IPA 'less is more' according to Reid, Flowers *et al.* (2005 p22). Quality not quantity is the aim, IPA studies benefit from a concentrated focus on a smaller number of cases (Smith, Flowers *et al.* 2009). The traditional linear relationship between participant numbers and the value of the research is challenged by IPA with Smith (2004) arguing for small sample sizes of around six participants, or indeed single case studies, and a maximum of around ten participants is recommended. However, Brocki and Wearden (2006) suggest that sample size and data saturation is a problematic concept in qualitative research generally, and research designs should instead aim to achieve a cohesive and integrated understanding that preserves nuances within a persuasive story. They add, though, that there is always the possibility that the next interview might produce confounding evidence and the process could continue *ad infinitum*. It is important, therefore, that researchers acknowledge that data is limited and representational in nature (Brocki and Wearden 2006) and that generalisation is not the goal of IPA research (James and Harvey 2015; Mapplebeck, Joseph *et al.* 2015; Waite, Knight *et al.* 2015). The focus is more on the possible transferability of findings towards similar groups together with a theoretical generalisability, which enables readers to assess the evidence in relation to existing professional and experiential knowledge (Hefferon and Gil-Rodriguez 2011).

In IPA, researchers aim for a relatively homogeneous sample where psychological and social similarities and differences are usually analysed within a group that has been purposively selected according to important characteristics.

Thus, a defined group is identified, which has direct relevance to the research problem, which itself has personal significance for each participant. The precise homogeneity of the group is determined by two main factors:

1. Interpretative concerns – degree of similarity or variation that can be contained in the analysis of the phenomenon.
2. Pragmatic considerations – ease or difficulty in contacting potential participants, relative rarity of the phenomenon.

(Adapted from Pietkiewicz and Smith 2012 p365)

The primary concern is always to elicit rich, detailed, and first-person accounts of experiences and phenomena under investigation (Pietkiewicz and Smith 2012).

Reflexive Box The original intention was to recruit participants from other branches of the mental health Trust which could include the Forensic Service and Community Mental Health Teams. However, pragmatic difficulties prevented ready access to these areas. It was considered adequate to recruit from one area (AOT) as these service-users matched the ‘standard’ profile for CTO service-users and could be recruited within the time period available.

5.4.1 Participants and consent

Recruitment for the current study was from a single mental health trust and potential participants identified initially by liaison and permission of the RC and the care coordinator. The care coordinator first approached potential participants to assess their general interest, provide the Participant Information Sheet and obtain permission from the service-user for the researcher to approach them in order to detail the study requirements, answer any questions, obtain written consent and opt individuals into the study following agreement.

5.4.2 Inclusion and exclusion

The main inclusion criteria were that the service-user was subject to a CTO at the time of the interviews, were able to conduct the interview in English, be willing to

be interviewed and have capacity as set out in The Mental Capacity Act 2005. According to the Act, a person lacks capacity if they are unable to make a specific decision, at a specific time, because of impairment of, or disturbance in, the functioning of mind or brain. Capacity was initially assessed and confirmed by the RC; then was further assessed by the researcher prior to the interviews. Capacity for exclusion was constantly reviewed throughout the research process in order to fulfil the 'specific time' criteria. Exclusion would apply at any point if the service-user:

- wished to exit the study for any reason
- lost capacity (as assessed by interviewer or member of the care team)
- was recalled to hospital, had the CTO revoked or is discharged
- was unduly distressed, angry or presented serious cause for concern
- relapsed significantly from baseline symptoms

5.4.3 Participation

Table 5.1 summarises the participation profiles of the ten individuals who agreed to participate. There were a further three people that did not wish to take part and were the first three individuals approached. The possible reasons for this reluctance are discussed later in this chapter. The diagnoses for participants were either Bi-polar Affective Disorder or Schizophrenia. The gender balance was equal and age ranged from 31 to 58 years at the time of the first interview. All had been in contact with mental health services for over twelve years, with one participant (Pam) in contact for 40 years. All had a history of repeated admissions to hospital ranging from six to twenty admissions with a mean of eleven periods as inpatients. All participants had the CTO in place for at least six months, therefore the CTO had been reviewed and renewed. Most participants had their CTO renewed several times, with 26 months as the longest duration of the order at the time of the first interview. Eight participants agreed to two interviews each, whilst two did not want to complete a second interview, stating they had nothing further to say. Participants also varied in the completion of research tasks. Despite initial agreement, three participants did not complete the diary sheets as they felt they had nothing to write about. Only four participants

Table 5.1 Participation summary

Name	Interview dates	Interview duration	Diary	Photo	*Age	Diagnosis	CTO implemented	*CTO months in place	First contact	Number of admissions (approx.)
BARBARA	14/06/12 05/09/12	32.35 65.55	✓	✓ 15 photos	45	Schizophrenia	Dec 2011	6	1989	10
JOYCE	21/11/12 12/12/12	49.42 11.04	✓	✓ 18 photos	31	Bipolar Affective Disorder	Apr 2012	8	1999	8
ELIZABETH	16/01/13	35.21	X	X	51	Schizophrenia	Jul 2011	18	1989	20
MICKY	06/03/13 03/04/13	23.26 43.13	✓	✓ 10 photos	52	Schizophrenia	Sep 2010	18	1983	15
JIM	20/02/13	47.11	X	X	46	Schizophrenia	Oct 2011	16	1990	6
GERRY	20/02/13 15/03/13	27.50 59.26	✓	✓ 1 photo	50	Schizophrenia	Nov 2011	15	1995	7
JOHN	19/06/13 03/08/13	31.36 18.17	X	X	50	Schizophrenia	Aug 2012	10	1986	15
WILLIAM	11/06/13 26/06/13	21.51 13.10	✓	X	48	Bipolar Affective Disorder	Sep 2011	21	1987	10
PAM	19/06/13 31/07/13	33.36 43.10	✓	X	58	Schizophrenia	Jan 2010	17	1972	12
MARY	29/06/13 06/08/13	27.29 43.28	✓	X	44	Schizophrenia	Apr 2011	26	1985	6
Mean		34.72			47.5			11.4		11

completed the photo elicitation exercise, with three people exposing a whole film, and one participant (Gerry), providing one exposure only. All participant names have been changed.

5.5 Data collection methods

Interviews have traditionally been used for qualitative studies with service-users, although, because of lack of confidence, some service-users sit in silence and wait passively for guidance on how to reply (Erdner and Magnusson 2011). Using multiple forms of data collection can improve an individual's ability to reflect and respond in an interview situation (Erdner, Andersson *et al.* 2009). Timelines, diaries and visual images were, therefore, used as methods that could help elicit responses, views, thoughts and reflections of otherwise underrepresented groups of disadvantaged service-users (Boxall and Ralph 2009). Semi-structured interviews were used in conjunction with diaries and photo-elicitation.

An equivalent self-directed diary and photo-journal exercise was undertaken by me (as researcher) prior to recruiting participants. This self-pilot was used as a demonstration, example and incentive for prospective participants. In between the two interviews, participants were asked to maintain a diary and produce a photo-journal for two weeks. Diary sheets were provided as well as disposable film camera(s). Each participant received £20 Argos vouchers for the first interview and £30 Argos vouchers for the second in remuneration for the inconvenience, time and effort taken in participation. Diary entries and photos were only used for elicitation purposes only and did not form part of the data set. Three service-users were approached initially, and all three declined to take part, citing a general reluctance to undertake diary entries; and a particular, unexplained, aversion to any photographic exercise. A pragmatic decision was therefore taken to 'play down' the need for diary entries and photo-elicitation, making these optional activities rather than a requirement. Subsequently, recruitment became much more successful using this 'softer' approach and resulted in most of the participants completing some of the diary entries and four participants attempting supporting photography. These are summarised in Table 5.1.

Reflexive Box The self-pilot was an enlightening exercise, revealing how self-conscious one felt to be out with a camera taking apparently random photographs in the street. As a consequence the photographic exercise was often limited to more private areas such as inside the home. I realised that I was asking more from participants than simply taking photographs, they also had to make themselves even more vulnerable in the community simply by wielding a camera. As a consequence I became less insistent on imposing this task on participants.

5.5.1 Interview schedules

The plan for the interviews was to encourage an informal and conversational approach where the participant could feel at ease and to foster a 'safe' interaction enabling honest and open dialogue. The declared aim was to ask people how they made sense of their CTO, to listen to their stories, accounts and descriptions of life before and after the CTO was in place. Interviews were relatively relaxed, but were sometimes difficult to arrange and confirm because of the unpredictable nature of service-users' lifestyles and priorities. In the first interview (see *Appendix 3* for the interview schedule) service-users were free to relate their narrative and experience with mental health services and anything they wanted to talk about regarding their CTO. The schedule contained a selection of pre-printed guidance questions for the interviewer to select as appropriate to the flow of the interaction. For example, a question relating to the participant's past may include 'How did your contact with mental health services start?' Depending on the response to this question, a dialogue around past experiences within the mental health system could develop. A question about current experiences may include 'Tell me how you're feeling about your CTO right now?' and a question towards the end of the interview may be 'How does the future look to you?' A very simple and basic timeline was used in this interview to orientate the person to significant time periods in the participant's story.

At the end of the first interview the participant was offered a disposable camera to take photographs representing their daily lives under a CTO and/or to capture

images that showed how the CTO affected the participant. At the same time, participants were offered blank dated diary entry sheets (see *Appendix 4.* for an example), with instructions to record ordinary daily events for a two week period. Arrangements were made for me to contact the participant after two weeks to collect the camera for processing and also to collect the diary entry sheets. Films were then processed and the prints copy scanned together with the diary sheets. The original negatives, prints and diary sheets were then returned to the participant at the start of the second interview.

The second interview (see *Appendix 3.* for the interview schedule) was a little more structured where the diary entries and photo images (if applicable) were discussed initially. Questions asked at the start of the interview included 'Can we discuss your photographs?' and 'Why did you include this/these photo[s]?' On completion of this discussion, the diary entries were then discussed in a similar manner using questions such as 'Can we look at your diary entries ... how does the CTO affect your day/week?' If the participant had elected not to undertake these photo or diary tasks a hypothetical review of what may have been included was pursued. The questions in these cases included 'What images would you have captured if you had taken any photographs?' and 'What daily events could you have recorded in a diary sheet?' The interview would then progress trying to build a picture of events and relationships that were significant to the participant and what was the impact the CTO. The interviews were digitally recorded, with service-users agreement, to allow for later transcription. Interviews ranged from 11 minutes to 65 minutes, with a mean duration of 34 minutes.

5.5.2 Timeline

The timeline was printed on the first interview schedule and was shown to the participant as containing three periods of interest – past, present and future. This served to show the participant the intended framework for the interview. Also the timeline could be used to maintain a progressive flow to the interview, and used as a visual prompt to return a participant to a particular point in time should they begin to wander or deviate from a specific temporal focus.

5.5.3 Diaries

Diaries were intended to record thoughts, feelings, hopes and aspirations. Service-users were encouraged to note their thoughts and feelings down whenever they could. Dated diary sheets were supplied (see *Appendix 4.* for an example), and service-users were reassured that presentation was not important. The diaries were intended to act as an 'ice-breaker' and then to instigate exploration of some of their CTO-associated problems. For example, Pam wrote about phoning her mother (see *Appendix 4.*), commenting in brackets that 'there's no one else here' (Friday 28th June 2013); which enabled a conversation about loneliness, which she associated with her CTO. Gerry used one entry on his diary sheet to record that he 'shopped for bananas and tonic water'. This gave rise to a conversation about attributing his physical pains as side-effects of his medication. He felt that he suffered 'leg pain' which a friend had told him may be simply cramp and could be helped by the potassium in bananas and the quinine in tonic water.

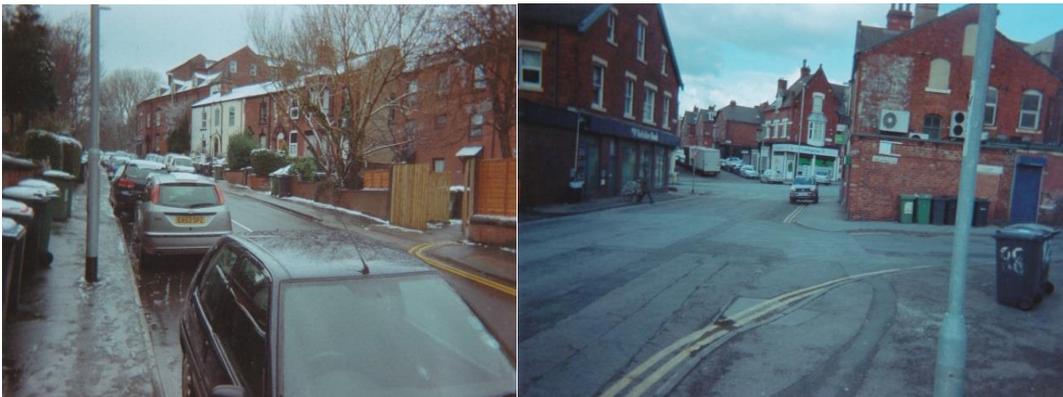
Reflexive Box I realised that some of the apparent reluctance to engage in this diary task was more about presentation and spelling than understanding the purpose of the exercise. Participants wrote very little at any time and were therefore not confident about their writing proficiencies, spelling abilities and skill in expressing themselves on paper. I was, again, asking more than I initially realised and this had an effect on recruitment. I therefore tried to reassure participants of my non-judgemental approach and was very grateful for their efforts.

5.5.4 Photo-elicitation

Photo-journals were proposed in order to capture everyday activities and ordinary life events under a CTO. Participants were asked to take photographs of their daily activities and other life events that may help in the interview discussions about their CTO. For example, simple visits to friends or family, or even just going out and about. This was described as 'just clicking away in your daily life' so that

the image reminded the service-user of the event and provided a focus for discussion. For example, Micky took several images, all taken very close to his home address (see below) and the researcher noted this fact. Micky then stated that he thought he could not present evidence of travelling further away as he thought the CTO put geographic limits on his movements. This was an important implication associated with his CTO and may have otherwise remained undiscovered.

**Examples of
Micky's
photographs**



Barbara also took several images of the view from her window which prompted an interaction about returning to familiar things and places, about 'memories in the making' and 'getting on with life in her home town'.

**Example of
Barbara's
photographs**



5.5.5 Transcription

The interviews were transferred from the digital recorder onto encrypted drives on a computer and stored as previously described in section 5.3.3. Transcription was undertaken by myself using Express Scribe software and positioned centrally in a three column format (see *Appendix 6.* for an example), allowing for the corresponding additions of codes and exploratory comments. This layout resulted in approximate pagination for analysis of one page (14 column/centimetres) per minute of narrative for each participant, and a total corpus transcription of 519 pages. The original transcript was separated into interviewer (I:) instructions, questions and comments; and responder (R:) replies, descriptions and answers.

5.6 Data analysis methods

Organisation and analysis of IPA data has been described by Smith (2007) as an iterative and inductive cycle with no single prescriptive method for working with the data. For the purposes of the present study the data comprised the narrative generated from the interview transcription, and did not include timeline, diary entries or photographs unless they were discussed in the interviews. Thus, the discussion around timeline, diary entry or photograph was analysed along with the rest of the narrative rather than the items themselves. In pursuing this protocol the data generated by participants was more balanced whether they engaged with all the research tasks or not, and could be considered with greater equipoise. However, whatever detailed strategies were adopted, IPA invites a reflective engagement with the participant's account, with the analysis developing a joint product from the participant and the researcher (Pietkiewicz and Smith 2012). Smith and colleagues (2009), encourage IPA researchers to move beyond description and to use 'interpretative flair' (Shaw 2011 p28). Whilst phenomenology is able to generate rich, detailed descriptions of participants' experiences of situations and events; interpretation is required to further understanding of why such experiences and events take place (Willig 2013).

The end product, therefore, is an account of how the analyst has read the participant's representation of experience, and hence claims about the interpretation are necessarily subjective and always tentative. However, this

subjectivity is dialogical, systematic and rigorous, with an inherent transparency in order to enable subsequent examination, checks and confirmations, by the reader (Smith, Flowers *et al.* 2009). Thus every interpretative step in the analysis of the dialogue can be consistently traced back to the original interview transcript in order to verify the conceptual processes involved. IPA encourages a set of practices to enhance credibility and the usefulness of the analysis. Smith, Flowers *et al.* (2009) maintain that the analytic process is complex, intuitive, intense and conceptually demanding and that it encourages creativity and innovation in order to generate a uniquely interesting, insightful and rewarding process.

For the current study, this process commenced with transcription of the data which enabled early immersion in the data as well as development of a 'dialogue' between analyst and participant. The interview transcripts for each participant were combined and analysed as a whole. The analytic process then progressed through various steps within a single case, which were analysed consecutively whilst the following cases were being interviewed and transcribed. When the analysis of all the single cases was completed, there was subsequent analysis across multiple cases to identify emergent patterns of similarity, convergence and divergence. Then psychological, social and contextual knowledge was employed to explore what it might mean for participants to have these experiences, generating a more interpretative account. The various steps involved in the generation of this interpretative account are: multiple reading of the transcript and exploratory notes; transforming these notes into codes; then generating sub-themes, themes and clusters.

5.6.1 Multiple reading and exploratory comments

According to Smith, Flowers *et al.* (2009) multiple readings of the transcript are necessary to enter into the participant's world and to actively engage with the data. Repeated reading allowed an overall structure of the interview to develop, helping the analyst to understand how different sections of the transcript link together within the interview structure (Pietkiewicz and Smith 2012). For example, the flow and rhythm of an interview tends to move from broad and general statements at the beginning to more specific micro-details of events

towards the middle, to some kind of synthesis at the end of the interview (Smith, Flowers *et al.* 2009). At any point during these readings, the time consuming process of adding exploratory comments were detailed in the right hand column (see *Appendix 6.* for examples). The layout of the transcript allowed for exploratory comments to be added at appropriate points adjacent to the original. As the re-reading progressed, any exploratory comments already added were checked for relevance and the more important words or phrases underlined for emphasis. According to Smith, Flowers *et al.* (2009), this is like free textual analysis:

‘There are no rules about what is commented upon and there is no requirement, for example, to divide the text into meaning units and assign a comment to each unit. Your aim is to produce a comprehensive and detailed set of notes and comments on the data’

(Smith, Flowers *et al.* 2009 p83).

In the example shown in *Appendix 6.*, the comments associated with Elizabeth’s interview initially captured the anger and hostility she felt when she referred to her enforced injection and the effect that had on her. Multiple readings suggested that she perceived the effects of her injection building and compounding as ‘punishment’, a ‘death sentence’ by doctors ‘practicing science’. Smith, Flowers *et al.* (2009) describe the development of an essential account through these exploratory comments, where a pattern of descriptive core comments will emerge and then new meanings and understandings may emerge. Core comments describe the things which matter to participants, such as relationships, processes, places, events, values, principles and the like; and conceptual noting can help understand how and why the participant has these concerns (Pietkiewicz and Smith 2012). For example, Elizabeth reported feeling ‘sentenced’ and described ‘blackmail, coercion and experimental science’, she later linked these comments to the feeling imprisoned in her own home - all expressions of her personal powerlessness in defiance of quasi-judicial enforcement (see *Appendix 6.*). This conceptual noting often involved examining the language used, exploring the context of their concerns and identifying more

abstract explanations of their lived world that helps make sense of what they were talking about.

5.6.2 Transforming comments into codes

By adding exploratory and conceptual comments, the data set increases in size, and although the original transcript remains foundational, this growing data set becomes the focus in the search for codes. These are short phrases that capture the essence of the interview by 'containing enough particularity to be grounded and enough abstraction to be conceptual' (Smith, Flowers *et al.* 2009 p92). The left hand column of the transcript was used to generate emergent codes (see *Appendix 6.*) simultaneously reducing the volume of detail but maintaining the complexity whilst mapping interrelationships, connections and patterns between the exploratory comments. In this way the data was synthesised and reorganised; the analytic process is to reassemble these into a new whole at the end of the analysis (Pietkiewicz and Smith 2012). Smith, Flowers *et al.* (2009) argue that although this may appear to take the research further away from the participant, it begins to include more of the analyst to produce a product of collaborative effort. For example, emergent codes from Elizabeth's transcript include words and phrases such as: sentenced; punishment; practicing science; experimental; and prison at home. These reflect her original words, but also include the analyst's interpretation; both capturing description and reflecting understanding (see *Appendix 6.* for more detail).

5.6.3 Generating sub-themes, themes and clusters

The next stage involved analysis of the columns of codes and highlighting in bold the words which demanded analytic attention as part of the ongoing interpretative process involved in developing sub-themes. Pietkiewicz and Smith (2012) describe the next stage as looking for connections between emerging sub-themes in each individual case, grouping them together according to conceptual similarities into themes and providing each with a descriptive label (see *Appendix 7.*). In the example shown for Elizabeth, the codes previously identified in the left hand column of the interview transcript were grouped under each of six descriptive sub-themes which reflected the essence of the original transcript. According to Larkin, Watts *et al.* (2006), development of sub-themes may draw

on considerable 'interpretative range' (p114), but has the clear primary focus of generating an insider's perspective of the phenomenon. At this point, each case analysis was presented as lists of connected codes, followed by their respective page number in the transcript, grouped under a labelled sub theme. For example, Elizabeth's analysis in *Appendix 7*, has a total of 97 codes grouped under one of six sub-themes with titles: Devalued and labelled; Depersonalisation; Abnormal experiments; Powerless against enforcement; Ruthless response; and Angry at experience. Each case had a similar type of analysis, ready for the development of emergent themes and clusters in a cross-case analysis of the ten cases of the data corpus.

Smith, Flowers *et al.* (2009) maintain that the development of emergent themes involves looking for patterns across cases, which can be a particularly creative task and involves a series of suggested questions:

- What connections are there across cases?
- How does a sub theme in one case help illuminate a different case?
- Which sub-themes are the most potent?
- Do sub-themes need reconfiguring and/or relabelling?
- Are higher order concepts becoming apparent?
- How can this best be presented?

(Adapted from Smith, Flowers *et al.* 2009 p100)

In the same way that codes were grouped according to conceptual and interpretive connections, so sub-themes were grouped together across cases under themes labelled using phrases from participant narrative in order to emphasise the continuing grounding in participants' original accounts. Finally, themes were grouped together under cross-case descriptive clusters sought to embody and represent the essence of original transcripts, as well as representing the interpretative development involved in the extensive analytical journey. The connections between clusters and themes are represented in diagrammatic form in Figure 6.1; and together with associated subthemes, tabular form in Table 6.1.

5.6.4 Recurrence

Smith, Flowers *et al.* (2009) maintain that when working with larger samples (they advocate six as an optimum sample size), measuring recurrence across cases is important in informing the key decisions about eliciting emergent themes across the group. However, defining the status of 'recurrent' is subject to the same levels of interpretation, pragmatic concerns and the weighting of commenting and sub theming (Willig 2013). According to Smith, Flowers *et al.* (2009), decisions about recurrence and, therefore, inclusion of themes involves a constant negotiation of the relationships between convergence, divergence, commonality and individuality. For the current study a criteria for inclusion of themes was decided at a recurrence rate of 40% and an ideal at 50% or present in half the sample. However, some minority themes were also included that were considered to be of significance from the weight of their associated comments and sub-themes, as well as their relevance to the research question as shown with the recurrence of clusters and themes in Table 6.2.

5.7 Validity and quality

Although an evaluation of the study is described in Chapter 8.4, it is useful here to acknowledge the research potential of IPA, but also to briefly review how some of the possible limitations of IPA could affect the study. According to Carla Willig (2013), IPA is concerned with capturing experience and unravelling meanings. However, quality and validity can be affected by the interplay of description, interpretation and explanation (Willig, 2013). Interpretation is necessary in the sense-making process, and if researchers want to move beyond sharing experience with participants, and understand those experiences well enough to explain them, researchers need to be aware of the context that gave rise to the experience (Willig 2013). This context may be 'found in past events, histories or the social and material structures within which [participants live their] lives' (Willig 2013 p95). In the current study, therefore, it was important for the researcher to understand and thoroughly investigate the background, context and histories which led to the development of CTOs. It was also important to have some background information for each participant.

5.8 Participant profiles

IPA's idiographic approach is concerned with the details of individual participants' life events and needs to be particularly sensitive to confidentiality and anonymity (Willig 2013). However, several authors suggest that adjustments and modifications to participant details can prevent identification whilst preserving the material form and content (Bowling 2002; Robson 2002; Willig 2013). In the present study the names of participants have been changed but the following summaries have been compiled from available Mental Health Review Tribunal reports. Certain features of their history and incidents have either been omitted or generalised in order to protect their identity among the mental health service-user population. However, enough detail has been retained to indicate the severity and duration of their illness, together with the justification for the use of a CTO and inclusion in the study. It must be acknowledged that these reports are prepared within a medical model from a psychiatric perspective.

5.8.1 Barbara

Barbara had been given a diagnosis of Paranoid Schizophrenia and described in Tribunal medical reports as having a poor response to treatment, lacking insight and with a history of poor compliance. Her symptoms, according to the report, included persecutory delusions with a hypochondriacal component, severe thought disorder and hallucinatory experiences. When unwell she could display severe agitation, hostility and behavioural disturbances. Barbara was 45 years old at the time she participated in two interviews, the first 32 minutes duration and the other 65 minutes. Barbara completed diary sheets as requested together with a photo journal of her home and family life for discussion. She was interviewed in her own flat and was alone at the time although presented as relaxed and comfortable, appearing to enjoy the experience where she was allowed to respond at will to open questions and minimal structure was imposed by the interviewer. Her CTO had at that time been in place for 6 months, and she had been in contact with mental health services for about 23 years with approximately ten lengthy admissions in that time mostly detained under the Mental Health Act (1983) (MHA) and usually with periods of care on the locked Psychiatric Intensive Care Unit (PICU). Barbara was living alone, although in contact with her two daughters at the time of her interviews. She was not working but was described

in her report as 'functioning well' and living independently in a council-rented one bedroom first floor flat. I felt welcomed into her home for the interviews, was offered tea and biscuits, and felt that Barbara embraced the opportunity to share her experiences of her CTO.

5.8.2 Joyce

Joyce's diagnosis was Bipolar Affective Disorder as well as a history of alcohol and illicit drug misuse. Her risk profile indicated that when unwell she could become sexually disinhibited, aggressive and violent, especially when intoxicated. She was described as impulsive with incidents of overdose and suicidal ideation. There were recorded acts of physical violence particularly towards her family and partner as well as damage to property and threatening behaviours. Other symptoms were described as labile mood, intrusive thoughts, persecutory delusions, flight of ideas and pressure of speech with an underlying irritability and suspiciousness. Joyce was 31 years old at interview; she was interviewed in her own house and admitted to feeling initially nervous and unable to organise her thoughts properly but nevertheless spoke clearly, rapidly and constantly for almost 50 minutes in her first participation. Joyce prepared a simple diary as requested together with photos of her life on a CTO which included mainly images of her house and partner. Her second interview was cut short at only 11 minutes by the unexpected arrival of her partner and she avoided subsequent invitations to rearrange. Her CTO had been in place for eight months and she had been in contact with mental health services since she was 17 years of age with eight formal admissions and several extended periods where she required nursing on PICU. At the time of the interviews, Joyce lived in a small, well kept, house with her partner of several years. She did not work at the time although had successfully done some recent voluntary work. She had a close relationship with her parents who looked after Joyce's daughter from a previous relationship, and I felt that Joyce's main incentive on the CTO was to regain full-time care of her daughter and to create an independent family unit. Although Joyce was very honest and open about her experience on her CTO, I felt that because of maintaining her family aspirations, she was very accepting of the CTO as an alternative to hospital admission.

5.8.3 Elizabeth

Elizabeth had a diagnosis of Paranoid Schizophrenia and a history of illicit substance misuse including solvents, cocaine, cannabis and amphetamine; she was also described in the report as having a history of non-compliance, leading to relapse and repeated compulsory admission to hospital. Symptoms included persecutory and hypochondriacal delusions, auditory hallucinations, ideas of reference and depressive episodes with severe self-neglect and attempted overdoses. She was 51 years at the time of her interview which lasted 35 minutes; she was not prepared to undertake a second interview, any diary work or take any photos. Elizabeth was clearly very angry at her circumstances and all her responses were delivered in a hostile and aggressive manner. She was interviewed in her flat and her son and grandson were present initially but did leave the room once the interaction commenced (but remained elsewhere within the flat); Elizabeth left the television on throughout the interview but did agree to turn the sound down on request. Her CTO had been in place for 18 months and at that time she had, very reluctantly, been in contact with mental health services for 23 years with over 20 MHA admissions including periods of care on PICU. Elizabeth's youngest son and grandson were living with her at the time of her interviews, and the atmosphere in the house was tense, with the family dynamics strained. Elizabeth was angry and resentful of her eldest son, who she described as an illicit drug user, and she felt that he was responsible for her most recent hospital admission. I felt very much an intruder in their home and was consequently wary when asking potentially difficult questions. Nevertheless, I also felt that we were able to become more relaxed with each other as the interview progressed, although I thought that the potential for hostility from Elizabeth was always just below the surface.

5.8.4 Micky

Micky, age 52, had numerous admissions to hospital over 30 years with periods in PICU and a lengthy inpatient stay in the rehabilitation service. He had a diagnosis of schizophrenia and his CTO had been in place for 18 months at the time of his interviews which lasted for over 23 and 43 minutes each. Micky was very willing to engage in all aspects of participation including diary entries and a

photo journal. As well as his mental illness diagnosis, Micky had used illicit drugs including cocaine, amphetamine and 'legal highs' which were reported to adversely affect his mental health. His symptoms included auditory hallucinations of a command nature telling him to harm himself and others; his relapses could be very rapid following stressful events or periods of non-compliance with treatment. He could quickly become guarded and suspicious with aggressive outbursts. He had attempted several overdoses in the past, could become vulnerable to financial exploitation by others. According to the report he had found the transition from hospital to home difficult at times. Micky was a pleasure to interview as he was always very open, honest and willing to engage in all the research tasks. He lamented his inability to work in the helping professions and, as a consequence, tried to help other service-users informally. He lived alone at the time of the interviews, but had many friends in the area and at the hospital where he had previously been an inpatient. He was aware of his own limitations in living independently and recognised that he did not always maintain his health and home in the best way. However, Micky was able to access statutory and voluntary services to augment his care in the community.

5.8.5 Jim

Jim had a diagnosis of Schizophrenia and, at 46 years of age, had been in contact with mental health services for half his life at the time of his interview. He declined to participate in the diary entries and photographic work as well as declining a second interview. However, he was happy to give his views on his CTO for over 47 minutes, and although I felt his narrative lacked coherence at times. His records indicated that he had six previous admissions to hospital both informally and also detained under MHA. Jim had a history of non-compliance with treatment and disengagement from services followed by deterioration in his mental health. This was reported to lead to eventual relapse, increased risk to self and others because of inappropriate behaviours which often resulted in police involvement. He also had a significant problem with alcohol abuse which had escalated out of control at times and resulted in irritable and aggressive interactions with practitioners and members of the public. Although Jim welcomed me into his home for his interview, it was clear that his self-care capability was questionable, his appearance was dishevelled and his home unclean. However,

Jim described himself as 'content' with his circumstances and as a consequence the interview was a pleasant experience. Jim lived alone in his flat, he described having few friends and his younger brother was the only family he saw. I found Jim easy to interview although he did tend to wander from the subject of his CTO experience but was readily re-orientated.

5.8.6 Gerry

Gerry had a diagnosis of Schizophrenia which he disputed and did not agree that mental health services should be involved in his life at all. He was 50 years of age at the time of his interviews, taking full advantage of the opportunity to put his views across. He undertook completion of the diary sheets and attempted to take photographs which unfortunately only captured one of the intended images due, probably, to a malfunction with the camera. However, Gerry's interviews lasted for just under half an hour for the first session and nearly a full hour for the second. He had been in contact with mental health services for 18 years with seven previous admissions where he had been non-compliant with treatment, becoming hostile and aggressive, making threats to kill and, at times, harming himself by overdose. He was described in the report as very changeable and unpredictable even when well, sometimes warm and approachable and at other times irritable and inappropriate. He had a history of significant issues with side-effects from his medication resulting in physical pain. However, his report indicated 'somatic problems' without being more specific. Gerry was reported to be very well educated and intellectually capable with a science honours degree but his career had been hindered by his mental health problems. When unwell his symptoms included severe paranoia, thought disorder and unpredictable behaviours, hostility and aggression. Gerry lived alone, with his cat, in a very clean and tidy flat. He lamented an inability to work at his previous (pre-illness) level, when he had a very responsible job. He had undertaken various voluntary work options but found these demeaning and unsatisfying. Gerry was previously married and has lost contact with his adolescent daughter from this relationship. Gerry approached the interview as a formal interaction and was initially very careful about his responses and choice of words, however, he relaxed and became more spontaneous as the interviews progressed.

5.8.7 John

John had been given a diagnosis of Paranoid Schizophrenia with multiple relapses and formal admissions under the MHA often requiring nursing on PICU. His reported care in the community had been characterised by non-compliance and disengagement. John's symptoms included auditory and visual hallucinations, severe thought disorder, delusional ideas and extreme paranoia often resulting in violence and aggression. John's history also indicated past use of amphetamine, lysergic acid diethylamide (LSD), cannabis and magic mushrooms which had, according to his report, often exacerbated his symptoms. John was 50 years old when he participated, his CTO had been in place for ten months and he had been in contact with mental health services for 26 years with 15 admissions during that time. John's report described his presentation as 'symptomatic all of the time', indicating that some level of thought disorder, delusional ideas and paranoia was present at the time of the interviews. Although John took part in two interviews he declined to undertake diary entries or take any photos; he became quite thought disordered and confused during the second interview and this interview was stopped by me, with John's agreement, so as not to distress John in any way. Both interviews took place in his home with the first interview lasting 31 minutes and the second stopped after 18 minutes. John was very personable throughout the interviews and was relatively relaxed in his cosy home. However, he was very clear that he did not want any form of voucher or payment for participation, and he declined to explain why this was problematic. His symptoms of a psychotic nature did become apparent from time-to-time during the interviews but he was able to maintain a rational and logical dialogue for most of the time. However, after about 15 minutes of the second interview, these break-through symptoms became more pronounced so I took the decision to terminate the interview as his capacity became questionable.

5.8.8 William

William had been diagnosed with Bipolar Affective Disorder and, according to his report, suffered from delusional beliefs about being famous people from history together with auditory hallucinations. This could result in extremely provocative behaviours that were both a risk to others as well as making him vulnerable and a risk to self. William's threatening and disruptive behaviours when unwell had

required nursing intervention on PICU. His report indicated that when he was well William was very supportive towards his partner and pursued a wide range of activities, hobbies and interests. William had a 26 year history of contact with mental health services with around ten admissions up to the age of 48 at the time of his interviews. I suspected that William was a reluctant participant and only engaged in both interviews to take maximum advantage of the financial incentives on offer, he declined the photo journal but did engage with the diary entries. William was not easy to interview as he tended towards one word answers or responding with short phrases. He was reluctant to expand on these short answers although he did slowly begin to be more forthcoming and open as the interviews progressed. I did feel as though William viewed the interview as something of a challenge or a game to be played where William's resistance was competing with my interviewing skills.

5.8.9 Pam

Pam had been arrested 15 times for Breach of the Peace offences; she had been given a diagnosis of Paranoid Schizophrenia and was reported to have been generally non-compliant with treatment, often disengaging from services in the past. She described her problems as starting post-partum with her first child in 1972; she was 58 years old at the time of her home interviews, her CTO had been in place for 17 months and she reluctantly agreed to attempt some diary entries although she did not fully understand the requirements or purpose of the exercise. Nevertheless she engaged well at interview with the first lasting for over 33 minutes and the second extending to over 43 minutes. She was reported to have had repeated problems with her neighbours wherever she had lived because of her anti-social behaviour; when unwell she was reported to be aggressive and hostile towards others, very changeable in mood and behaviour, could also become withdrawn with poor self-care and take impulsive overdoses requiring hospital treatment. She had 12 admissions in the past both formal and informal and was reported as a 'paranoid and angry inpatient, lacking insight into her problems'. Pam lived alone in a small, neat flat where her life was limited by mobility problems as well as her mental health issues. She stated that she found interacting with others difficult, and she displayed some angry outbursts with little warning, although this quickly passed and more measured interaction resumed.

When Pam was angry she became very difficult to understand as she talked very rapidly and consequently some of her responses only became clear on slow-speed playback of the digital recorder. Although Pam found relating and interacting with others difficult, she lamented the loss of relationships with her family and former friends. As a consequence she tried hard to engage with the interviews and describe her experiences.

5.8.10 Mary

Mary had been given a diagnosis of Schizophrenia which, according to her report, had been compounded by numerous physical health problems as well as gender-identity confusion. Her age was 44 years at the time of her two interviews and she had been in contact with mental health services for 28 of those years. Her CTO had been in place for over two years and she had needed six admissions prior to the CTO being implemented, usually requiring periods of nursing on PICU. When she was unwell she was reported to become non-compliant with treatment and disengaged from services. She was also reported as aggressive and irritable with delusional and paranoid beliefs together with auditory and visual hallucinations. The report also detailed experiences of depressive episodes with suicidal ideation. Mary had two significant female relationships at the time of the interviews. She described both as 'partners', one lived with her in their flat and the other lived nearby. Mary appeared to easily confuse past and present incidents, events and relationships, which required frequent re-orientation (using the basic timeline) to the present to clarify her descriptions and experiences. Nevertheless, the interviews were undertaken in a jovial and relaxed manner where Mary was able to express her thoughts and feelings as an animated and sometimes flamboyant character. Mary's physical problems prevent her from venturing out of her flat and she therefore welcomed a chance to talk with someone about her experiences with mental health services and her CTO.

5.9 Summary

IPA method has been extensively described and detailed in a growing body of literature, and is flexible enough to incorporate bolder designs that are particularly

suitable for mental health service-users. This chapter has outlined the study design and methods of data collection and analysis, highlighting some ethical and practical issues. Finally, participant profiles are presented of the ten individuals involved in the study as background to the following chapter, which details the findings and analysis of the data.

Chapter 6

Findings and analysis

6.1 Introduction

This chapter presents the analysis of the interview data. The generated clusters and themes and associated sub-themes are presented with supporting extracts. References to extant literature, theory and associated discussion will be taken up in the next chapter to afford initial close attention to the data in and of itself in this chapter. Any specific words, phrases or sections can be identified and located in the original transcript by the participant's name, interview number (1 or 2), page number, and then line number(s). Thus in the example shown in *Appendix 6*, Elizabeth's reference to "feels like a death sentence" would be identified by her name followed by 1:1:15-16 representing interview one, page one, lines fifteen to sixteen. Three clusters shown below were generated to encompass twelve themes representing participant experience of CTOs.

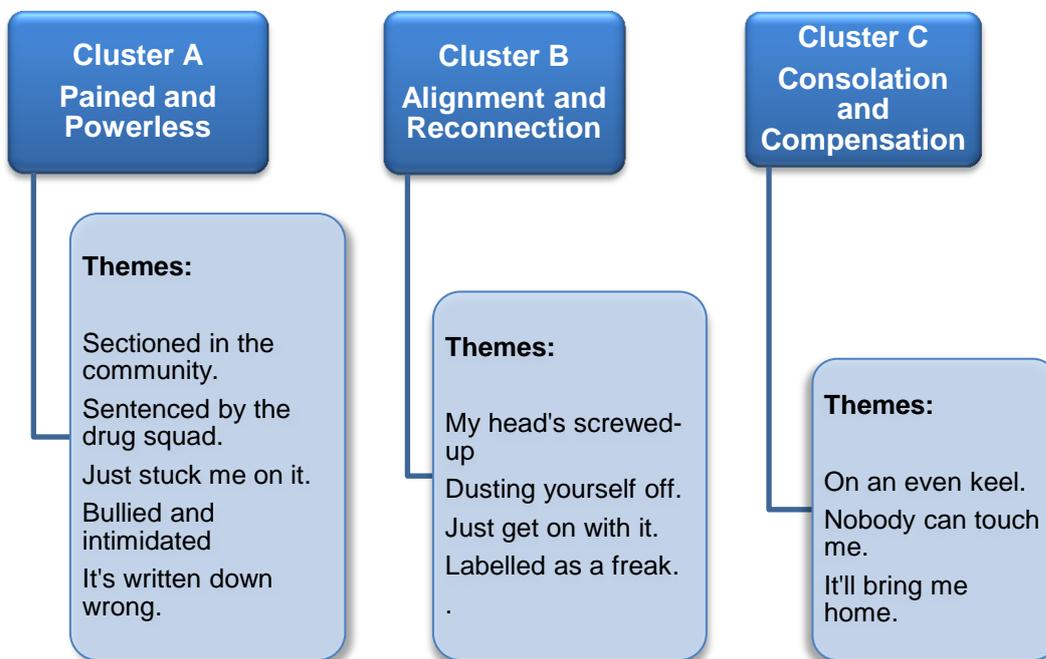


Figure 6.1 Clusters and associated themes

Table 6.1: Interconnections of sub-themes, themes and clusters

Sub-theme	Theme	Cluster
Broken by pain (Barbara)	Sectioned in the community	Pained and Powerless
Testing times (Joyce)		
Angry at experience (Elizabeth)		
Struggling with pressure (Jim)		
Back ground influences (Pam)		
Accepting nearly normal (Joyce)		
Flourishing from trauma (Mary)		
Joy of normal (Joyce)		
Powerless to challenge (John)		
Broken by pain (Barbara)	Sentenced by the drug squad	
Abnormal experiments (Elizabeth)		
Powerless against enforcement (Elizabeth)		
Ruthless response (Elizabeth)		
Powerless against conspiracy (Micky)		
Finding abnormal (Gerry)		
Unfair provocation (John)		
Punished by medication (John)		
Professional cruelty (Pam)		
Frustrated by treatment (Gerry)	They stuck me on it	
Broken by pain (Barbara)		
Neglected and forgotten (John)		
Invisible control (Micky)		
Unfair provocation (John)		
Information as power (Barbara)		
Powerless against enforcement (Elizabeth)		
Insidious consequences (William)		
Threatening and intimidating (Barbara)	Bullied and intimidated	
Resentful and oppressed (Gerry)		
Powerless against enforcement (Elizabeth)		
False reports (John)		
Powerless to challenge (John)		
Bullied and rejected (Pam)		
Broken by pain (Barbara)		
Invisible control (Micky)		
Information as power (Barbara)	It's written down wrong	
False reports (John)		
Worried about others (Micky)		
Legacy of the past (William)		
Labelled by the past (John)		
Threatening and intimidating (Barbara)		

Sub-theme	Theme	Cluster
Accepting nearly normal (Joyce)	My head's screwed-up	Alignment and Reconnection
Information as power (Barbara)		
Insidious consequences (William)		
Empathising with others (Micky)		
Struggling with pressure (Jim)		
Broken by pain (Barbara)		
False judgement (William)	Dusting yourself off	
Broken by pain (Barbara)		
Exploring normal (Gerry)		
Testing times (Joyce)		
Needing help coping (Jim)		
Neglected and forgotten (John)	Just get on with it	
Searching for support (Barbara)		
Uncertainty and blame (Joyce)		
Burden of burden (Joyce)		
Void of need (Pam)		
Monitored insulation (Mary)	Labelled as a freak	
Exposure and collusion (Barbara)		
Devalued and labelled (Elizabeth)		
Depersonalised (Elizabeth)		
Powerless against conspiracy (Micky)		
Feels different (Jim)		
Powerless to challenge (John)		
Resentful and oppressed (Gerry)		

Sub-theme	Theme	Cluster
Searching for normal (Joyce)	On an even keel	Consolation and Compensation
Fate, luck, destiny (Joyce)		
Searching for support (Barbara)		
Needing help coping (Jim)		
Finding meaning (Micky)		
Accepting nearly normal (Joyce)	Nobody can touch me	
Finding meaning (Micky)		
Positive control (Jim)		
Liberty and freedom (Mary)		
Monitored insulation (Mary)	It'll bring me home	
Legitimised care (Mary)		
Searching for support (Barbara)		
Needing help coping (Jim)		
Flourishing from trauma (Mary)		
Joy of normal (Joyce)		

Table 6.2: Recurrence of clusters and themes

	Barbara	Joyce	Elizabeth	Micky	Jim	Gerry	John	William	Pam	Mary	Present in over half sample
Cluster A Pained and Powerless	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Yes
Sectioned in the community	✓	✓	✓		✓		✓		✓	✓	Yes
Sentenced by drug squad	✓		✓	✓		✓	✓		✓		Yes
They stuck me on it	✓		✓	✓		✓	✓	✓			Yes
Bullied & intimidated	✓		✓	✓		✓	✓		✓		Yes
It's written down wrong	✓			✓			✓	✓			40/60
Cluster B Alignment and Reconnection	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Yes
My head's screwed-up	✓	✓		✓	✓			✓			50/50
Dusting yourself off	✓	✓			✓	✓	✓	✓			Yes
Just get on with it	✓	✓							✓	✓	40/60
Labelled as a freak	✓		✓	✓	✓	✓	✓				Yes
Cluster C Consolation and Compensation	✓	✓		✓	✓					✓	50/50
On an even keel	✓	✓		✓	✓						40/60
Nobody can touch me		✓		✓	✓					✓	40/60
It'll bring me home	✓	✓			✓					✓	40/60

6.2 Clusters, themes and sub-themes

Clusters and themes were, in turn, generated from 49 sub-themes (see Table 6.1 for interconnections of sub-themes, themes and clusters). In the following sections, themes and extracts for analysis are presented and organised under each cluster described in turn. The arrangement of the clusters reflect predominately negative (Cluster A), ambivalent (Cluster B) and positive (Cluster C) responses. The themes illustrate why and how CTOs elicit these differently textured experiences. Table 6.1 shows that the majority of sub-theme participant responses were in Cluster A followed by B and C, but the analytic output of the three clusters was driven by the data and felt to be the most accurate and comprehensive arrangement to capture the quality of participant experiences. The relevant participant's name, transcript page and line numbers are shown in brackets for tracking, audit and confirmation purposes.

6.2.1 Cluster A – Pained and Powerless

This cluster comprised the largest proportion of themes (42%) generated by all of the ten participants. All of the themes generated within this cluster represented a negative attitude towards CTOs. Participants felt confused about the nature of the CTO and compared the order with previous experiences detained in hospital under a section of the Mental Health Act. Participants also conflated convictions, sentences and punishments of the criminal justice system with the continuing imposed therapeutic intent of the mental health system. Overall, in this cluster, participants communicated feelings of upset, pain and powerlessness around their CTO, using different language and approaches, some stronger and more direct than others. Barbara in Extract 6:1 used metaphor to explain experience of the CTO:

Extract 6:1

'Chop a, chop a, chop a kebab. It's not funny you know.

(...) This happened in the past, I'm reliving a donner kebab.'

(Barbara 1:12:6-11)

When Barbara was asked to explain her metaphor, she simply repeated the phrase. A döner kebab is usually cooked on display to attract potential

consumers as they pass by. The actual kebab is pinned in place and continually exposed to heat so that slices of meat can be carved as required, all within an unprotected, open and observable setting. For Barbara, the physical properties of the döner kebab may have represented the way she felt in the past, and still felt at the time, when professionals (from her perspective) inflicted emotionally, physically and mentally painful interventions, during which she felt vulnerable, unprotected and 'pinned'. The kebab metaphor also connected Barbara's account of feeling exposed to constant medical gaze [heat], where she was 'watched and observed' by mental health services (see Extract 6:2). This metaphor represents the quality and texture of reliving the experience of pain and powerlessness captured in this cluster. There are five themes in this cluster, each representing different aspects of the perceived pained and powerless nature of the participants' CTO experience, which will now be reported in turn.

6.2.1.1 Theme 1 – Sectioned in the community

This theme represents the ways in which some participants oriented to the experience of being given a CTO as similar to being 'sectioned in the community', and brought with it association of surveillance, lack of choice and powerlessness. Participants who contributed to this theme reported feeling confused about the nature of a CTO. Some understood the CTO as being similar to a hospital Mental Health Act 'section'. Most individuals perceived the CTO as a preferable alternative compared to an inpatient detention which they perceived as rigid, restrictive and deeply undesirable. Participants usually referred to being 'on a section' rather than 'under' or 'subject to a section'. The same language was used for a CTO where participants described themselves as 'on' a CTO. This suggests that people viewed and experienced these as legislative instruments, perceiving themselves to be carried along by the constant progression of certain orders or sections.

Many participants described the CTO as a hospital section of the Mental Health Act applied in the community. For example, in Extract 6:2, Barbara was asked about the circumstances when the CTO was first mentioned and she reported what the professional team had told her:

Extract 6:2

'Oh, we want to put you on a section in the community. (...) you'll be watched and observed.'

(Barbara 1:3:24-26 & 1:4:3-4)

Her report of the decision to place her on a CTO was as a 'section in the community' and her dominant recollection was that its outlined purpose was to conduct surveillance on her. Her description evokes a sense of powerlessness, in the face of actors who have more power to enact their 'wants' and to 'put you on a section' to 'watch' and 'observe' her. Thus, Barbara presents the CTO as fundamentally about the authority others have to decide where she goes, and how. Being affected by mental health difficulties, she is subject to the intense and persistent surveillance by powerful others.

John also used the phrase 'on a section' in Extract 6:3, but he felt confused, and subsequently distressed, as he believed the 'section' would last for a year. In the short excerpt below, the assumed standard 'twelve months' upset John, and there is an air of deflation, sadness and helplessness.

Extract 6:3

'Twelve months on a section, that's upsetting is that, I find that upsetting'

(John 1:6:24-26)

John used the word 'find' as if he had discovered and verified details of the 'section' that had been disguised or hidden in some way. Later in the interview, John explained that when his 'section [CTO] was renewed he felt they 'threw the book at me' (1:8:21-23) – a metaphorical reference to the weight of a sentence passed down by authorities by way of punishment in a criminal court, suggesting that John felt singled out for unjustified and disproportionate penalisation.

In Extract 6:4, Joyce also compared her CTO with a hospital section although she felt that the CTO was 'not the same' there were similarities in that medication compliance was mandatory and monitoring was routine, so 'abid[ing] by the rules'

was the expectation. In the extract below she highlighted what features of a CTO seemed uppermost in her mind:

Extract 6:4

‘Just that. Just like, you’ve got to take your meds, it’s like.

Oh, I can’t, erm, it’s monitoring me but you’re not in hospital, like similar, you’re not on a section, obviously, ‘cos , but you’re not in hospital, you’re not on a section, obviously, ‘cos if you were on a section you’d be in hospital, erm, basically you’ve got to abide by the rules of the CTO.’ (Joyce 1:10:24-26 & 1:11:1-3)

However, Joyce’s description of the CTO as ‘got to’, ‘monitoring me’ and ‘rules’, suggest that for her it was the required submission to others, and lack of personal autonomy, that were troubling aspects of the experience. Later in her interview, Joyce stated that ‘I was so determined not to go to the hospital ‘cos I hate it so much’ (Joyce 1:19:19-21), suggesting that the CTO was perceived as the preferable alternative to the even more oppressive possibility of hospital admission.

Most participants, when asked about the CTO, made comparisons with their hospital stays which were usually negative experiences, as illustrated in this extract from Jim:

Extract 6:5

‘That was very bad when I was in hospital, I did not like it in there. Didn’t like it at all in there, it seemed to be like a prison sentence in there. It were, like er, I stayed in there for three months as well, I wouldn’t like to go back in there again.’ (Jim 1:12:19-26)

This association resurrected ‘very bad’ feelings for Jim where his detention was likened to a perceived ‘prison sentence’. Jim repeatedly used the phrase ‘in there’ when referring to hospital, suggesting that he felt this a confining and controlling experience where he was detained and contained for three months rather than expressing some anticipated benefit such as sanctuary, recuperation or therapy.

His language was very impersonal when referring to hospital as if he wanted to distance himself from recalling this difficult memory.

In summary, this theme of being sectioned in the community represented participants' feelings of confusion between hospital inpatient sections as a frame of reference and comparison point for their experience on a CTO. Their experience of being on a CTO reminded them of a previous 'sentence', and distressing and negative past episodes when detained in hospital. Although being 'on' a CTO suggested a less restrictive option for service-users, the CTO was nonetheless experienced as controlling and was paralleled to the rigid and oppressive practices they experienced under the Mental Health Act. Thus for some participants, a CTO was not a therapeutic or a liberating opportunity, but rather just another way to experience 'pain' through feelings of fear, powerlessness and distress associated with hospital inpatient sections.

6.2.1.2 Theme 2 – Sentenced by the drug squad

Alongside comparisons to being 'sectioned', whereby they felt that they were fundamentally being controlled, some participants described the CTO as a malevolent 'sentence' awarded by a quasi-law court. They referred to a sentence being imposed under the CTO by a non-specific group, often professionals, who were perceived as practicing in an abusive manner under the guise of therapeutic treatment. Participants recounted incidents that they experienced as malpractice and an unacceptable use of authority and power, spanning painful psychological and physical interventions to outright cruelty. Participants reported suffering through the perceived misuse of medication, ruthless behaviours and experimental actions.

Some participants often drew parallels between the sentences of the criminal justice system and the 'treatments' by the mental health system. For example, in Extract 6:6, Barbara felt that the CTO had been 'sentenced on' her as if punishing a convicted criminal.

Extract 6:6

'(...) that's my treatment order, that's what's been sentenced on me and that's what I've been through and it feels, it keeps, unfair' (Barbara 1:17:21-26)

She alluded to being victimised; having been through a difficult period, which she felt was being unfairly perpetuated. In other parts of her narrative, Barbara detailed some of what she had 'been through' as being 'subjected to some quite horrific treatments' (Barbara, 1:20:3-4) to the point where her 'body can't take all that any more, it's been through too much' (Barbara, 2:34:4-6). The past treatment Barbara received was enforced psychotropic medication administered whilst detained in hospital under the Mental Health Act. Barbara perceived close similarities between this past compulsory treatment and her CTO where one of the main conditions was to accept medication as prescribed by her doctors. For Barbara, the 'treatment' was not experienced as necessary, rational or supportive, but rather barbaric, and actionable only because of the inequalities in power between patients and professionals.

Many participants were sceptical about the motives of professionals responsible for their care and treatment. For example, John felt that the medication prescribed by his doctors led to unnecessary suffering. In Extract 6:7, he felt that there was a therapeutic intent inherent in the treatment, but it did not make him 'feel well', in fact, it made him feel 'poorly'.

Extract 6:7

'I am suffering and that, and I feel like death warmed-up all day and stuff. Somebody told me it's [made] from snake venom, pipiothone [sic]. I don't know about that and that but, er, it doesn't make me well, it makes me feel poorly, it makes me feel like death warmed-up.'

(John 1:22:16-20)

John suspected that his medication was made 'from snake venom', suggesting he was being deliberately poisoned by his enforced treatment, which must have been a very frightening and undermining experience. He described feeling 'like death warmed-up' and also being 'in a coma, in a trance' (John, 1:7:17) and 'it

would be six months before I started feeling alive and well again' (John, 1:22:7-10). This, again, is a reference to feeling that his doctors have imposed a type of sentence on him using unidentified psychotropic drugs under the conditions of the CTO. In describing the feeling as 'death warmed-up', John suggested that the treatment had left him feeling only just alive, and that the treatment – rather than sustaining him – had diminished him.

Some participants felt unable to identify and verify the authenticity of the drugs they were forced to accept from doctors. Pam, for example in Extract 6:8 felt that the usual trusting relationship between practitioner and patient had deteriorated and she no longer had a firm belief in the safety of their interventions.

Extract 6:8

'They could have been giving me dope for all I know. I didn't know what they were giving me, they were just a drug squad, could have been dope for all I know, dope was going about. I'd led a sheltered life, I don't know, I didn't know.' (Pam 1:4:4-10)

Here, Pam compared the nursing staff to gangsters with a 'cold-heartedness' (Pam, 2:27:17) that she feared, and she felt they may have deliberately drugged her with illicit substances. The abusive nature of the nursing response was reported by Pam as a forceful, vicious and unnecessary action: 'he stuck two bloody needles in did that nurse' (Pam, 1:12:24). Even when Pam talked about oral medication she referred to an aggressive action of administration where nurses 'stuffed tablets down my throat' (Pam, 1:13:7) indicating a hostile and painful action rather than therapeutic intent from expected care givers.

Pam compared her medically prescribed drugs to illicit street drugs. She emphasised her feelings of vulnerability, stating that she had led a sheltered life and lacked knowledge of illicit drugs and associated culture. It is a measure of her mistrust of her medical team that she referred to them as a 'drug squad'. This reference could be a perceived amalgamation of a specialist enforcement unit and an illegal drug dealer. Pam felt very uncertain about the status of the supplier

and the nature of the substance supplied, as she repeated her insecurity with the phrase 'I don't know'.

This uncertainty about the therapeutic intentions of practitioners and the resultant questionable outcomes were echoed by other participants. Elizabeth, in Extract 6:9, was also unsure what the enforced medication was doing to her and was perplexed at why she was injected.

Extract 6:9

'For something I might not have done and I've been injected. And it feels like it's a death sentence, you don't know what this injection's doing, I take seizures now I have this injection. Well It's like blackmail' cos they say I can't stay at home unless I have the injection. So I say, you're making me feel suicidal.'
(Elizabeth 1:1:18-22 & 1:2:2-7).

She linked the injection to the onset of 'seizures' and because she was 'blackmail[ed]' into accepting the injection, she felt suicidal, explaining her perception of the injection as a 'death sentence'. She reported being coerced into accepting the medication otherwise she would be unable to remain at home. Elizabeth felt that this 'sentence' had been imposed unfairly for something she 'might not have done', suggesting there was a lack of evidence or justification.

Like John, Elizabeth also paralleled treatment to 'like death', evoking a sinister sense of treatment detracting from living rather than enhancing life. As a consequence, Elizabeth was angry 'with everybody' although more specifically this anger targeted 'medical science' represented by professionals and practitioners.

Extract 6:10

'Yeah, angry with everybody. A guinea pig for medical science and it's wrong, it's wrong, practice on their own body, see if they like it. If I wanted my body to go to medical science I'd have done it years ago (...) This country is f*cked and there'll be a load of people that are getting these injections and when

it's all said and done it's for your medical science. Well forget it, there's nowt wrong with my brain, never has been. I've never hurt my kids, I've looked after them well, I've brought 'em up.'

(Elizabeth (1:13:1-5 & 1:17:6-13))

Elizabeth felt that she has been the subject of 'experimental science' practicing on her body. She then projected this practice onto a 'load of other people' that were forced to accept similar injections and associated this coercive behaviour with the wider problems of the 'country'. Towards the end of Extract 6:10, Elizabeth personalised her experience stating that there was nothing wrong with her 'brain', citing the safe care of her children as evidence. Elizabeth wondered how well these treatments would be tolerated by the people who administered them (literally, a taste of their own medicine) and concluded that this would be deplored. Here, she conveyed her sense that the system is not only abusive but broken - and she is a casualty.

In summary, the feelings and perceptions represented in this theme were described by participants in terms of the criminal justice system. People felt sentenced under the guise of therapeutic treatment. Doctors were perceived as continually subjecting individuals to frightening treatments using powerful drugs. Some participants felt they were forced into unnecessary suffering leading to anger and mistrust. Participants disputed the value and authenticity of medication as well as the motivation and purpose of practitioners' actions whilst enforcing treatment under the CTO. Individuals perceived their treatment as a miscarriage of justice which was unfair, disproportionate, illicit and illegitimate.

6.2.1.3 Theme 3 – They stuck me on it

Several participants felt that the motivation of practitioners and professionals involved in assigning their CTO was questionable, and that the purpose of the CTO was dubious, careless, neglectful or underpinned by malevolent motives. Some participants could not understand the reasoning behind the CTO and felt that the legislation was used arbitrarily without valid justification or explanation. In their narratives these participants referred to the perceived indiscriminate, irrational and tyrannical nature of the order rather than a planned therapeutic

intervention with defined outcomes and clear objectives. Some participants felt that the CTO simply happened; others felt the order was imposed in a clandestine manner, and certain individuals felt that any mitigating circumstances were not considered. The perception of some participants was that the use of a CTO was more a casual and indiscriminate decision where they were 'stuck' on it, rather than a carefully planned intervention with a clear rationale.

Some participants linked the indiscriminate nature of the CTO with feelings of sub-standard care and questionable levels of professional involvement. For example, in Extract 6:11, John felt that he had been deliberately neglected, abandoned and forgotten by his professionals.

Extract 6:11

'I can't really trust the doctor, the big complaint I have about the treatment I've had is that I don't get to see Dr [name] enough, you'd think he'd be more concerned about seeing me more regular. You see, I can't help feeling that I'm forgotten. I'm just abandoned, you know what I mean. They've stuck me on this treatment order and, it's not neglect as such 'cos the guys come around twice a week, I'm a bit upset that the doctors don't want to see me more.' (John 1:14:10-18)

A key complaint of John's was that the CTO had, in his eyes, shifted him from a place of attentive care from his doctor, to being forgotten about in the community. He therefore lost trust in doctors perceiving them to have just 'stuck' him on a CTO rather than 'dropping round', home visiting for consultation. He interpreted this as a careless approach where 'the guys' (two regular male community mental health nurses) are sent round and the doctor maintains oversight and treats remotely. Elsewhere in the interview, John described feeling that being 'stuck' on a CTO was expedient, convenient and opportunistic rather than a carefully planned, rational and evidenced intervention. Having not seen his doctor meant John not only felt abandoned - but alone and neglected by a supposedly caring profession. Here, there is a sense of personal rejection, of being dismissed as a person of worth, unimportant within the mental health system.

Other participants felt they had been neglected and deceived as they felt that the CTO had been imposed in a clandestine manner. In Extract 6:12, Micky felt that the CTO had been assigned 'behind [his] back' in a hospital meeting when he was not able to attend.

Extract 6:12

'Well it were mentioned to me but they did it behind my back. Put me on a CTO behind my back, erm, I had a dental appointment, I went to my dentist and I comes back [to hospital] and it were all over and done with, I didn't get a choice of who were there or nothing. Doctor [name] was there, but they said I was on a CTO, but I wasn't in the meeting.' (Micky 1:9:5-11)

Micky described feeling excluded from important decisions, with others making choices for him, indicating that Micky's views were of no consequence. Similarly, in Extracts 6:13 and 6:14, Barbara and Elizabeth report that the CTO was imposed by doctors without consultation or negotiation. For Barbara, this felt like punishment and Elizabeth felt she had been given no option but to accept the imposition. Neither felt that they had been given any opportunity for discussion, negotiation or expression of their views.

Extract 6:13

'(...) they were telling me nothing, it was just like punishment the way it was told me at the beginning.' (Barbara 1:4:14-16)

Extract 6:14

'They didn't mention it to me, they just put me on it and told me about it when I came home. (...) They didn't tell me. (...) I didn't get no option. They told me when I came home.' (Elizabeth 1:8:16-23)

These combined accounts from Micky, Barbara and Elizabeth indicate how service-users had held a strong desire to speak for themselves, to represent

themselves as people around them talked about, and made decisions, about their lives. Yet they felt entirely silenced in the CTO decision-making process, and notably, perceived this silencing to have been executed purposefully and surreptitiously by people with the power to exclude them.

Some participants felt that contextual and mitigating circumstances should have been considered before the CTO was imposed. In Extract 6:15, John felt deliberately provoked towards aggression by doctors who gave him the 'third degree' (John, 1:22:18).

Extract 6:15

'Again, I've learnt my lesson, but, I can't help but feel I was provoked and they should bear that into some consideration (...) We've all got tempers and that, er, thresholds. Er, but, er, I get the idea. Why do I always get the short straw, why is it always me. Er, how am I supposed to react.' (John 1:24:15-26)

John described himself as 'reacting' and subsequently taking 'the law into my [own] hands' (1:24:12-13) against this perceived malevolent intent. He felt targeted and singled out wondering 'why is it always me' and whether he would be allowed a human reaction or if passivity was required with a diagnosis of schizophrenia. He felt that his right to have feelings was removed, and his anger, in the face of perceived provocation, was at risk of being pathologised. Although he maintained that he has 'learnt his lesson' this still left him no room for negotiation or discussion, leaving him with 'the short straw' to randomly suffer an associated penalty.

Certain participants felt that similar provocative tactics were being employed in order to maintain the CTO. William, for example, described feeling that dubious and potentially malevolent intent was being deployed to keep the CTO in place. In Extract 6:16 he perceived this as a 'Catch 22' (1:11:2) discharge dilemma, where a service-user felt well and would, therefore, like to be discharged from the CTO, but the doctors maintain he or she is only well because they remain on the CTO.

Extract 6:16

'Yeah, but, I suppose one of the bad bits is once you're on it, it's hard to get off it because they'd say it were working on the CTO, they'd say it's in place and it's working. Well how do they know if I wasn't on a CTO it still wouldn't be the same.' (William 1:10:10-15)

William considered the professional logic as illogical, 'bad' and indicative of a coercive form of treatment. He posed the question of an alternative viewpoint from a therapeutic risk perspective, which he perceived as an equally plausible alternative view. He felt stuck with an emphasis on maintenance with the CTO 'in place and working' rather than a less restrictive therapeutic risk approach.

In sum, this theme captured the way in which some professionals were perceived to use their powers in a random and arbitrary manner, and some to the point of neglect and malevolence. This left participants feeling silenced, abandoned and deceived. These feelings were sometimes compounded by the detached and remote care practices of the professionals involved. There was also a strong suggestion that excluding service-users from decision-making was an intentional action by practitioners with full knowledge of the potential outcome. The provocative use of CTOs was perceived by some participants as an all-powerful regime comprising ongoing potentially malevolent practice.

6.2.1.4 Theme 4 – Bullied and intimidated

Some participants described feelings of intimidation, coercion and a domineering, controlling approach from mental health practitioners. They described feeling powerless and unable to take action against the imposition and maintenance of the order. Some felt they were unable to respond to the perceived harsh treatment from a powerful mental health system. Often, participants were unable to identify a specific source of this power and oppression, instead expressing it in comparative terms in relation to their own perceived lack of power and ability to resist. Participants often perceived adversarial alliances and associations between agencies, practitioners and professionals who combine in non-specific

ways to form 'they'. Participants described feeling bullied and intimidated by a tyrannical system that served to control and persecute through the CTO.

As already shown, some participants felt that the CTO had been enforced in a covert and clandestine manner; however, for some participants this deception developed a more sinister nature. For example, Micky was asked in Extract 6:17, when was the CTO first mentioned to him. He described feeling that the order was implemented in secret and the meeting to discuss the order was organised 'behind [his] back'. This suggested that the order was deliberately arranged without his knowledge in a deceitful and furtive manner. Micky felt that he was the victim a 'clique', an exclusive and powerful circle of people with the common purpose of imposing a CTO. He perceived that this group conspired together to finalise the CTO in a carefully orchestrated and controlling manner. He contrasted the irony of being expected to take responsibility for his own physical dental health needs, whilst his mental health care was being malevolently controlled by others.

Extract 6:17

'(...) nobody asked me or nothing, no (...) it were all very clique, very clique. I didn't realise I were on one till they told me (...) But the actual meeting where, why I was supposed to be in, I wasn't there so they carried on behind my back and, well I had a dentists appointment on the same day so I went to the dentist and nobody told me I had a meeting as well so I went to the dentist, come back and it were all over and done with (...) me not being there and me not choosing who were so, well I felt it were a bit of an infringement on my rights, were that.'

(Micky 1:9:12-26 & 1:10:1-16)

Micky felt powerless to prevent the meeting taking place in his absence and he was unable to influence the outcome in any way. He perceived that 'they carried on' without his knowledge and he was unable to rectify the situation as it was 'all over and done with' and therefore fixed and completed before his return. Micky felt that this secretive conspiracy excluded him but involved his doctor and represented a surreptitious form of bullying and intimidation. He described this

unfair practice as an 'infringement on [his] rights' whilst accepting as axiomatic the rights of the 'clique' to impose the order in such an authoritarian manner. Micky's narrative indicated that he felt he was 'supposed' to be at the meeting and the outcome may have been different had he been there. The power imbalance was as a consequence of his exclusion and reinforced by the combined strength of the group described collectively as 'they'. This combined strength was effectively used to bully and intimidate.

Many participants perceived this sense of power imbalance and inevitability as a consequence of the CTO. For example, when Elizabeth was asked about her future life, in Extract 6:18, she felt strongly that her prescribed injection limited her life choices and freedoms.

Extract 6:18

'On an injection there is no future 'cos there is no life. You can't go on holiday, you can't go abroad, you've to have a nurse come every fortnight to stick a needle up your backside. If you're not here they send the police for you, take you to the hospital, inject you and send you home, that's what they said they'll do. There's just no justice in this f*cking country and if they're allowed to pick people out and inject 'em.' (Elizabeth 1:13:18-26 & 14:1-3).

Elizabeth described feeling powerless to prevent the enforcement of her treatment, and bullied into allowing access to practitioners in order for them to administer her injection. If she refused or resisted she could be returned to hospital for compulsory treatment. She emphasised the dehumanising, humiliating and painful nature of the intervention which she felt lacked any compassion by simply 'stick[ing] a needle up your backside'. Elizabeth summarised this situation despairingly as denying her a future and a life or even a holiday. She felt powerless in the face of an intimidating and coercive force where she was unable to resist the enforcement imposed by mental health services.

Elizabeth referred to this feeling of bullying and intimidation in the first minute of her interview, dramatically linking her CTO to feelings of 'death' (1:1:15-16); an indicator of the importance of this recurring theme for her. She then, again (see Extract 6:10), extended her feelings of personal powerlessness onto a perceived wider social injustice where the mental health system was sanctioned by society to 'pick people out' and treat them in a similar way. She suggested there was a lack of therapeutic intent, instead turning otherwise normal individuals into 'freaks' (1:6:26). Thus, the injustice is a suggestion that the enforced injection actually causes the symptoms of mental illness rather than an attempt at treatment.

Other participants perceived themselves victims of injustice under the CTO. For example, in Extract 6:19, John also experienced a feeling of intimidation and powerlessness based on his diagnosis. Because of his schizophrenia he was taught a 'lesson' by enforced injection rather than a fine or probation 'like a normal man'. As a consequence he felt 'part' of a miscarriage of justice and, although confused about this abnormal approach, he felt the unfairness was compounded by lack of access to a solicitor. For John this was a bullying tactic, which effectively disempowered him by denying legal assistance, instead providing only a doctor who, by implication, was of little value to his cause.

Extract 6:19

'Why I can't be put on probation, like a normal man, be put on probation, a fine or probation, I'd learnt my lesson, I thought I'd learnt my lesson, it's making ends meet, or probation or something, why they choose to write me down as paranoid schizophrenic I don't know and put me on injections (....) I can't help but feel, er a bit er, can't help but feel part of a miscarriage of justice and that; although you're not welcome to a solicitor unless you've got a job, that's what they always get me with these days, they always get me a doctor, they never get me a solicitor.' (John 1:19:3-20)

John felt this denial was because he had not got a job and was, therefore, not valued as a majority member of society. This created a power imbalance cycle for

John where his diagnosis precluded employment; unemployment precluded value; worthlessness precluded rights; and the denial of rights precluded power and the opportunity to change or challenge the CTO together with associated injections.

Some participants perceived intimidation and the power imbalance with professionals as a form of personal control. Barbara used a navigational metaphor to describe her feelings of bullying, intimidation and control. In Extract 6:20, she felt that she no longer had a need for psychiatrists who she perceived as attempting to control her path and chosen direction.

Extract 6:20

'(...) well look I don't really need psychiatrists any more, you know, trying to push me in this hedge and in that hedge, throw me over here and duck me in the canal and river and everywhere ; know what I mean.'

(Barbara 1:12:1-6)

Barbara felt that doctors had used their power and strength to 'push' her from her preferred direction into 'hedges', a 'canal' and 'river'. Although the metaphorical assaults were not described in particularly violent or aggressive terms, they were significant in their demonstration of power and the ability to control. Barbara was able to name her persecutors as psychiatrists as she invited the interviewer to interpret her use of metaphor and to 'know' the meaning rather than use direct descriptive language. However, there is also an element of aspiration in Barbara's perceptions as she recognised that she no longer 'needs' this type of control and the use of the word 'trying' indicates that, despite every effort, her aggressors had not been successful in deviating her from her chosen course.

Other participants felt that they were physically restricted and controlled by the CTO. Micky, for example in Extract 6:21 was also concerned about restrictions to his movement and activity. He felt that the CTO was imposed by the mental health system as a form of invisible control over him, implemented without

explanation or discussion and now forming an unseen barrier limiting his travel and leaving him feeling coerced, trapped and mistrusting of others. Whilst looking through Micky's photo journal, LM commented that all of the photographs were very local to where he lived and did not show many people. Micky said that he did not speak to many people and he felt that he was constrained within a temporal limit or geographical area.

Extract 6:21

'All these pictures I've took, I feel sometimes there's a barrier against where I'm going. (...) That's what my feeling is on the CTO. I don't mind being on it but sometimes I feel there is a barrier, a certain distance or something, or I can't stay out of [city] for too long. It's stuff like that arrives in my mind. (...) An invisible barrier, the amount of length, the distance I can go. (...) For a CTO to be in place. I think I might break a barrier, or be away from [city] too long. Not on purpose, but say I went on holiday and didn't tell anybody. That sort of barrier that I have to tell people. (...) So, the photographs are quite localised (...) I mean I'm in the local, sort of, area. Most of the pictures quite localised, the town and that and then here in my house and places where I go around the area. [LM: What do you think would happen if you broke outside that barrier?] Well, [laughs] I think I might be jumped on by the police and shifted off to hospital.'

(Micky 2:31:15-26 & 32:1-25)

Micky refers to 'barriers' – both real and invisible – five times in this short extract, conveying a sense of being held back and without freedom. He felt that this was in the back of his mind all the time and was worried that 'when I want to get away from [city] for a while' (Micky, 2:33:6-7), he would be unable to do so. He perceived that professionals had used this deception to purposefully control and contain him through the CTO. This bullying and intimidation was backed by the power of the police to 'jump' on him if he breached these undefined restrictions and boundaries.

Although the participants contributing to this theme experienced bullying and intimidation in different ways, they all experienced associated painful feelings of powerlessness. Gerry summarised these feelings of powerlessness using dramatic and powerful language. He felt as though he was 'being raped and treated like an animal' (Gerry, 1:2:16-17). Such dehumanising and demeaning treatment was perceived by participants as practitioners and professionals exercising power in a malevolent display of strength. Such displays could be covert, insidious and secretive where practitioners could conspire together to further intimidate participants. Some participants felt punished and the victims of injustice to the point where they were denied a life and a future. Professionals were also perceived to be able to use the mental health system to exercise constant control over participants' behaviours, movements and actions.

6.2.1.5 Theme 5 – It's written down wrong

Some participants felt that information was collected, retained and used by professionals in order to coerce and control individuals using a re-scripted version of their personal history. Certain essential elements of documented information were perceived to be withheld, or to be an inaccurate representation of the truth or remain uncorrected and then recycled as supporting historical factual evidence. Many participants felt that information managed and manipulated in this way may be presented as legitimate and truthful, which could then be used to support and justify control by powerful professionals operating in the mental health system.

For example, according to John, perceived control of information often resulted in false reports, which then formed the basis of interventions that made him feel like a criminal and law-breaker as well as being 'marked down as a paranoid schizophrenic' (John, 1:18:15-16). When he was asked if anything stood out for him during his contact with mental health services, including the implementation of his CTO, he responded with Extract 6:22. He felt that the report in question was based on misinformation that became fundamental to, and formed the basis of, his treatment since that time.

Extract 6:22

'I was up on [a famous location] and I was quite well, so I'm a bit disturbed to be on medication to be quite honest although they say I'm too violent, my social workers report says I've been attacking coppers and been attacking neighbours, attacked a woman on the park. It's all lies, don't know where it came from, it's all lies.'

(John 1:3:21-26 & 4:1-3)

John had been unable to establish the source of this information and also been unable to challenge, counter or amend the content of the report. John remained 'disturbed' that as a consequence of the 'lies' he had been prescribed medication and compulsory treatment under a CTO. He perceived this period of his life as being rewritten and effectively scripted by his social worker's report.

Some participants felt they were coerced and subjected to force in accepting or colluding in the production of misinformation. For example, in Extract 6:23, Barbara was asked to supply her own information. She was asked what made her think about her CTO in her daily life and she answered that the constant questions were a reminder.

Extract 6:23

'What made me think about it, because the reality of it, the interviews, the questions, the questions [CPN] was asking all the time and they were asking me at [previous address]. Every three weeks they made me fill in about a dozen questionnaire sheets; it was getting me down a bit, I thought well I know what this is 'cos I'm on a community treatment section, blah, blah, blah, that's why they're doing it to me.' (Barbara 1:13:8-19)

Barbara felt she had been repeatedly asked questions, in interviews and by her CPN, over a long period of time. As well as these repeated questions she was also required to complete questionnaires, which she found tedious and suggested 'they' were doing this by way of retribution. The repetitions also suggested this was some test of consistency, which Barbara eventually found boring and meaningless. However, there was also an element of force attached

to the written responses as she was 'made' to comply and it was done 'to' her rather than offered as choice.

When this perceived force was attempted with Micky, in Extract 6:24, he was reported to become 'aggravated'.

Extract 6:24

'They do say that I get a bit aggravated at times when someone wants to control the issue, when somebody comes in from outside or, like, services. I get aggressive, shouting. It's not aggressive, just shouting 'cos I want my point to be heard.'
(Micky 2:34:17-24)

Micky reported his shouting was an attempt to 'be heard'. His experience of not feeling heard was interpreted as aggressive because of previous reports or notes indicated by 'they say' where previous behaviours were recorded as fact and recalled out of context to influence current circumstances. As a consequence of this preconditioning, Micky could be dismissed as aggressive rather than listening to his point. This may have resulted in a frustrating cycle for Micky of being ignored, thus involving the need to shout, then dismissed as aggressive and further ignored. Elizabeth perceived a similar frustration where it did not 'matter how many times [she] mention[ed] it they're always going to listen to the medical science and it's a load of shite' (1:20:23-26). She refers to the power of written medical information and notes as 'science' and undisputed fact, thus frustratingly reducing her oral accounts to the implausible or unremarkable.

By contrast, in extract 6:26 William felt as though people did listen to him; but that what he verbalised was outranked by the competing written historical information. Yet William was convinced that this written information was inaccurate, but had to accept that this misinformation remained on record and retained its power to inform.

Extract 6:25

'No they listened to me but they can only go on what's written can't they, you know, on the history. (...) There's summat wrong what's wrote there (...) 'Cos, obviously it'll have got wrote down at some point (...) So that's one of the things, and there must be other things, over the years those things have added up. And it works against [me] now.' (William 1:12:1-7 & 1:13:5-13)

William explained how his view was 'listened' to, but was de-prioritised in relation to the power of patient records. He conceded the situation as 'one of those things' and that there were other examples of misuse of information from people in positions of power. Further, he felt that these examples had compounded over the years to become a significant force that 'works against' him.

This theme reflected the control of information, particularly written information, by professionals and practitioners within mental health services. This information could contain significant inaccuracies, but still be recorded, stored and reused as required. This type of information retained its power from past events in order to influence current circumstances. Some participants described the forceful extraction of information, which could then be used as a preconditioning influence and misused as judgemental information. The participants generating this theme all recognised the authority associated with this medical information; it had the ability to be interpreted as fact and outweighed current personal service-user accounts in the balance of evidential supremacy; even if the documented details were inaccurate.

6.2.2 Cluster A – Summary

This cluster comprised five themes under the title of *Pained and Powerless*. Participants felt that the CTO was comparable to, and often confused with, a hospital inpatient detention under the Mental Health Act. For many participants these previous detentions had been very negative, deeply undesirable and often traumatic experiences. In a similar way to previous detentions, participants felt that the CTO was a continuation of administration by a quasi-court of law where

they were convicted, sentenced and punished under the guise of therapeutic treatment. Some participants perceived that the CTO was implemented in an arbitrary manner where professionals and practitioners maintained the CTO in using a careless, neglectful approach with malevolent motives. Often, participants felt powerless to resist the coercive practices of professionals responsible for their care; they perceived that they were subjected to a domineering and controlling approach from practitioners in a position of relative strength. Certain participants felt that the documented evidence imposed by mental health services was manipulated and managed to re-script their personal histories and to exploit incident and events to disadvantage participants. All of the participants generating the themes comprising this cluster felt pained by their experiences and felt powerless to challenge the 'sentence' which was likely to continue throughout the duration of the CTO.

6.2.3 Cluster B – Alignment and Reconnection

This cluster could be classified as representing an ambivalent overall response and comprised 30% of the themes generated by all ten participants. The data reflected participants' uncertainties and fragile nature of reconnecting with the community and maintaining an alignment towards recovery and independence. Most participants have been closely connected with mental health services for many years, often for lengthy inpatient admissions; the CTO should represent a re-focus towards community living (Jones 2013). Paradoxically, the CTO appeared to focus participants' attention back towards inpatient care with the threat of recall to hospital under the constant gaze of mental health services. Participants also felt that the CTO contaminated their alignment towards and reconnection with, community living. The episodic nature of mental illness added to the confusion and the faltering emotional pull of community living against the relative familiarity of continuing contact with mental health services. Family, friends and wider society also added to these feelings of uncertainty and precarious recovery, and even their well-meaning advice added to feelings of confusion. Participants also described feelings of hostility from some community groups which gave rise to participant expressions of isolation and being different. However, most participants contributing to this cluster experienced feelings of

personal responsibility and progress despite difficulties and set-backs requiring tenacity, perseverance and resilience.

This wavering uncertainty around remaining connected to mental health services together with an alignment and reconnection with the community was captured by Jim. In Extract 6:26 he used metaphor to convey his perceptions and feelings around the opportunities offered by the CTO:

Extract 6:26

'I mean when you've got a colourful fish tank you can also feel sorry for the fish that are in there, that they can't come out. And like with mental illness it's a little bit like that. You won't take on the challenges in life 'cos you're afraid of what the consequences might be.'

(Jim 1:33:10-13)

One reading of this description is that, via the CTO, Jim felt that he had been provided with an attractive and safe environment in which he could enjoy some freedom. However, he suggests this is a limited and artificial environment where he is protected and his needs are largely met by others. Although other people can see into his environment and he is able to see out, he feels unable to move beyond the boundaries of the glass. In order to move beyond the safe space he would have to risk breaking the glass and accepting some of the perceived dangers this entailed. There is a suggestion that Jim felt he had been cushioned and sheltered by the CTO and by mental health services, which made finding his own space and engaging with mainstream society even more challenging. This metaphor represented Jim's dilemma of remaining aligned towards the familiarity of mental health services, or moving away from these services towards the challenge of reconnecting with the community. A similar dilemma was experienced by other participants which led some to confusion and conflict, and others to a commitment to persevere. Most described feeling a need to cope with the setbacks associated with illness, and for many participants a determination to overcome barriers in the community. These feelings are represented in the following themes.

6.2.3.1 Theme 1 – My head’s screwed-up

Some participants indicated that they were conflicted and unsure about their potential to cope with re-joining ‘normal’ life and the expected associated pressures. Participants expressed an awareness that they had to live with limitations as they attempted to balance optimism with uncertainty. The descriptions, perceptions, thoughts and emotions were influenced by the confusing and misleading status associated with a CTO. Some of their misgivings about the CTO were further compounded as they compared their normality with others who were not limited by mental illness. Participants were ambivalent about, yet hopeful for, a recovery within society, but worked with the view that progress would be limited and possibly compromised by their mental health difficulties.

For several participants the uncertainty and indecision associated with the CTO affected their progression towards recovery. For example, in Extract 6:27, Joyce described disorientation around her direction, movements and options.

Extract 6:27

‘I think this is the most my head’s been screwed up since I got poorly, right in the initial stages. I think like I’ve done a full circle and I’ve been absolutely crazy for the last twelve years and I’m now, touch wood, now getting back to where, you can’t say normal can you, but [long silence] (...) Where I should have been, yeah. And hopefully all the hopes that I mentioned earlier on, in my mental health, is my next step forward. Whether that will come off I don’t know, how long it takes or how I’ll take to it but hopefully that it’s going to be a proper option that I can follow up.’ (Joyce 1:10:2-18)

She described having been unwell, confused and unsure about how she felt about her illness status and ‘next step forward’ at that point in time. She recounted the cyclic and intermittent nature of her condition as well as the enduring nature of the illness, which made community integration and reconnection problematic. Joyce was also very uncertain about her progress and

potential outcomes, which she expressed as 'hope' in her narrative. She used language associated with superstition when she referred to a return to normality reinforced by touching 'wood' and avoiding the direct use of the reference to 'normal'. However, Joyce incorporated some optimism in her response, looking to move incrementally towards the future as a 'proper option'. This suggested an element of confidence and reality was incorporated in her plans, which contrasted with the reference to her 'head' being 'screwed up' suggesting an imaginary or unrealistic response to her experience of the CTO.

Barbara also expressed confusion and ambivalence about her circumstances under the CTO.

Extract 6:28

'Physically and er, emotionally, not being able to get my head round the situation I'm in and deal with it properly'

(Barbara 1:5:21-23)

She indicated feeling confused 'physically' which may be a reflection of a conflicted position where she is neither yet comfortable in the community nor did she want to remain within mental health services. This conflict is also reflected 'emotionally' as she was attempting to understand the implications of her CTO. She described attempting to understand the whole situation possibly contemplating a wider view of the CTO as she attempted to get her 'head round the situation' in order to 'deal with it properly'. This suggests that for Barbara there was a correct and incorrect way of responding to the CTO and in order for Barbara to respond in the right way she should be able to fully understand the implications of the CTO. This would place a heavy responsibility on Barbara to respond in the right way, potentially adding further anxiety to a situation imposed on Barbara by mental health services.

The CTO mechanisms and the operation of mental health services were also described as confusing by some participants. In Extract 6:29, William described that he felt 'strange' when confronted with differing discharge criteria from hospital.

Extract 6:29

'It seems a bit strange really when you're considered well enough to get discharged one way and then the other way you're not, if you don't agree to being put on a CTO, you stay in hospital, on the other hand if you say you'll go on a CTO you're considered well enough to be discharged' (William 2:23:10-17)

He considered that if he did not agree to a CTO he would be detained longer in hospital; he considered the options as irrational and as preventing him from severing his connection with hospital. Hospital and community were presented as a polarised and provocative contrast that introduced a coercive component, expressed through the phrases 'if you don't agree' and 'if you say you'll go on' when considering CTO or discharge from hospital.

A few participants described a need to continue aligning themselves towards mental health services in general, and hospital in particular, in order to act as advocates for others still detained as inpatients to help them receive appropriate care. For example, in Extract 6:30, Micky felt the need to intervene, feeling that the hospital system 'doesn't care' and felt that he had to advocate for those left in hospital.

Extract 6:30

'Well, hospital system doesn't care about people, erm, I see people worse off than me and it makes me lose sleep and stuff, worrying about people there as well. And feeling that I have to take up their cases with people and start talking to the nurses about them as we [laughs]. What they're getting treat like and stuff. I always worry about other people. I care about people a lot, I do.'

(Micky 1:14:10-24)

He explained that this caring approach caused him 'worry' and made him lose sleep, yet he felt compelled to 'take up their cases'. He implied that nurses needed educating in their treatment of service-users and Micky had to act to help them. He aligned himself with patients still in hospital and although he softened

the statement with a laugh, he was serious in his concern for their welfare. However, he was not specific about the reality of care deficits, instead describing loose perceptions of care deficits as the way others were 'treat like and stuff'. He perceived that his status on a CTO rendered him fortunate to be in the community, leaving people still in hospital as 'worse off' in an uncaring system that is capable of mistreatment. Micky perceived the system of care as flawed and the remaining patients as victims rather than being supported towards a recovery and re-integration back into the community.

Participant descriptions generated throughout this theme were characterised by confusion and ambivalence about alignment towards being in hospital, in the community on a CTO or discharged altogether. Jim, in Extract 6:31 for example, was responding to a question that explored his feelings about being in the community rather than hospital, and also periods feeling stronger, and at other times more fragile.

Extract 6:31

'You don't particularly, sort of, like, want to have any problems in life and you don't feel as if you can cope with the pressures which life offers to you if you're not in, if you're not in the right places. I think erm, it's a little bit like everything else in life is fairly relevant to mental illness as well. Sort of like, everybody has these problems. The pressures of life are, sort of like, as to whether you are going to be happy and successful in the fact that, you don't see failure for what it is as well as success for what it is. You basically, sort of like, find everything working out for you in a more positive manner, but you can't be bothered because it doesn't work that way. So, like, you give up. I mean I give up very easily anyway, me.'

(Jim 1:16:7-26 & 17:1-7)

His response represented his feeling of ambivalence and confusion when exploring his perceived problems on the CTO, his struggles with mental illness and the pressures he experienced out of hospital. He felt that mental illness impacted on every area of his life which compounded the pressures that most

other people experienced. Mental illness also modified his views of happiness, success and failure such that even if he found 'everything working out', it rarely concluded favourably and he 'gave up' attempting to influence the outcome. However, there was a lack of clarity and evidence of confusion throughout the extract, which added to the feeling of defeat, with Jim using the pronoun 'you [give up]', possibly in an effort to include others with similar problems. The overall impression of Jim's response from this extract is one of him not being able to align himself or connect effectively with the community, as well as being unable to fully disconnect from the care of mental health services.

Participants represented in this theme all expressed confusion and conflicted feelings when describing the 'limbo state' between hospital and the community. Some reflected on the cyclic and intermittent nature of their mental health as well as the practical and emotional responses involved. Participants continued to make comparisons between hospital and community functioning as well as recognising that the mental health system and the use of CTOs gave rise to further problems of alignment and connection with hospital, CTO care and independent community living. Certain individuals were involved in advocacy activity and action involving the welfare of their peers, which retained a connection with inpatient services. All of the participants expressed some feelings of uncertainty in aligning themselves with the community and away from mental health services. However, the CTO appeared to add to this uncertainty rather than promote clarity or consistency.

6.2.3.2 Theme 2 – Dusting yourself off

Participants contributing to this theme reflected on their perceptions of personal responsibility for recovery and reintegration into the community despite significant difficulties and set-backs. They attempted to reach a decision point whether to progress towards a recovery or maintain their current status. Individuals talked about the problems involved as well as recognising the need for personal motivation and resilience when aiming for recovery. Certain participants felt that their illness prevented them reconnecting fully with the community and so adopted a modified or more cautious approach, which involved retaining a connection with mental health services. Some participants talked about

incentives that were particularly important to them and translated these incentives into action. As well as expressing personal strengths and determination, participants also talked about the influence of fear, possible neglect and the adverse effects of treatment on their recovery potential.

Joyce, in Extract 6:32, described reaching a point where 'everything went down' and then she 'had to think' to herself about continuing toward her 'positive future'. She expressed the difficulty involved in restarting her recovery from a painful and retrograde position. Joyce felt optimistic that she could move towards health, but a relapse of her illness appeared to jeopardise this. She not only had to come to terms with the devastation involved, but also had to motivate herself to start the recovery process all over again. Effectively, Joyce recovered her recovery.

Extract 6:32

'So it was, like, I had a really positive future then I got poorly and then everything went down and then you have to think to yourself, dust yourself off and start all over again, but it's difficult to start again.'

(Joyce 2:48:23-26 & 2:49:1-2)

Joyce expressed a sense of being taken over by her illness, which was felt to render her future vulnerable again. For her, illness caused a downward spiral that could only be arrested by a certain frame of mind where she takes stock of what's been happening and then somehow dusts herself off from the knocks she has taken. The ability to dust oneself off suggests resilience, determination and drive.

Gerry also described this 'drive and inclination to get it all back', but again, this beginning anew was both painful and difficult. In Extract 6:33 he emphasised that his emotional pain stemmed from separation and loss of material possessions. He made it clear he could supply photographic evidence to verify the difference between his past life and present circumstances. Gerry used the metaphor of chalk and cheese, suggesting that the two realities were fundamentally different although superficially alike.

Extract 6:33

'Yeah, there's different sorts of pain that you can get and mine's really being separated from my daughter and being isolated in this flat, you know, it does get quite, it's emotionally, you know. If I was to show you the pictures of the mansion that I had in [place] before coming back here you'd see a difference, it's like chalk and cheese. That's what I'm referring to, you know, I had a car, house and wife and a sex life and, you know, all of that's not there anymore (...) You know, I've always had that drive and inclination to get it back, always would. If I feel like somebody's taken something I would try to get it back.'

(Gerry 2:67:23-26 & 2:68:1-9 & 2:70:3-6)

Gerry appeared to find it difficult to express his emotions associated with this loss, instead expecting the interviewer to 'know' the emotional implications, but quickly moving on to more concrete references to material losses. However, Gerry also used this memory as an emotional springboard towards a recovery. His decision to align himself towards, and reconnect with these lost relationships and possessions are expressed in feeling that 'somebody has taken something and [he] would try to get it back'.

Jim talked about how dusting himself off and reconnection was much more difficult. He described his illness as preventing recovery or 'successes in life'. He was generally hesitant in describing his perceptions, but was often able to identify deficits as a consequence of illness. In Extract 6:34, Jim suggested that because of mental illness he failed to recognise some of the positive and helpful aspects of his 'normal day-to-day life' that could assist him in his future recovery. The illness compromised his 'full control' over the work involved in 'feeling better', thus lacking the motivation to progress. Jim felt that this lack of motivation had relieved him of his ambitions and associated energy, enthusiasm and 'stuff like that'.

Extract 6:34

'It's basically an illness which you can't have full control over and the fact that, you've got to, sort of like, work on how you feel, to sort of, like, to feel a lot better. And like, erm, you generally, sort of, like, erm, you generally sort of, like erm, what's the word for it, you generally, neglect a lot of your existence, from being mentally ill. You neglect the way that you see a normal day-to-day life and like, erm, you neglect things which could be important to, sort of like, help you carry on to help you achieve your successes in life. You no longer have any great ambitions and stuff like that.' (Jim 1:3:22-26 & 1:4:1-11)

John, however, expressed how he felt able to use his negative perceptions and fear as motivation towards dusting himself off through self-determination. In Extract 6:35, he engaged in a dialogue with himself to acknowledge the effect that fear and paranoia were having on his 'wits' or thinking; but also to encourage himself to 'sort it out yourself', suggesting he is able to align himself towards and reconnect with life despite the adverse effect of his illness.

Extract 6:35

'John, [you've] got to sort it out yourself. But, er, I'm scared of my own shadow sometimes on medication, about your wits, you get paranoid about your wits.'
(John 1:25:14-23).

John's description suggests that he finds his mental illness very frightening that he cannot trust his own perceptions and cognitions. He alludes to unseen images and actions under the 'shadow' of his medication. Also he cannot fully trust his thinking processes which he, again, associated with the effects of medication. For John, the medication induced an altered state of consciousness, which was artificial and uncertain. This, despite attempts at self-help, induced fear of the unknown which undermined his confidence and ability to align himself with the 'real world' of the community.

Barbara used a similar self-help approach to dust herself off in Extract 6:36, where she declared a tough and hard stance to resist being bettered or beaten, or pulled down or knocked-out by 'them'. She also talked about how she has been injured and was in pain, but this had only served in hardening and 'toughening' her up, making her more determined to progress. Even though she described 'still hurting' she expressed a desire to stand and face her situation, again, suggesting a determination to move towards a positive future.

Extract 6:36

'My arse is still hurting from that but I'm toughening up and I'm getting harder, I won't let any of 'em achieve or beat me, or pull me down or knock me out or so to speak.'

(Barbara 1:12:14-23)

This theme represents the ways in which some participants felt determined and resilient in the face of illness adversity. This enabled them to align themselves towards and reconnect with recovery, or to consolidate and strengthen with a more static approach. Participants described how their relapses and symptoms of illness could cause difficulties, devastation, set-backs and losses in their lives but, for most, they were able to summon reserves that enabled them to overcome these problems. These negative circumstances resulted in certain participants losing motivation, energy and drive; whilst others regained strength, resolve and resilience from the adversity. All of the participants generating this theme felt that moving themselves towards recovery and reconnecting with the community required commitment, courage and determination.

6.2.3.3 Theme 3 – Just get on with it

Some participants felt that they had to accept the conditions, limitations and restrictions that the CTO imposed on their lives and, where possible, simply carry on as best they could. They talked about how they relied on their own capacity for acceptance, tenacity and perseverance although, at times, sought reassurance and guidance from mental health services, family and friends. This reassurance often took the form of assuming participants' had the strength and capacity to overcome problems. This did encourage participants towards self-reliance rather

than offering direct assistance or specific solutions. This became particularly apparent when people were unwell or were experiencing acute difficulty. At these times, participants felt they were striving for some kind of assisted normalcy, but friends and family often directed responsibility back to the individual in order to motivate them towards overcoming their own inertia. This combination of self-determination and encouragement helped participants to stay committed towards a recovery and a connection with community living.

For example, in Extract 6:37, Barbara described how her thinking was not changed by the CTO. She talked about how, once she was able to accept that she was subject to a 'community section', she was then able to relax a little and go 'with the flow', to get on with her daily life without worry.

Extract 6:37

'What I actually think on a daily basis doesn't change, on a daily basis what I actually think about the community section on me, it takes a while to accept things and once you start accepting things and going with the flow and getting on with your life and don't worry about the fact that I'm accepting being detained in my flat.'

(Barbara 2:32:17-24)

However, as part of this process, Barbara was 'accepting' that she was still 'detained' in her flat. She expressed a developing ability to reconcile her internal concerns with her need to get on with her daily living within the conditions and restrictions imposed by the CTO. For Barbara, a state of acceptance was a necessary condition for successful daily living.

Gerry, in Extract 6:38, described feeling a similar state of acceptance, although he attempted to place some limits on the duration of the order by stating that his doctor will, at some point, want to 'take it off'.

Extract 6:38

'Well, I feel like I just live with the CTO, until such time as Dr [name] wants to take it off, or feel that's it's pertinent to take it

off. Just live with his, er, the team's guidance and decisions, basically' (Gerry 2:28:22-26 & 2:29:1)

Gerry described feeling able to 'just live with the CTO' along with guidance from his care team. However, Gerry also described an element of enforcement associated with the CTO, where he also had to 'live with' the doctor's and the care team's decisions. Whilst Gerry expressed he was able to just get on with his daily living, he implied that the CTO imposed restrictions and limited his choices. His extract suggests he perceived he was subject to the direction and judgement of others until he was discharged from the order. Jim, in Extract 6:39, also expressed his acceptance of his CTO; he had no desire for confrontation or disagreement, simply accepting his situation much as he accepted nourishment.

Extract 6:39

'I mean, I'm not, like erm, I'm not, I'm not an athletic type of person and I'm not an argumentative type of person. I'm, erm, basically somebody who just accepts, you know, dinner what's on the plate' (Jim 1:17:8-13)

In Extract 6:40, Micky accepted 'sticking with' his CTO in the face of significant adversity. He described suffering from a listed side-effect of his medication (none of which are pleasant), and accepted approval from 'them' because he did not want to cause disturbance.

Extract 6:40

'Well that's it. That's definitely one of mine [listed side effects of medication], to get me, I mean, they've said I'm sticking with it really well, you know. I don't want to cause too much of a kerfuffle' (Micky 2:45:20-23)

Micky felt that just getting on with it was preferable to complaining, attracting attention and potentially losing the approval of mental health services. By remaining inconspicuous, Micky felt he could retain some personal control of his circumstances without risking further scrutiny, or 'kerfuffle', by intervention from powerful professionals who could potentially worsen his situation. Although

Micky's side-effect was a recognised and common experience, he preferred that his problem remained unacknowledged so he could retain a low profile.

Pam, by contrast in Extract 6:41, talked about how she could not accept her situation, feeling that her friends and family tended to abandon her when she was on a CTO. She described how her partner, Geoff had been very caring and close to her at one stage, even asking her to marry him, but that he had been unable to support her in her time of perceived need, citing his own problems. Pam felt he had directed responsibility back to her to 'just do it' in an attempt to motivate her towards self-care.

Extract 6:41

'Geoff, he used to take care of me. He used to ring to take me out, he says it's too much, I can't take you out, I've got my own problems. He says "chill out", just do it. That's him who asked me to marry him. But he said when you get poorly I don't want you. What did my sister say when I was down there, "when you get poorly I don't want you".' (Pam 1:17:19-26)

A similar response was issued by her sister. Pam expressed her sister's refusal to help in exactly the same terms as Geoff's, which served to emphasise the perceived uniform negative response of friends and family. Pam's experience was one of conditional care, based on her perceived wellness and Geoff's capacity to take care of her. This suggested that care is effortful and unmanageable for her partner and sister, instead directing Pam to take care of herself.

In Extract 6:42, Joyce perceived negative responses from her close family. Joyce asked a very searching and wide-ranging question about her life experiences with mental illness, but she reported that both her parents reflected responsibility back to her.

Extract 6:42

'You've just got to plod along haven't you? Give whatever life throws to you, and I said to my dad a while ago, erm. "Why do all these things happen to me and why is it all like this". My mum would say to me like there's a lot of people worse off than you. But my dad said to me "Look, you've just got to deal with the cards you're dealt with".' (Joyce 1:36:24-26 & 37:1-26 & 38:1-3)

She described her mother as minimising Joyce's distress saying there are others 'worse off'. This implied a criticism of Joyce for feeling sad and complaining about her life rather than self-helping. Her dad's response was presented as one of resignation, encouraging her to accept her situation rather than feeling the associated pain. Both responses were felt by Joyce to emphasise the random element of destiny, fate and chance. Both parents directed Joyce back to her opening remarks in the extract of the motivational need to 'plod along' and accept 'whatever life throws' at her.

Barbara's daughters, in Extract 6:43 offered a similar type of response when Barbara asked to discuss her CTO with them.

Extract 6:43

'Actually, I've talked to me daughters about it and they haven't said owt to me. They've said, "Oh, you'll be alright mum".'
(Barbara 2:76:8-10)

Barbara reported that her daughters effectively had not really 'said owt [anything]' although the response had a more positive connotation. However, the response could have had the effect of redirecting responsibility back to Barbara to monitor her own mental health on the CTO and predicted that she would be 'alright'. This suggests an effort to motivate Barbara towards self-care and to self-assess her health in positive terms in order to fulfil this potential.

However, the response from Mary's friend, Yvonne, was very different when discussing Mary's medication side-effects. In Extract 6:44, Mary was told in very direct terms to stop taking the medication and to contact her doctor:

Extract 6:44

'Yvonne said "don't take it, ring your doctor up, go see your doctor, you know, that's all you have to do, you're on a CTO for God's sake".' (Mary 2:29:5-8)

Mary was encouraged not to accept the situation and motivation was redirected back to her to make the necessary changes. Yvonne reminded Mary of her entitlement, but also perceived responsibility under the order with the phrase 'you're on a CTO for God's sake' as this displayed some annoyance at the situation thus contributing to Mary's motivation by way of imperative to act. Mary's friend encouraged her to get on with making the necessary changes in her life by exercising her rights under the CTO and challenging professionals to help.

Micky, in Extract 6:45 lamented the loss of potential family encouragement because of the onset of his illness when his family 'stopped bothering'. He described feeling that his family 'gave up on' him at this point and, by implication, expected him to fail. Micky apportioned some of the blame for this situation on his family in that they did not support him previously, but he also apportioned a large amount of blame on his illness, which was perceived as the point where they severed contact and were 'knocked straight off [his] paths'.

Extract 6:45

'Because my family gave up on me when I got this mental health problem they just stopped bothering. They didn't bother much before anyway, but, you know, but this illness just knocked 'em straight off my paths. They didn't want to be near me at all, you know. So, I mean, that's that.' (Micky 2:51:25-26 & 2:52:1-7)

The family did not want contact with Micky and his comments suggested they had not followed his journey through mental health services. Micky ended this extract with 'that's that' suggesting that he accepted the situation and was resigned to

the implications of just getting on with it. This reluctant acceptance in the face of illness implied that Micky blamed this loss on mental health problems rather than family dysfunction. However, this description indicated that Micky was left alone and isolated with his mental illness, and it was clear that the illness was responsible as his family did bother to some extent prior to illness onset.

In summary, participants described feeling able to accept the conditions, restrictions and implications of their CTO by developing an ability to 'just get on with it'. However, some participants attempted to enlist the assistance, advice or counsel of friends and family and were usually encouraged and motivated to use this self-help capability. Some participants did not feel they could accept their current circumstances and were encouraged to make the necessary changes to realign themselves with a recovery in the community. Some perceived that friends and family had abandoned them, particularly when they became unwell. Any advice offered by others tended to redirect responsibility back to the participant in order (apparently) to motivate them to keep progressing with their daily living. In these differing ways of just getting on with it, participants could maintain an alignment with recovery and a connection with living independently in the community. The strategies that participants used ranged from simply carrying-on the best they could, accepting their situation and attempting to relax, as well as trying to enlist the help of family and friends.

6.2.3.4 Theme 4 – Labelled as a freak

Often, participants talked about how they felt different and separated from other people in the community and apart from wider society. They felt labelled and visible as unusual, irregular and abnormal, which affected their ability to maintain a trajectory towards recovery and reconnection with their community. This had a significant impact on relationships. They also felt labelled by professionals, which contributed to participants' perceived stigma. Individuals felt that these shame-based attitudes were widely held and deeply entrenched leading to real problems associated with difference and deviance. Participants managed their perceived labelling in different ways. Some questioned and challenged the application of labels, others accepted that labelling would occur, but were frustrated and angry by the consequences. Participants did not want to be labelled as different and

were aware this would be a potential barrier in aligning themselves away from the protection of mental health services and towards reconnecting with the community.

For example, in Extract 6:46, Elizabeth was indignant and became assertive when she perceived she had been labelled 'a freak'. She identified and challenged a chain of events leading to the application of the label. She wanted to know what the CTO was 'all' about; why she had been placed on a CTO and why she had been labelled as a consequence. By denying she was a 'freak', she attempted to invalidate the entire chain of events, therefore challenging the fundamental rationale of why she had been placed on a CTO at all.

Extract 6:46

'Well I want to know what it's all about, I want to know why I'm on it and what have they put me on it for and why have I been labelled a freak when I'm not.'

(Elizabeth 1:6:24-26 & 1:7:1-2)

There was a strong desire for Elizabeth to understand why she had been placed in this situation and, she wanted explanations from those responsible. Elizabeth was throwing out a general challenge to society rather than seeking specific responses from professionals or services as she perceived a great injustice and a need to defend herself. In her wider interview, she expressed feelings of powerlessness and frustration at the lack of knowledge and the potential that change could offer.

Gerry, by contrast in Extract 6:47, was more specific about the components and effect of the mental illness label and perceived stigma. He expressed that the label affected his relationships with people and suggested that, although he still 'wanted' such relationships, the mental illness label meant that people 'back away straight away'.

Extract 6:47

'Well it affects me wanting to have relationships with people really, erm, I don't like divulging, you know, I'm conscious of transferring all the mental health negativities onto somebody else and I don't think that's fair really. Yeah. 'cos what I've found in the past is they tend to, when they hear mental illness they back away straight away, so you don't get any social interaction. There's a stigma, yeah, it would be nice to be on a voluntary basis again. I just, er, I think tablet medication would be less extreme than the injection and that being voluntary would be less extreme than being under a CTO.'

(Gerry 2:46:26 & 47:1-26 & 48:1)

Gerry felt that there were links between labelling, stigma, relationship problems and the 'extreme' effect of the CTO.

Pam described feeling that she received unwanted negative comments in social relationships as a direct consequence of her mental illness. Although the CTO encouraged alignment and reconnection with the community, the reality was not always an attractive option, sometimes involving difficult interactions. In Extract 6:48, she gave an example of one such interaction that she felt escalated into a social confrontation, which resulted in an inevitable hospital admission.

Extract 6:48

'Yeah, she'd pester and pester, know what I mean. And then I'd end up in [hospital]. I'd get snide remarks, 'had your tablets yet, love'. I don't need that (...) Neighbours. Her. That one. (...) She'd go out in the car and come back with more. Laughing their bloody heads off.'

(Pam 1:5:17-26 & 6:1-4)

Pam felt that references to her medication were 'snide remarks' and identifiable symbols of her mental illness; she further felt that she had no 'need' for such disparaging and derogatory remarks. She was able to identify a specific neighbour who then recruited others in order to escalate the social abuse. Pam

felt they were 'laughing their (...) heads off' at her thus enjoying her discomfort and ridicule to the point where her tormentors were beyond control and rational thought. The result for Pam was that she would 'end up in', suggesting that the confrontation progressed beyond humiliation and shaming towards retaliation and escalating behaviours that resulted in hospital admission. This suggests that, for Pam, aligning towards and reconnecting with the community was a risk as a negative relationship could have serious consequences for her under the gaze of mental health services.

In Extract 6:49, John conflated labels, diagnosis and symptoms. John felt that he had attempted unsuccessfully over time to change his diagnosis of paranoid schizophrenia, citing 'not hearing voices' as evidence. He also cited conflicting evidence where his previous doctor had used a different diagnosis. John wanted to distance himself from any labels, citing 'others, not me', also John referred back to an 'old doctor' who offered an alternative label, which he felt may undermine the accuracy of the current 'schizophrenic' label. All this was done in an attempt to avoid the validity of any distressing label associated with mental illness. John described this experience as if the labels are somehow visible to others and the CTO acts as confirmation of mental illness, which remained attached to him when he was out of hospital and in the community.

Extract 6:49

'I'm still being labelled as a paranoid, well a paranoid schizophrenic although my old doctor called it an affective disorder, it was others, not me. I'm not hearing voices.'

(John 1:3:15-19)

Micky, in Extract 6:50, talked about reluctantly accepting his situation and negative appearance in the community. These visible side-effects are associated with medication and a regular sight in hospital, but now are displayed when Micky is taking this (enforced) medication out of hospital on a CTO.

Extract 6:50

'Yeah. It's just the look of me, you know, when I'm walking, my mouth is moving from side to side and my jaw moving, pulling faces on the bus and pulling faces everywhere I go, it's not right good.' (Micky 2:47:15-20)

His physical symptoms were visible to others when he was out in the community either walking or on the bus, in fact, 'everywhere' he went. Although Micky perceived these involuntary movements as 'not right good' any personal distress was not apparent and the narrative had an underlying tone of resignation.

In sum, this theme was generated from participants' perceptions of labelling and associated stigma attached to their mental illness. This often resulted in participants denying and challenging diagnoses, signs and symptoms; leading to feelings of anger, frustration, confusion and distress. Situations involving labelling and stigma could escalate into wider relationship problems and social altercations involving humiliation, ridicule and retaliation. All the experiences perceived by participants were negative experiences and varied in severity and associated levels of distress. Participants felt less uncomfortable when they were able to accept some of the labels attached because of their illness whilst still acknowledging their disagreement and negative impact. However, the power of these labels affected attempts at remaining aligned towards recovery and reconnecting with the community.

6.2.4 Cluster B – Summary

This cluster entitled *Alignment and Reconnection* comprised four themes in which participants revealed some of the feelings of living with disability and balancing optimism with the uncertainty of illness on a CTO. Participants perceived a range of responses to the CTO in themselves, their relationships with friends and family or the local community and wider society. Individuals were also able to recognise some of their personal responsibilities and abilities associated with recovery. These included an ability to be adaptable in the face of conflicting emotions; resilience and the ability to cope with set-backs; stoicism and ability to simply carry-on where possible; and a determination when faced with adversity and

disadvantage. Friends and family were often described as helpful in redirecting responsibility in order to encourage and motivate the individual. Participants also described feeling different from others in society; they felt highlighted, labelled and visible in the community on a CTO which, in turn, had a significant impact on their relationships. However, participants generally reported feeling committed to their own recovery and able to aim to reintegrate back to day-to-day living in the community.

6.2.5 Cluster C – Consolation and Compensation

This cluster represents participant experiences, which could be classified as positive and comprised 25% of the overall themes and five of the ten participants contributed to this cluster. These participants felt that the CTO provided a sense of balance and stability, and with a little more confidence to reflect on their current circumstances. A perception of security and protection was also felt, which insulated them at home and in the community. However, these perceived benefits were not unconditionally positive and were recognised as providing consolatory and compensatory advantages, which were sought out by participants rather than as an automatic and direct function of the CTO. This resulted in participants expressing feelings that the CTO improved the quality of their lives whilst retaining the recognition of potential threat, community danger and possible financial problems. Joyce, in Extract 6:51, used a metaphor to describe these feelings:

Extract 6:51

“I think it’s a safety net really.” (Joyce 1:30:14)

This is a readily understood metaphor where Joyce compares the function of the CTO to the perceived functions of a safety net. The net is designed to prevent serious injury in case of a fall. The net is not obvious or immediately apparent and is discrete in its supportive function. It is intended to give confidence to those undertaking precarious or risky movement. The net does not guarantee that a fall will or will not occur, and indicates inherent danger and potential harm. There is still a risk of severe injury and the need for a safety net is often associated with inexperience and lack of expertise. Joyce broadly expressed this metaphor as a

positive association with her CTO where the net of the CTO helped her to feel more able to progress towards a recovery. However, there is also an implication that the situation would be more 'normal' without the need for a net and therefore the compensatory and consolatory nature of the benefit cannot be ignored. Other participants expressed similar mixed feelings of monitoring and support, as well as safety and protection; and the reassuring feelings that the CTO represented a potential return to the familiar. However, there was an underlying sense that participants would prefer to be free of the CTO and forgo the benefits they identified, hence the consolatory and compensatory nature of this cluster. The following three themes represented the maintenance of a feeling of balance, insulation from dangers, and an assurance of a return to the familiar.

6.2.5.1 Theme 1 – On an even keel

Some participants felt that the CTO provided and maintained elements of stability in their mental health and balance between competing pressures in their lives. This feeling of stability appeared to be possible through positive and encouraging monitoring and support participants received. Assistance was offered that enabled participants to leave hospital and also to remain at home. Supporters were often practitioners who knew individual participants well and were knowledgeable about their problems and difficulties. This resulted in participants feeling more relaxed, confident and optimistic about their potential. Such support allowed participants to both progress towards a more optimistic future and to appreciate their current circumstances.

For example, in Extract 6:52, Joyce perceived that representatives of mental health services had offered her a 'chance' and 'lucky break' and this modelled a providential opportunity for Joyce:

Extract 6:52

'(...) it's just a good idea for them to be there to provide you with freedom and say, rather than like put you on another six month section, say "Right we'll give you this opportunity to". When they're removing you from hospital and putting you on the CTO. "Right we're taking you out of hospital, giving you a

chance because we want to make sure you take your meds but follow our rules". But if it wasn't there you'd just be in hospital, probably. But you're not given that lucky break to be given a chance and, obviously, you've got people monitoring you to see how you are and they can tell. "Look she isn't following these CTO things" and they say 'Right, then maybe she should come in'. It's just extra people that are there, sort of like, back you up and help you on your way, I suppose' (Joyce 1:35:17-26 & 36:1-12)

In her narrative, Joyce placed herself in the position of these representatives and spoke from their perspective, as if speaking to Joyce. She articulated how she felt that mental health services were taking a risk by discharging her from hospital, monitoring how she 'takes meds' and followed 'the rules'. Joyce also recognised that if she defaulted on the conditions of the CTO she would be returned to hospital because the monitoring is effective and as a consequence 'they can tell'. Joyce perceived that professionals acted as 'back-up', extra people who can help her on her way towards recovery but can also monitor her compliance with the CTO conditions. Joyce described feeling positive about the opportunity to behave in expected ways within pre-determined rules and boundaries. She perceived the 'extra people' who monitor such behaviour as 'back-up' and able to help as she perhaps feels more vulnerable 'on [her] way'.

Barbara also took comfort from the safety of knowing that practitioners would visit her at home. In Extract 6:53, she described feeling more secure, relaxed and supported with practitioners 'looking out' for her. She felt that the CTO represented support in her own home with others guiding her, giving her advice and help with 'bits and pieces'. Barbara felt that mental health services acted as a replacement family which enabled her to accept the CTO, particularly appreciating the associated visits:

Extract 6:53

'Yeah. It makes it a bit more comfortable being at home knowing that if I stay in for a few days and know that at some point during the week I'm going to have a visit from someone

like yourself or one of the other workers that works at the agency. 'Cos it is an agency, is that what you call it? And I can feel a bit more secure and a bit relaxed that you're looking out for me. I have the opinion, I feel that you're looking out for my welfare, you want the best for me, you know what I mean? Like supporting me in my own home. I don't know if I need that or not but that's what this section is to me, that's what I think it is and, erm, guiding me, giving me advice and helping me with my bits and pieces. 'Cos I really haven't got no family to do all that for me, you know that don't you. Yeah, I don't mind, I really don't mind, I really don't mind about the CTO. If they want to knock the CTO off, good but I'll still appreciate a visit every now and again.'

(Barbara 2:35:7-26 & 36:1-5)

A replacement supportive family was important to Barbara and she ensured that it was understood that she has no family of her own to guide, advise, help and wanting 'the best' for her. The visits that Barbara received as part of her CTO acted as an anchor for her in her home, offering the type of reassurance and confidence that 'family' would normally offer. Barbara suggested that this regular support helped maintain positive mental health and the absence of such contact would result in increased anxiety, insecurity and stress. She experienced the CTO as a form of service which acted as an incentive, helping her to make decisions and do practical things. The CTO also acted as an assurance of future visits, which helped regulate her isolation, safe in the knowledge that someone will call 'at some point during the week'.

Jim, in Extract 6:54, talked about a need to better himself, and also recognised the value of a 'cool', 'positive' person who understood the problems of living with schizophrenia and could advise others on coping with the condition. He suggested that the varied knowledge of his mental health team offered him an alternative view, to help maintain stability in coping and recovering. Jim felt that he could welcome support from his team because they were experts and could therefore support him more effectively.

Extract 6:54

'I mean, erm, we all want to, sort of like, better ourselves but when you've got schizophrenia you don't think it's as important. As, sort of like, erm, in having a cool, sort of like, positive person who you can speak to who understands your situation. That is why I, sort of like, welcome the mental health team because there have been different degrees of knowledge that they've studied to find out what was wrong with schizophrenia and like how people cope with it (...) It's a little bit like having somebody to hold your hand a little bit.' (Jim 1:8:6-24)

Jim refers to the value of being understood, and possibly validated, by a knowledgeable person, who can possibly explain the illness of schizophrenia and give examples of how other sufferers have coped with the symptoms. He suggested that practitioners associated with his CTO offered this reassuring and positive approach, holding his hand, and guiding him as he negotiates his illness experience. These qualified people appeared to help Jim maintain stability and balance whilst he attempted to 'better' himself by exploring and understanding his illness.

Some participants also described getting help on the CTO from sources other than mental health services. For example, Micky felt that non-statutory workers from the voluntary sector offered help on a regular basis as a direct consequence of the CTO. In Extract 6:55, Micky perceived that his Touchstone worker was paid to spend time with him and to help him socialise. Micky was asked if the worker knew about his CTO and Micky agreed to the shared knowledge. Although Micky was confused about the number of hours he was allocated, he was clear about the purpose of the visits and the way it was intended to help him.

Extract 6:55

'He is a Touchstone worker. He works for Touchstone. I get SDA, self-directed assessment. That goes to social services to people who might get paid to help me. Touchstone are one that get paid to help through me getting that money. Six hours, I think it's six hours a week, I get. Six hours a day, not six hours

a week. Six hours a day they can spend with me... or a week. I don't know. Confusing. Not sure (...) They're informed about me, yeah. Yeah, I'm OK with that, yeah (...) Yeah, they can be very helpful, they take my mind off things, they get me involved in socialising with people. I went to the Christmas party. We have us Christmas party every year.'

(Micky 2:55:11-26 & 2:56:1-6)

By the end of the extract he had aligned himself with the service, telling that 'we have us' a party every year. For participants such as Micky, the CTO enabled additional help to be enlisted for important ancillary therapeutic activity. It was important for Micky to 'take his mind off' his perceived problems by socialising with others. Micky described that workers helped him to get 'involved', which he had previously been unable to do, and was particularly important at certain times of the year such as Christmas, which may have been lonely periods in the past.

This theme reflected participants' need for, and value of, contact and assistance from mental health services and other associated agencies. Although the interventions offered during visits were not extensive or intensive, they did support and reassure participants, which translated into general feelings of stability and having key needs met. Participants valued the informal and unstructured approach offered by services and agencies, which were described as highly effective even though the techniques used were low visibility and non-specific, such as 'help with bits and pieces' and 'socialising with others'. Participants indicated that their mental health problems could destabilise and relapse could occur without intervention from others and that the CTO offered regular contact with these skilled helpers who were often perceived as replacement family offering practical help and advice. The descriptions offered by participants reflected the need for regular minor interventions from practitioners to maintain 'an even keel' even though participants would still prefer to be able to remain well by their own efforts alone or with the help of family members rather than statutory services.

6.2.5.2 Theme 2 – Nobody can touch me

Above and beyond the safety net in transitional times, some participants felt that the CTO offered a new level of protection not previously experienced. This perceived security was from non-specific threats, from community dangers and financial difficulties. Participants perceived that although community living offered opportunities and freedoms it could also involve hazards, uncertainty and trouble for people with mental health problems. Certain participants felt that the CTO offered comprehensive protection from these potential problems, giving rise to feeling sheltered at home and in the community, affording them additional protection from external pressures and a better quality of life.

Previous themes have featured participants' mistrust of CTOs because of the emphasis on a return to hospital if certain conditions were not met. However, Mary, for example in Extract 6:56, after initial mistrust and suspicion, felt comprehensively protected, emphasising that this protection was unlimited and extended 'round the clock'.

Extract 6:56

'At first I thought, a trap, if I did owt wrong I'd go in hospital but it's not that at all. You're more protected out in the community than I've ever had before and that's not just during the day, it's at night, round the clock twenty four hours protected is that.'
(Mary 1:12:2-8)

She initially felt that the CTO was a 'trap' to return her to hospital if she contravened her conditions by doing 'wrong'. She later felt this was not the case and there was flexibility in the system to incorporate some leniency and tolerance thus relieving her of responsibility to behave perfectly all the time. She perceived this liberal approach as protection under the CTO. This extract suggested that Mary felt protected from threatening elements of the community by the 'official' nature of the CTO. She also felt protected from a low threshold for admission to hospital if she 'did [anything] wrong'. Her response suggested that she felt that the CTO is respected by other agencies she had come into contact with in the

past out-of-hours, and had possibly been subjected to perceived mistreatment as a result.

The sanction of a return to hospital was a recurrent feature of participants' narratives and was often quoted as an undesirable consequence of behaviours that suggested relapse or which contravened the conditions of the CTO. However, Mary went on to describe, in Extract 6:57 that she felt insulated from this type of sanction, as well as feeling able to do as she 'wanted'.

Extract 6:57

'Well, I was one of the first people that went on it and I was a test to see if it works. Most people went on it and are on it would rather end up in jail or [locked PICU], at the time I was a success story 'cos I'd been on it twelve months and loved every minute of it I were doing this doing that, doing everything I wanted and nobody could touch me. Because how can they ring up and say "this person needs locking away" when they already are in the community and they're not really doing much. It gave me a new lease of life which did me good.' (Mary 1:14:15-26)

She felt protected and secure in that nobody could 'touch' her as she was already metaphorically 'locked-up' in the community. Mary reported that most people would 'end up' in hospital or jail, but for her the CTO was an alternative 'success story'. The CTO enabled Mary to make a new start that had successfully already given her a 'new' life for twelve months at the time of the interview. Thus, Mary also felt more secure and protected from unwarranted admission whilst on the CTO even though she felt that she was acting as a 'test' case and would be monitored 'to see if it works'.

Other participants felt protected by this monitoring in the community; they were positive about being supervised in order to avoid problems that they had found difficult to manage in the past. For example, Jim was generally positive about his experience of the CTO. In Extract 6:58, he felt that the CTO kept him from choosing 'dangerous paths'. Jim described feeling this as a form of positive

control which helped offset his hesitancy in 'keeping' him from taking the options that he associated with danger:

Extract 6:58

'Well it keeps me, sort of like, keeping me out of going down dangerous paths.' (Jim 1:19:20-21)

Jim described in Extract 6:59, feeling that the world can be a dangerous place when you have a mental illness. Jim felt that the CTO helped him to 'take on' some of life's challenges and appreciated the support around potential consequences. Jim described feeling afraid of possible outcomes in this 'unsafe' place and valued the perceived security offered by the CTO:

Extract 6:59

'And like with mental illness it's a little bit like that. You won't take on the challenges in life 'cos you're afraid of what the consequences might be. I mean, er, the world's not really, well, it's not as safe as what it could be. I mean er, it can be quite a dangerous place out there sometimes.' (Jim 1:33:13-20)

As a consequence of the CTO, Jim therefore felt insulated and protected from his own tendencies to inadvertently expose himself to danger, and that those dangers were inherent to the world 'out there'. He implied that the CTO allowed him to accept additional uncertainties because he felt more secure within the framework of the CTO.

Not all the protective characteristics perceived by participants were as a direct consequence of the CTO; rather, they could be available as ancillary services intended to supplement the formal CTO process. For example, Joyce described feeling that being on a CTO gave her access to counsellors and psychologists and 'things like that'. In Extract 6:60, she described feeling that the CTO allowed her to live her life 'as' a normal person although she did feel that taking tablets was outside this 'normal' activity.

Extract 6:60

'You're just living your life as a normal person apart from you've got a few tablets to take, and, you know, I think it's good that you've got the facility to, that you can use counsellors, psychologists and things like that.'

(Joyce 1:31:16-21)

Joyce felt that taking tablets was an inconvenience, but it formed part of a holistic approach when combined with psychological therapies. Joyce felt that she had a choice about using the psychological 'facility'; this contrasted with mandated compliance associated with medication. Joyce felt that the CTO offered the security and protection of a holistic approach to treatment and to live as an otherwise 'normal' person.

Other participants perceived the CTO process as offering attitudinal and material benefits in their pursuit of a better quality of life. Micky, in Extract 6:61, felt he was given choices under the CTO which he described as 'pluses' that encouraged him to improve his health and made him feel more comfortable. However, Micky also felt that being on a CTO signified that he was a 'more serious case', which authorised entitlement to additional financial benefits. Micky contrasted his situation with service-users not on a CTO who he felt got 'it hard'. Micky felt that although he did not really want to be on a CTO, he perceived himself as more supported and generally 'better off' as a consequence:

Extract 6:61

'It makes me comfortable, it makes me feel comfortable in being on a CTO that way, you know, it does. I don't really want to be on a CTO but at the same time I'm thinking there's pluses to being on a CTO, you know (...) It does make a difference, yeah. Better quality of life really. I think. You know. It encourages me to do things for myself health wise, you know. It does, yeah (...) Well yeah, I feel more supported and better off than other people, in fact (...) it also improves the amount of money I get, social and that. I get more money than most people and the CTO, being on the CTO makes you better off

as well, moneywise (...) Yeah, you get more money. Them, not on a CTO they get it hard, you know. You get somebody on a CTO and they're considered a more serious case, you know, still ill but basic lunacy. It's like [unclear] but being on a CTO I get more money and it helps me get benefits that other people don't really get, less seriously ill, you know, or whatever.'
(Micky 1:17:6-26 & 18:1-18)

Micky perceived the CTO as a marker for being 'still ill but [with] basic lunacy', which he felt entitled him to additional benefits and placed him in a comparatively advantageous position. The CTO afforded him 'more serious case' status which also helped with his health motivation; it generally encouraged him; and even helped him get benefits that others, suffering from less serious mental illness, were denied. Thus, Micky felt the CTO provided him with an advantage over others and legitimised some aspects of his illness. This would feel especially important for Micky who, otherwise, felt marginalised and misunderstood, therefore contributing to his quality of life.

This theme comprised participants' descriptions and perceptions of stability, security and protection offered by the CTO and associated care. Participants felt that their day-to-day choices were limited, controlled and guided in a positive manner so that they could be therapeutically directed towards a better quality of life. In this way the anxieties associated with unwise decisions and unpredictable outcomes were minimised or eliminated. As well as assisting with choices and alternatives, participants also perceived the CTO as offering necessary incentives that could offset the difficulties associated with severe mental illness in the community. The CTO represented a commitment from mental health services to ensure that extra levels of care, security and protection were available to participants throughout the duration of the order. However, there was also an undercurrent of regret that participants were suffering from an illness, as without this diagnosis there would be no need for any additional care, security or protection.

6.2.5.3 Theme 3 – It'll bring me home

This theme reflected participants' perceptions of being maintained or returned to their comfort zones where participants felt more at ease, in control and experienced low levels of anxiety and stress. These personal spaces could be perceived as the country; a familiar home city; and a more abstract, indeterminate personal environment; within the home, or, more specifically, within the close family circle. Participants felt that the CTO could protect them from removal from, or securely return them to, these important places if they found themselves with the threat or reality of being, abandoned or displaced.

For example, Mary described feeling protected from certain elements of the local community and also if she went abroad. In Extract 6:62, she felt that if she experienced problem in a foreign country, the power of the CTO would allow safe return home.

Extract 6:62

'They know already and just put the phone down on them and this is what's been happening and this is why it protects me in the community (...) So if I go to a foreign country it's going to protect me straight away, 'cos if I can't get home, the CTO will bring me home.'

(Mary 2:27:7-19)

Mary felt that the power of the CTO was far-reaching and extensive, if it could offer international protection, then the power it is able to offer in her local area would be considerable. She perceived that people in her local area would already know about the security offered by the CTO and if she experienced problems over the phone, the CTO would offer protection. Mary felt that the local community would be aware of the comprehensive protective power of the CTO and that this power could even reach beyond national borders; able to return her to her place of safety.

William, in Extract 6:63, had a similar feeling that the 'official' nature of the CTO would ensure he was listened to in an emergency and be given the appropriate

response. However, William is not entirely committed to this potential benefit, only 'suppos[ing]' that the CTO would help in this contrived scenario.

Extract 6:63

'I suppose it does, yea... 'Cos if I'm on a CTO staff would take more notice of me if I needed to phone up in an emergency or something like that' (William 1:9:22-26)

Barbara, in Extract 6:64, described feeling relieved when she was returned to her home town on a CTO following a lengthy hospital admission in a distant city.

Extract 6:64

'It was just a mental relief just to be back in [town name], nearer my family, near things that are familiar to me, memories, some that I want to keep and some that I don't want to keep, new memories that are in the making and I just got on with my life as soon as I got back in [town] from day one, picked up where I dropped off with in mind the mistakes that I've made in the past to correct myself as I went on.' (Barbara 1:11:8-18)

Barbara not only felt important 'mental relief' at being near familiar people and belongings, but also to be reunited with familiar memories. She further described that some memories she would want to keep and others to attempt to forget. She also felt that she could create new memories as she returned to renew her life in her home town. Barbara perceived the new start as an opportunity to learn from her past mistakes and restart where she left to go to hospital. Barbara felt that the CTO offered her the security and protection associated with a return to familiar surroundings, but also the opportunity to make a new start, learning from, and attempting to correct, past mistakes.

Other participants felt that the CTO offered opportunities to 'make the most' of life back from hospital into the community. Although, in Extract 6:65, Jim had a more abstract and non-specific perception of these opportunities, he felt that being a hospital patient was not solving his problems.

Extract 6:65

'And I know the fact that, basically, erm, the hospitals and the people around coping with me as a patient find that they really can't solve the problem what I've actually got in the fact that I'm very lack of, I don't try hard enough to sort of, like, find my way through it. (...) try and make the most of what life offers you in the opportunities that it gives you.'

(Jim 1:17:26 & 1:18:1-6 then 1:18:26 & 1:19:1-2)

He perceived his comfort zone as not being as being at home and the CTO afforded that opportunity. Jim described being aware that he did not 'try hard enough' to work his way through his problems, but suggested that he felt the solution was restricted in hospital, amongst staff and other patients, but supported on a CTO in the community he was free to make 'the most of' life.

Other participants described feeling increased opportunity and freedom on a CTO, with more choices and greater liberty. In Extract 6:66 Mary described leaving hospital with more geographical options as well as occupational choices.

Extract 6:66

'If I wanted to go off somewhere, at any time I was saying 'what shall I do now, shall I do this shall I do that'. Whereas before when I left hospital I always had that niggling feeling that I was going to get the knock on the door. I remember, you know stuff like that and it was a horrible feeling. This, keeps you in step, you're not going to get the knock on the door you're worried about.'

(Mary 1:15:2-12)

She contrasted this feeling with previously inhibiting and 'niggling' sense that there would be a 'knock' on the door that signalled a premature return to hospital, which she re-experienced as a 'horrible' feeling. For Mary this potential invasion of her personal and secure space was a constant subconscious threat and worry. She perceived that the CTO protected her from this sanction and allowed her to be 'in step' with the flow of her life and to maintain a normality free from

unnecessary worry and anxiety. Essentially, Mary felt that she could not be unexpectedly readmitted to hospital as she was already 'detained' in the community on a CTO.

For several participants, an important aspect of the CTO was the perceived freedom to be with family at home rather than being in hospital. Joyce, in Extract 6:67, described feeling that the CTO offered her some security that she could remain at home and she felt protected from a return to hospital.

Extract 6:67

'Just, even, just to see her smile and to see her every day. I just think this, you know. This is it this is life, know what I mean, and seeing my partner every day without him having to come to the other side of [city] every day just to visit me in hospital and it's like you lose so much freedom when you're in hospital.'
(Joyce 1:14:18-26)

She was confident of being able to see her daughter and partner every day rather than uncertain visits to a distant hospital. Like many of the participants, she experienced a feeling of joy at the 'normality' of everyday life without the constant threat of hospital admission. For them the CTO represented 'freedom' and 'life', protected from negative inpatient experiences, securely in contact with loved ones at home.

For participants contributing to this theme, the CTO was perceived as offering stability and security for important personal contact in the community and the protection of comfortable and safe spaces. Some of the constant worries and anxieties associated with possible hospital admission were perceived to be minimised. As a consequence participants could engage in 'normal' activities on a personal, social and community level. Participants described feeling more relaxed, carefree and able to enjoy their perceived normalcy without fear of resultant problems or difficulties contributing towards another hospital admission. They variously described only being able to really 'live' outside of hospital and out in the community.

6.2.6 Cluster C – Summary

This cluster comprised three themes under the title *Consolation and Compensation*. The themes were broadly all positive about the benefits the CTO. The promotion of stability was a consequence of knowledgeable monitoring and support from practitioners involved in care. Some participants felt insulated from community hazards and dangers under the safety and protection offered by the CTO. People felt that they could be maintained within their recognised comfort zones, or returned to these safe spaces if they found themselves isolated. Some felt that this protection could operate at a subtle interpersonal level and also at a higher official level where international incidents could even be rectified. All of these positive elements of CTOs combined to leave individuals feeling more secure, less anxious and, paradoxically, more in control, able to live their own daily life because of the small interactions.

6.3 Findings and analysis conclusion

Participant descriptions, feelings and perceptions of CTOs were organised into three clusters which comprised five themes of negative responses; four themes of ambivalent responses; and three themes of positive responses respectively.

The cluster with the most themes and which most participants contributed, Cluster A, was grouped under the heading *Pained and Powerless*. Participants felt that the CTO was an extension of their previous inpatient detentions (Sec 3 of the MHA). They compared their understanding and feelings under the CTO to the traumatic experiences as a previously detained inpatient. Those combined past and present feelings were often described in criminal justice terms of sentencing and punishment. The punishment was sometimes perceived as extreme and abusive which left individuals feeling oppressed and powerless. The use of powerful drugs added to the perception of relived trauma where participants described bullying and intimidation rather than therapeutic input and compassionate care. Often, participants felt that their CTO had been imposed without rationale or due consideration and past information had been misused in order to justify and maintain abusive actions by professionals and practitioners.

Cluster B was titled *Alignment and Reconnection*, where participants were tentatively negotiating a recovery away from mental health services in the community. This was perceived by participants as a difficult, confusing and unpredictable process where the CTO could both help and hinder. Participants experienced problems in making sense of these feelings, with recovery compromised by unresolved ambivalence. However, despite inherent difficulties, participants perceived themselves capable of recovery and able to identify personal action. Attempts at enlisting the help of family and friends were, again, met with ambivalence; with ultimate responsibility remaining with the individual participant. Participants felt separate, visible and labelled as different in the community which could have a significant impact on societal relationships. The CTO both assisted participants and also acted as a barrier to a recovery towards normalcy; but despite some potential problems, was always better than being in hospital for participants. Participants sought advice and guidance from kinship groups although were often unsuccessful in maintaining affinities with such groups.

Cluster C was headed *Consolation and Compensation*, and was a conditional positive response to the CTO. The order was perceived to provide balance and stability in a problematic and potentially hazardous environment. A better quality of life was felt to be a consequence of the perceived protection and security offered by the CTO. Participants felt that the CTO could maintain them in their comfortable spaces or even return them to these places of safety if individuals found themselves isolated and vulnerable.

Participant responses were mixed within the clusters but, in general terms, the three clusters could be strongly aligned with negative, ambivalent and positive responses respectively. More specifically, participants felt negative because the CTO involved re-living, and sometimes amplifying, previous trauma: ambivalent because of the uncertainty and difficulty involved in recovering a normalcy in the community; and conditionally positive because of perceived ability for the CTO to perform an official maintenance or rescue function. Across the responses, participants also experienced differing positions in relation to mental health

service decisions. Participants also differed in their perceptions of the intent of others, and their own sense of wanting to recover within a sometimes difficult community environment. Overall, the findings and analysis indicated that participants felt that they were subjected to negative coercive and controlling interventions rather more positive therapeutic approaches under a CTO. However, this tentative position was also subject to significant ambivalence that could, at times, modify this experience for participants.

Chapter 7

Discussion

7.1 Introduction

It is evident from earlier developmental considerations and examination of the effectiveness literature in Chapters 2 and 3, that there is considerable ambivalence about the continued use of CTOs. This ambivalence is echoed in reported service-user experiences of CTOs. Although ongoing CTO use is indicated both nationally and internationally, their impact on service-users is still not fully understood and remains the subject of much controversy and contention within the mental health community (O'Brien, McKenna *et al.* 2009). It is important, therefore to better understand the service-user lived experience on a CTO and to further understand the impact of the diverse range of those experiences. Service-user responses to CTOs have broadly been categorised in the literature into negative, ambivalent and positive responses. The detailed data from the current study can also be organised into these general categories, but the richness and texture of the current data enables greater understanding of how this diverse range of responses can directly impact on daily lives.

The current study has generated in-depth data on the lived experience of service-users subject to a CTO, represented by clusters entitled *Pained and Powerless; Alignment and Reconnection; and Consolation and Compensation*. The following discussion may further inform the debate about CTOs and offer new perspectives, alternative viewpoints and interpretations of the service-user CTO experience. By incorporating and combining themes, emergent constructs and theory from existing qualitative studies and associated literature with the findings and analysis of the present study, the body of knowledge may be extended and clarified. As well as comparing findings, this chapter examines emergent constructs from the literature. These constructs are then used as interpretive lenses to facilitate further understanding of how service-users make sense of their CTO. The emergent constructs can also act as wider sensitising concepts that may provide alternative considerations and approaches to CTO implementation. These additional perspectives may subsequently inform and

guide practitioners towards interventions that could modify, and enhance the service-users' CTO experience. The richness and depth of data from the current study can combine with these alternative viewpoints to add detail and precision to potential CTO interventions. These interventions would be aimed at reducing negative reactions to CTOs, increasing positive reaction and clarifying ambivalent responses, thereby improving overall CTO experience and effectiveness. Finally, this chapter investigates the use of a theoretical framework to provide a simplified structure of elements that could modify and mediate the service-user response to CTOs.

7.2 Comparison of findings

Many of the existing qualitative studies identified three main typologies of responses to CTOs namely: a negative response, an ambivalent response, and a positive response (Gibbs, Dawson *et al.* 2005; Gjesfjeld and Kennedy 2011; Jobling 2014). The findings of the present study corresponded to these typologies in that Cluster A was mainly generated from negative participant experiences; Cluster B from ambivalent experiences; and Cluster C more positive participant experiences. However, the majority response across the present study data set was a perceived negative experience of CTOs and was associated with a 'pained' reaction, indicating hurt and upset. Brophy and Ring (2004) as well as Riley and Hoyer (2014), also identified a majority negative response from CTO service-users, with Gibbs, Dawson *et al.* (2005) and Iris Gault (2009) reporting a positive majority response, the remainder variously described ambivalent majority responses.

Other existing qualitative studies identified alternative groupings and themes that indicated potential for a shift in attitudes across the typologies. For example, some studies suggested that CTO service-users experienced a process of change over time leading to acceptance or resignation (Canvin, Bartlett *et al.* 2002; Gault 2009; Scheid-Cook 1993), which suggested a change from negative to more positive response. A few of the existing studies grouped responses around service-user understandings of the legal processes involved (Atkinson, Garner *et al.* 2002; Canvin, Rugkasa *et al.* 2014; Gjesfjeld and Kennedy 2011) with the suggestion that understanding led to a more positive response and

misunderstandings leading to a negative response. The remaining studies reported an amalgam or generalised variation of some of the positive or negative themes. The themes generated from the current study, although often resonating with the negative, ambivalent and positive themes of the extant literature, were potentially more informative as they focused on the texture of individual participants' thoughts, feelings, understanding and lived experience on a CTO as outlined in the following discussion.

7.2.1 Negative experiences of CTOs

In the extant literature there is a reported general acceptance by both professional and community groups that the negative effects of CTOs include reducing a patient's autonomy, effectively limiting their choice to either accepting treatment in the community or being recalled to hospital (Newton-Howes and Banks 2014). This has been termed by some as 'coercive practice' (see 7.3.1) and is repeatedly identified throughout the existing qualitative literature as being against the service-users' best interests (Lawton-Smith, Dawson *et al.* 2008), as well as compounding service-users' feelings of powerlessness (Schwartz, O'Brien *et al.* 2010). Some of the existing studies identified problems for service-users negotiating and communicating with professionals as well as problems accessing services and wider treatment options (Atkinson, Garner *et al.* 2002; Light, Robertson *et al.* 2014; McDonnell and Bartholomew 1997). Other extant studies found that service-users were subjected to increased stigmatisation, disempowerment, excessive control and discrimination as a consequence of the CTO (Brophy and Ring 2004; Riley, Hoyer *et al.* 2014; Scheid-Cook 1993; Schwartz, O'Brien *et al.* 2010). It is clear from the extant literature that the negative experiences of CTOs are complex and diverse, but are generally experienced as unpleasant by service-users. However, these experiences are generally interpreted in clinical and professional terms, such as disempowerment, stigmatisation and discrimination, which add a further layer of complexity and potential for misunderstanding.

These reported complex negative experiences and outcomes identified in the extant literature resonated with the negative themes generated in Cluster A of the present study. Some of the themes incorporated in this cluster were voiced by all

participants and reflected the feelings of pain and powerlessness associated with the order and provided more detail about the nature and intensity of these feelings from richer data and in-depth interpretation. For example, participants in the current study felt that the CTO was similar to, and conflated with a hospital section, akin to re-living negative hospital experiences. This led to increased confusion and distress for service-users. Participants reported feeling that the CTO was a type of disguised or hidden 'section' which equated to the authoritarian-type sections applied in hospital.

These feelings would confirm and provide essential detail to the 'coercive practice' described in the extant literature. Service-users also felt they had been sentenced to the CTO without due consideration or an explicit rationale which would correspond to the discriminatory practice reported in the literature. Descriptions from participants included horrific treatments implemented as criminal punishments by professionals with uncertain motives, questionable therapeutic intent and even perceived as practicing experimental science. All of which adds detail to the previously reported disempowerment and excess control which is contrary to service-user best interests. The qualitative literature (for example, Gault 2009; Light, Robertson *et al.* 2014; Ridley and Hunter 2013) recommended that any therapeutic interventions should attempt to address these potentially distressing feelings. The data from the current study indicates, for example, that providing written and verbal information to service-users about the clear differences between a CTO and hospital inpatient section would allow service-users to challenge, discuss and re-evaluate the similarities and differences in the two types of detention.

The perceptions of sentencing and quasi-judicial process were reinforced by participants in the current study by constant comparison to experiences when previously detained in hospital. For many participants, the CTO was viewed as an extension of their legally and physically enforced inpatient section, thus adding to the perceived power and effect of the CTO. As a consequence, participants felt that they had been deceived and neglected and that their care was substandard, imposed without negotiation, and any mitigating circumstances had been ignored. Participants, therefore, felt bullied and intimidated into accepting unwanted

treatment and felt that their history of deviant behaviours, incidents and responses had been misrepresented and incorrectly recorded as misleading re-scripted evidence. For participants in the current study, CTOs had a covert and clandestine quality, characterised by secret meetings, injustice and infringement of service-user rights, which they found dehumanising and humiliating. Most, but not all, participants felt that they were victims of a power imbalance with practitioners, where they had little personal control over the restrictions imposed by professionals under the CTO.

The literature highlighted the need for collaborative and reciprocal practice (Gault 2009; Light, Robertson *et al.* 2014; McDonnell and Bartholomew 1997) in order to improve this experience, but is limited on the precise interventions and approaches that may be necessary. The current study details experiences that would benefit from the development of open and honest relationships with service-users, concentrating on establishing legal rights and developing lines of communication between service-users and professionals. Service-users could also be assisted in identifying areas of personal power, for example, possibly fostering links with other service-user groups and advocacy services. Thus, by using the detailed descriptions generated by participants in the current study, practitioners may be assisted and guided towards more therapeutic implementation strategies that could reduce the negative experiences currently associated with CTOs.

7.2.2 Ambivalent experiences of CTOs

The major typology grouping of themes identified in the existing qualitative literature was one of ambivalence. For example, Canvin, Bartlett *et al.* (2002) found that:

‘Individual service-users are capable of seemingly contradictory responses, simultaneously accepting and resisting the orders’. (p361)

Light, Robertson *et al.* (2014) described service-users’ lived experience of CTOs as one of complexity and ‘profound ambivalence’ (p345) whilst simultaneously

acknowledging that these are imprecise terms. This arose as a consequence of service-users' simultaneous perception that CTOs are coercive, constrain both agency and autonomy; but that they may also be beneficial in terms of treatment. O'Reilly, Keegan *et al.* (2006) also found that patients had contradictory feelings about CTOs citing coercion versus necessary structure. Dawson, Romans *et al.* (2003) found that 'freedom' was also a relative and ambiguous term for service-users such that the CTO could advance or limit freedom depending on life circumstances. However, in their discussion of ambivalence, researchers often combined the mixed feelings of practitioners, users and carers together with subjective service-user views about efficacy, ethical perspectives and treatment (Canvin, Rugkasa *et al.* 2014; Gjesfjeld and Kennedy 2011; Stroud, Banks *et al.* 2015). Thus, authors reported wide ranging, diverse and complex responses which, according to Dawson, Romans *et al.* (2003), can be subject to radically different, contradictory, interpretations or judgements.

In the current study, participants were able to describe more specific feelings that contributed to ambivalence under the title of *Alignment and Reconnection* in Cluster B. Some of the themes incorporated in this cluster were voiced by all participants and reflected the uncertainties and indecision associated with CTOs whilst attempting to balance the competing connections to mental health services and community independence. Participants in the present study perceived difficulty in understanding and reconciling the impact of mental illness on their ability to function in the community. Comparisons were made by participants between periods in hospital and periods in the community, which were both subject to the cyclic and intermittent nature of mental illness. Such detailed descriptions indicated that additional strategies could be adopted when the CTO is implemented. For example, the identification early warning signs of relapse with service-users and development of self-management strategies could help service-users avoid the extremes of the condition.

As a consequence of possible periods of relapse and recovery, participants in the current study felt fearful and uncertain about their future, and experienced perceptions of separation and loss, as well as difficulties in self-motivation. Despite these problems, participants in the present study also felt a strong sense

of resilience and a determination to overcome difficulties. Participants described a perceived ability to accept the enforcement and restriction associated with CTOs, despite the adversity that the order imposed, but they also described a perception that family and friends tended to minimise or avoid the detrimental effects of the CTO. A strong feeling of difference was described by some participants in the current study, where perceived abnormalities resulted in increased stigma, confrontation and ridicule from others as a consequence of symptoms of mental illness and the side-effects associated with medication. By encouraging service-users towards peer groups and other 'experts-by-experience', for example, these feelings of separation and difference could be addressed.

7.2.3 Positive experiences of CTOs

According to Newton-Howes and Banks (2014), positive themes in the existing qualitative studies were broadly based around increased access to services and the advantages of CTOs over hospital admission. Gibbs, Dawson *et al.* (2005) found that the majority of participants in their study were generally supportive of CTOs, especially as an alternative to hospital. They found that many patients valued access to services, a sense of security and improved mental health as a consequence of treatment (Gibbs, Dawson *et al.* 2005). Other existing qualitative studies emphasised positive aspects of CTOs as being able to live at home, having access to assistance and stable therapeutic relationships (Riley, Hoyer *et al.* 2014). Ridley and Hunter (2013) found that service-users viewed CTOs as a 'welcome development' (p516), particularly when compared with hospital-based alternatives. However, though they were not entirely antagonistic towards CTOs, they felt that it would better to be able to live a completely free 'normal life' (p516) away from powerful medication and intrusive mental health services (Ridley and Hunter 2013).

Positive experiences in the current study were only voiced by 40% of the sample and were confined to the *Consolatory and Compensatory* themes of Cluster C. Participants in the present study felt that, ideally, they would prefer not to be on an order at all, but given that this was imposed on them, they described the details of positive interpretation on some aspects of their CTO experience. They

felt that they were assisted in maintaining stability and balance in their life; and a form of control, which enabled them to take some risks with the confidence offered by the security and support inherent in the CTO framework. This framework was perceived as offering security and protection through a monitoring and guidance function. Some participants also felt that CTOs were implemented with a leniency and tolerance that insulated service-users from some of the hardships of community life and half of the sample welcomed CTOs as an alternative to hospital admission offering additional choices and options.

These experiences resonate with the extant qualitative literature, both in content and proportionate response, although participants in the present study perceived them as more compensatory and consolatory in nature rather than unquestionably beneficial. However, the data indicated that basic interventions, such as reinforcing the practical benefits of regular contact with practitioners, may facilitate a shift from compensation towards essential benefit. Similarly, emphasising the importance of balance and stability, as opposed to the potentially extreme cyclic nature of mental illness, may help shift the perception of minor interventions from consolation towards highly valued benefit.

7.2.4 Diverse range of responses

On analysis, all participants in the present study contributed to at least one theme in Cluster A and also in Cluster B, and half of the sample contributed to themes in Cluster C (see Table 6.2). Participant responses in Cluster A indicated a robust and, at times, very forceful negative response. In contrast, participant descriptions in Cluster C indicated a more conditional and more subtle experience reflected in the consolatory and compensatory nature of the responses. However, when considering Cluster B, almost all the participants felt conflicted, inconsistent and lacking confidence, which was often as a consequence of uncertainty and subsequent confusion. This range of responses represented the diverse nature of participants' experience, which at different times, suggested a conflicting and contradictory perception of their CTO. However, when considering the wider literature some important conceptual constructs emerge from the body of knowledge, which may offer additional interpretive insight and elucidation into this diverse range of responses. These

emergent constructs may also offer a wider interpretive viewpoint for better understanding the differing responses as service-users attempt to make sense of their CTO experience. These conceptual constructs are examined and evaluated in the following discussion.

7.3 Examining emergent constructs

A conceptual construct can be defined as a complex of objects or perceptions, which share a common attribute or property and which are not directly observable or objectively measurable (Reber 1995). Several important conceptual constructs have been identified by service-users, practitioners and other stakeholders in the literature as closely associated with CTOs. This section will examine each of these constructs in combination with the present data. As previously mentioned, the following constructs may offer more expansive and alternative interpretive perspectives that indicate the use of other approaches in CTO implementation. Several of the constructs are general in nature and may characterise the experience of many people living with severe and enduring mental health problems. These constructs are: coercion; control; freedom; powerlessness; living at home; assistance; normality; and stigma. Other constructs apply more to individuals using specific mental health services and include: therapeutic relationships; medication and treatment. The final group is more applicable to those subject to CTOs and other mental health legislation, these more complex constructs include: dangerousness; uniqueness; asylum in the community; sanctuary trauma; recovery and institutionalisation. When examined in combination with specific experiential descriptions from the current study, these constructs may help practitioners formulate more effective approaches to improve the implementation of CTOs.

7.3.1 Coercion

According to Newton-Howes and Mullen (2011) there is potential coercion in every clinical encounter. Coercion has long been recognised as part of community mental health care (Geller 1995; Molodynski, Rugkasa *et al.* 2010; Newton-Howes and Stanley 2012). In the early years of compulsory community treatment in America, Mulvey, Geller *et al.* (1987), reviewed the practice as

'benevolent coercion' (p575), where treatment was provided under the threat of statutory action for patient non-compliance. However, the review proposed that such an approach rarely provided effective therapy, instead quickly becoming a function of social monitoring (Mulvey, Geller *et al.* 1987). Coercion in the context of CTOs incorporated other concepts, such as compulsion, leverage and threat (Molodynski, Rugkasa *et al.* 2010) and is used increasingly in community psychiatric treatment (Rugkasa and Dawson 2013). Coercion in psychiatry is considered a negative subjective service-user experience involving the loss of autonomy caused by the action of mental health services (Dennis and Monahan 1996; Newton-Howes and Stanley 2012; Rhodes 2000).

The use of coercion in mental health services is highly controversial within the current socio-political climate (Health 2013). The national guiding principles recommend that independence should be encouraged; with patients fully involved in decisions; they should be listened to; and treatment should have clear therapeutic aims that promote recovery (Health 2015). Participants in Cluster A of the present study felt that independence was denied, (Theme 1 *Sectioned in the community*). They did not feel involved in decisions, (Theme 3 *They stuck me on it*). They did not feel listened to, (Theme 5 *It's written down wrong*). Treatment did not appear to them to have clear therapeutic aims, (Theme 2 *Sentenced by the drug squad*); and, in fact, appeared counter-therapeutic (Theme 4 *Bullied and intimidated*).

According to Dunn, Sinclair *et al.* (2014) four ethical duties could be applied to decisions involving coercion in psychiatry. Although these were primarily intended for consideration by professionals, it is enlightening to consider these duties from a service-user perspective. The four ethical duties are:

1. To benefit the individual patient
2. To benefit other individuals (carers, dependents and the wider public)
3. To treat patients fairly
4. To respect patients' autonomy

The participants in the present study offered a mixed response about the extent to which these four criteria had been met through their experience on a CTO.

In consideration of Duty 1 for example, in Cluster A, Themes 2, 3 and 4, participants reported feeling 'sentenced' and 'stuck' on the CTO as well as 'bullied and intimidated'. Participants felt their treatment was more like abuse in the guise of therapeutic intent; they felt angry at being compelled to take powerful and dangerous drugs; they perceived care as malevolent and clandestine implementation of under a tyrannical system of services. However, in Cluster B, participants were unsure about the benefits of the CTO, with their 'head screwed-up'. Participants felt unsure about their personal capabilities; they were dubious about the contribution of friends and family; and felt the weight of societal pressures. In Cluster C, participants were more positive about the benefits of CTOs. Participants described perceptions of security and protection, as well as a feeling of insulation in the community. They were less anxious about potential threats, danger and problems; all leading to a perceived better quality of life. Practitioner interventions, therefore, could be aimed at emphasising the positive aspects of CTOs identified in Cluster C, which may then offset the more negative aspects, such as long alternative hospital admissions. However, the current data indicates that therapeutic evidence could be usefully offered to service-users around the use of medication and psychiatric treatment in the community.

When assessing the participant response to Duty 2, there was little evidence in the present study data that participants considered other individuals apart from limited perceptions in Cluster B around a desire to remain with, and not be a burden to, partners and close family relations. In examining participant feelings towards Duty 3, a thread of unfairness ran through Cluster A and, minimally, in Cluster B but, again, this would not constitute an overwhelming rejection of this duty. Finally, in considering Duty 4 and respect for autonomy, this thread did run through the whole sample and the three clusters. However, whilst in Cluster A and B, the lack of autonomy was a negative perception; in Cluster C the perception was more positive as participants appreciated the benefits associated with statutory services, professionals and practitioners taking responsibility. However, it is clear that service-users did not feel that these ethical duties were

generally being fulfilled, and that coercive decisions were being taken by psychiatry.

In the existing qualitative studies, the concept of coercion is implicit throughout the literature, but not explicitly explored in the subsequent discussions. Gjesfjeld and Kennedy (2011) found that service-users had little voice in the coercive process in general, but did not fully understand the coercive requirements of the orders. In their review of the literature, O'Brien, McKenna *et al.* (2009) stated that several commentators noted that research had been unable to determine whether it was the services provided under compulsion or the compulsory and coercive nature of services that accounted for any observable benefits. Iris Gault (2009) identified a category string which indicated that therapeutic incompetence by involved practitioners increased the need for service-user coercion. Riley, Hoyer *et al.* (2014) discussed the perception that coercion was relocated from hospital into service-users' homes, and Gibbs, Dawson *et al.* (2005) found that coercion was necessary because it was strongly opposed by some service-users. These studies discussed the elusive and abstract nature of the construct and were unable to determine if coercion was a function or a product of CTOs.

Many participants in the current study did feel coerced and, at times, very distressed as a consequence. When assessed through the lens of the national guiding principles, participants in Cluster A of the current study clearly perceived coercion as a negative experience. For example, Elizabeth in Extract 6:9 felt suicidal because she was 'blackmailed' into accepting an injection in order to remain at home. Participants in Cluster C did not feel the same coercive practice. For example Joyce, in Extract 6:61, feels she just has to 'take a few tablets' in order to feel 'normal'. Thus coercion was perceived with ambivalence by participants in the current study. Participants described coercive practice as specific interventions, often linked to the use of enforced medication. In the current study, participants differentiated between coercive practice of professionals and the controlling approaches of mental health services which were more pervasive and perceived as directing the course of their lives.

7.3.2 Control

Participants in the present study expressed specific feelings of being controlled by mental health services; as well as feelings involving values and control imposed on them by the wider community. Teresa Scheid-Cook (1993) referred to these concepts as 'therapeutic social control and social control by normalisation' (p180 & p191). In the first of these concepts, she argued that 'treatment' becomes a psychiatric justification for control (Scheid-Cook 1991). In the second, normalisation controls choice by accepting that the 'normal' values and roles promoted by society are worthwhile and desirable (Scheid-Cook 1993). She further argued that when service-users accept CTOs as a means of greater liberty, by implication they participate in the consolidation of CTOs as an alternative to hospital admission. If service-users 'agree' to a CTO, they also agree to the norms and values operating in the wider community. Thus, it is argued that the combination of treatment and normalisation allows mental health services to use CTOs as greater social control (Scheid-Cook 1993).

These arguments are reflected in the present data, for example in Cluster A, Theme 4, participants felt 'bullied and intimidated'. Some participants within this theme felt they had to be available all the time for treatment, and they felt controlled to the point where Elizabeth, for example, felt she could not go on holiday (Extract 6:18); Barbara had been metaphorically manhandled by psychiatrists to remain in treatment (Extract 6:20); and Micky felt there were geographic barriers to preventing him leaving treatment in its wider sense (Extract 6:21). The threat of a return to hospital if treatment conditions were not met was implicit in these perceived controlling interactions. Goffman (1961) argued that institutional practice controlled service-users by creating and sustaining a particular kind of tension between the home world and the institutional world of the hospital and used this persistent tension as strategic leverage.

The data in the present study demonstrated that the threat of recall back to hospital created this strategic leverage. If the conditions of the CTO were not met or where early warning signs of non-compliance or deterioration were evident, service-users were subjected to corrective sanctions. For example, in Extract 6:18 Elizabeth feels that if she is not at home, 'they' send the police for her, who

take her to hospital, inject her and then send her home. However, these service-user perceptions could be 'softened' by the careful use of language. In his classic theory of freedom and control, Jack Brehm (1966) argued that the use of non-directional language had a softening effect on mandatory instructions. For example, the hard directional language implying 'you must ...' could be modified by language which implies 'some people find that ...'. Careful use of language such as 'looking out for people' can be considered instead of the language quoted by Barbara 'you will be watched and observed' (1:4:3-4). Such alternatives would be beneficial in the service-user experience of control.

In order to maintain control in the community, mental health services become involved in increased levels of surveillance (Rose 1999) and recognised by Michel Foucault as 'Panopticism' (Foucault 1977 p195).

'(...) everything the individual does is exposed to the gaze of an observer who watches (...) in such a way as to be able to see everything without anyone being able to see him (...) whether an individual was behaving as he should, in accordance with the rule or not, and whether he was progressing or not, in terms of what was normal or not (...) supervision and examination, organised around the norm, through supervisory control of individuals throughout their existence.' (Faubion 1994 p58-59)

In this way, the community's gaze is turned upon itself and participants described feelings of being watched and judged by allied and ancillary services, neighbours and the wider community. Data from the present study indicated that this community gaze searched for negative characteristics which then formed the basis of negative judgements. For example, in the current study, Cluster B, Theme 4, participants perceived they were 'labelled as a freak'. Elizabeth felt judged and stigmatised by society (Extract 6:46); Gerry avoided social interaction because of his mental health label (Extract 6:47); John felt labelled as a paranoid schizophrenic (Extract 6:49); and Pam felt that her neighbours examined her compliance, tested her reactions and ridiculed her because of her illness (Extract

6:48). These were all examples of the community watching suspicious individuals for potential signs of deviation from the norm, but the deviation was always in a negative direction, any positive movement was not acknowledged. The identification and subsequent emphasis on the more positive progress made by service-users could influence their presentation in the community and enhance self-esteem.

The majority of participants in the current study perceived being controlled negatively. However, some of the service-user responses in the extant literature did refer to the experience of 'positive' control (O'Reilly, Keegan *et al.* 2006). This positive form of control was only described by Jim in Cluster C of the present study. In Extract 6:58, he felt that the CTO prevented him from going down 'dangerous paths' (1:19:21). In this way, the CTO fulfilled a protective function, but more as a perceived consolatory or compensatory by-product of control rather than an unconditional benefit. When participants in the current study referred negatively to control, there was inherent implication that the preferred antithesis of this concept was the more positive construct of freedom.

7.3.3 Freedom

Nikolas Rose (1999) in his discussions on freedom, emphasised the distinction between 'negative liberty', where people are free to do as they choose regardless of impact on others; and 'positive liberty' in which the state sought to free people by coercing them to become wiser, more virtuous and healthier in order to achieve their freedom potential. This was described as mental health care or 'moral policing', which is imposed as freedom (Rose 1999 p67-68). As the concept of freedom becomes more important to service-users, so the threat to freedom becomes more effective in terms of leverage as a strategy to pressurise individuals into accepting treatment (Dennis and Monahan 1996). The strongest threat to freedom for participants was the potential for a return to hospital; a threat inherent in the CTO mechanism, and one which often remains persistent, subtle and unspoken in the consciousness of participants. The more insidious nature of this threat could be modified by identifying with the service-user, the precise conditions under which recall to hospital would become operative.

For participants in the current study, particularly in Clusters B and C, both the positive and negative aspects of liberty were considered far more preferable to remaining in hospital. For example, in Extract 6:52, Joyce felt she had been given 'a chance' (1:35:25) when she was removed from hospital onto a CTO. She perceived that she had been given 'an opportunity' (1:35:22) and a 'lucky break' (1:36:3-4) to treatment in the community on the condition that if she did not 'follow the rules' (1:36:1) she would be readmitted. However, in the community she could be free to be with her daughter (Extract 6:67), and 'just see her smile and to see her every day' (1:14:18-21). Mary tended to experience negative liberty. For example, in Extract 6:57, she felt she could do what she wanted and 'nobody could touch me' (1:14:20-21); and in Extract 6:66 she adopted a hedonistic approach, thinking 'what shall I do now, shall I do this, shall I do that' (1:15:4-5), safe in the feeling that the CTO would protect her from any adverse consequences. These two participants perceived their freedoms differently. For Joyce, an important aspect of her freedom was the altruistic benefit it conferred on her daughter. By contrast, for Mary, a more hedonistic aspect was important where freedom allowed her to do what she wanted.

Dennis and Monahan (1996) highlight the potential for leverage in two practical areas closely associated with freedom: money and housing. The implication was that withdrawal of community support in these two important areas would impact directly on the individuals' ability to maintain freedom. Data in the current study resonated with this recognised freedom. For example, in Extract 6:61 Micky felt that his CTO improved the 'amount of money [he] get[s]' (1:18:4). In Extract 6:65, Barbara perceived the CTO as providing relief in returning to her home town, 'nearer my family, near things that are familiar' (1:11:10). When attempting to describe their feelings of freedom, participants in the current study used specific examples that demonstrated the importance of the construct. Paradoxically, this importance allows mental health services to exert leverage using threats to withdraw freedom by way of recall to hospital. This paradox has been demonstrated throughout the current study.

The wider literature confirmed the complex and indeterminate nature of the concept of freedom. For example, Thomas Szasz (2008) who considered

involuntary treatment for mental illness as psychiatric slavery by depriving the mentally-ill their freedom and, if necessary, liberty. Other authors have discussed this issue of liberty versus therapeutic leverage and the use of 'therapeutic justice' (p199) to defend psychiatric paternalism and state intervention (Miller and Rose 1986). However, the relationship between freedom, therapy and paternalism remains divisive, contentious and only possible when power imbalance exists between service-user and mental health service-provider. Some of the difficulties associated with power imbalance could be modified by the development of effective therapeutic relationship which involves a 'temporary act of unison' (Barker and Buchanan-Barker 2005 p23).

7.3.4 Powerlessness

All the themes in Cluster A refer to the powerlessness of participants in the face of mental health services. Service-users are powerless to resist being *Sectioned in the community* (Theme 1); and *Sentenced by the drug squad* (Theme 2). This feeling of powerlessness is confirmed by Theme 3 (*Just stuck me on it*), as well as the feeling of being *Bullied and intimidated* (Theme 4), in spite of challenging the supporting evidence where *It's written down wrong* (Theme 5). It is not surprising that service-users experience such power disadvantages with respect to practitioners and professionals (McCubbin and Cohen 1996), as in order for CTOs, or any service leverage, to be effective they must be implemented by people who are perceived to have the power to act upon the conditions they impose (Dunn, Sinclair *et al.* 2014). Where the respect for authority of a CTO, for example, was absent then it was unlikely to achieve any positive impact (Stroud, Banks *et al.* 2015). Therefore, there has to be an inherent power imbalance integral to service provision in general and, more specifically, to CTOs in order for them to be effective (Dunn, Sinclair *et al.* 2014).

In the current study, John reports that his doctors force him, in Extract 6:7, to accept medication when John insisted that this treatment actually made him feel like 'death warmed-up' (John 1:22:20), and Elizabeth in Extract 6:10, felt like her treatment induced 'seizures' (1:1:21). Elizabeth attempted some resistance to this power in Extract 6:10, where she felt commodified as "a Guinea Pig for medical science" (1:13:1), she denied anything 'wrong with [her] brain' and was angry that

doctors were 'practicing' on her body (1:17:10-11). However, McCubbin and Cohen (1996), argue that powerful professionals assume that service-users are unable to identify the nature of their problems; therefore treatments are chosen by the practitioner, who was chosen by mental health services, and *applied to* the service-user (emphasis in the original). This medical model approach assumes a therapeutic paradigm where the passive, objectified service-user becomes more commodity for repair rather than person and his or her behaviour becomes medicalised into biochemical disease, residing inside the service-user but outside their power (McCubbin and Cohen 1996).

Unfortunately, the types of expression used in the preceding extracts are often viewed by psychiatrists as disordered and precisely what needs to be modified by treatment (McCubbin and Cohen 1996). Service-users are therefore sometimes reluctant to articulate their subjective experiences using direct language (Bentall 2009). Service-users then often use metaphor to compactly convey what otherwise would be dismissed as unreliable (Mould, Oades *et al.* 2010). For example, in the current study Barbara used a powerful metaphor to express the pain she has endured through her contact with medical professionals (Extract 6:1). However, this use of indirect language can increase powerlessness (McCubbin and Cohen 1996) and can be misinterpreted as an indicator of moral weakness or poor character; often reinforcing a service-user stereotype as socially awkward, odd and different (Link, Mirotnick *et al.* 1991). In order to avoid this moral weakness paradigm, participants can seek refuge in an extended medical model and expanded practice of psychiatry (Rose 1999). For example, in the current study, Joyce, as well as using a safety net metaphor in Extract 6:51, she also considered herself 'normal', in Extract 6:60, except she has to take 'a few tablets' and has access to counsellors, psychologists 'and things like that' (1:31:19-22).

Enforced medication and treatment-induced dysfunction can also increase service-user powerlessness (McCubbin and Cohen 1996). Peter Breggin introduced the term 'iatrogenic helplessness' (Morgan 1983 p39) where psychiatry induces fear and helplessness in patients through the use of authority and powerful psychoactive medication. This iatrogenic helplessness can often be

as a consequence of side-effects of psychotropic medication although it is claimed that these are often underestimated, denied, ignored or rationalised by clinicians (Bentall 2009). Participants in the present study perceived themselves as being effectively punished, silenced or ignored by their doctors and their use of medication. For example in the current study, Micky described, in Extract 6:50, feeling vulnerable with involuntary movement where he 'pulls faces on the bus' and lacks confidence as a result of 'just the look of me' (2:47:15). John also felt a lack of power when he could not enlist the help he needed as he was denied legal advice or representation; in Extract 6:19, he perceived 'they' always get him a doctor instead of a solicitor. This type of prohibition limits service-user access to expert knowledge and Foucault argued that knowledge was integral to the 'power relations at work in the problem of madness [and] medicine' (Faubion 1994 p284). Zur (2009) discussed two methods that professionals employ using their knowledge to exercise power over clients. These were 'expert-knowledge power' and 'imbalance of knowledge power' where clients cannot avoid 'losing power' (p163).

In the current study this use of knowledge usually referred to psychiatrists using their 'expert knowledge' to impose diagnoses through the interpretation of symptoms but also reinforcing an imbalance of knowledge through the 'threat of the medical record' (Freidson 1975 p167). This refers to the use of notes and records to reinforce and communicate decisions by recording rationales, conclusions and interpretations. These then become permanent 'facts' that are attached to the service-user even though he or she can vehemently dispute them. Examples of this phenomenon were described by participants in Cluster A, Theme 5 of the present study where participants felt that their history had, at times, been re-scripted and 'written down wrong'. John felt that a major report influencing his psychiatric journey was based on lies (Extract 6:22); in Extract 6:24, Micky felt that his attempts to be heard were misinterpreted as aggression; and William, in Extract 6:25, felt that his written history, although incorrect, was presented as fact that subsequently 'worked against' him (1:13:13). Participants in the present study felt powerless to challenge or change these records and perceived the maintenance of such notes as inaccurate and unfair. An alternative

approach is indicated where service-user challenges are also acknowledged and recorded in order to incorporate their life script.

In part, these power differentials can persist because of the reliance society and the State has placed on psychiatry to lawfully control mental illness and in exchange has often privileged medical opinion and power (Pilgrim and Rogers 2009). This privileged position, according to Szasz (2002), should be challenged by alternative perspectives and competing paradigms (Miller and Rose 1986; Rogers and Pilgrim 2014; Scull 1977) but, as yet, has not impacted on the lived experience of service-users (Stein, Leith *et al.* 2015). Elizabeth in the current study, for example in Extract 6:10 lamented on the decline of the country because she perceived a future where many people would be compulsorily treated with injections. In fact, in Extract 6:18, she perceived a situation where 'they're allowed to pick people out and inject 'em', (1:14:1-3). Pilgrim and Rogers (2009) argued that the current medical hierarchy and power base is under threat and the biomedical model is not sustainable; they predict that a biopsychosocial model with 'convivial multi-disciplinarity' (p959) is an essential factor in the future of psychiatry. This would suggest a shift in power relations in collaboration with service-users and the service-user movement (Bracken, Thomas *et al.* 2012).

The data from the current study and examples from the extant qualitative literature provide evidence of perceived powerlessness among CTO service-users. Individuals employ strategies that attempt to offset the associated power imbalance between clinicians and service-users. Such strategies are usually an effort to regain some degree of choice and control, or at least, to resist the authority and dominance of mental health services, often exercised in the guise of therapeutic intent. This authority is exercised by way of threat to perceived freedom to be able to live independently in the community. Participants in the current study react against such threats by challenging the supporting evidence, authority and power. However, the balance of power between practitioner and service-user is such that often such challenges are ineffective.

7.3.5 Living at home

Community living and integration is an essential element of treatment and recovery (Pahwa, Bromley *et al.* 2014). In a number of studies, living at home in the community conferred benefits of wider social networks, increased autonomy and a marked preference for community living as opposed to hospital admission (Roldan-Merino, Garcia *et al.* 2013; Tempier, Balbuena *et al.* 2012; Thornicroft, Bebbington *et al.* 2005). However, the data in the current study suggested that there was difficulty and uncertainty associated with *Alignment and Reconnection* (Cluster B) and community living. Participants in the current study were negative, or at best, ambivalent about being in the community. For example, in Extract 6:32 Joyce described feeling difficulty being in the community and trying to start again, and Jim, in Extract 6:34, felt he no longer had any great ambitions when he was living at home again. However, according to Lin and Peek (1999), a well-integrated community produces a sense of security and comfort, reduces deviant behaviour, and individuals can contribute to the group's welfare thus enhancing self-worth.

The UK Department of Health (2011) issued Guiding Values and Principles for better mental health care and stressed the importance of reducing isolation and building supportive community networks. The contention being that an individual in a wider social network is likely to perceive and receive stronger social support and role modelling (Lin and Peek 1999). The data from the current study suggests that the episodic nature of severe mental illness may prevent service-users with severe mental illness from integrating effectively in the community. When a participant has to *Dust yourself off* (Theme 2) following relapse, and is worn down by the need to *Just get on with it* (Theme 3), as well as experiencing being *Labelled as a freak* (Theme 4); it may be difficult to benefit fully from being at home in the community. Therefore, developing contact with peer groups and 'understanding others' may therefore have additional benefit for service-users.

Familial relationships are often at the core of social networks and enhance the ability to form close attachments to others (Nijdam-Jones, Livingston *et al.* 2015). Participants in the current study perceived difficulties in enlisting support from close family; for example, Joyce (Extract 6:42) and Barbara (Extract 6:43) felt

they were left to *Just get on with it* (Cluster B, Theme 3) with family passing responsibility back to them. Pam felt that her friends and family could not fulfil her needs (Extract 6:41) and Mary felt she was referred to her doctors rather than helped by close friends at home (Extract 6:44). Although participants cited these difficulties with family relationships as significant losses, they also reported that they sought replacement family relationships from practitioners involved in their care.

7.3.6 Assistance

Discharge from hospital onto a CTO is often conditional on allowing access to community mental health teams offering close support, but which also incorporates a monitoring and supervision function (Coffey 2010). Participants in the current study recognised that monitoring was inherent in the construct of assistance. For example, in Extract 6:2, Barbara felt that she was being watched and observed in the community; and Joyce, in Extract 6:52 accepted that she had got people monitoring her in the community. This combined assistance and surveillance function operated in a public climate of fear associated with mental illness; the 'risky image' (p176) of service-users has heightened the need to manage risk and future behaviours in community settings (Rogers and Pilgrim 2014). This is a reflection of 'wider risk-averse culture' where public anxiety is still attached to past high profile incidents (Coffey 2010). This, in turn, has led to the increasing use of 'surveillance medicine' and associated 'network of visibility' (p395) where future illness and risk potential is identified at an early stage. With CTOs, this conflation of assistance, support, illness potential, prediction of risk and deviant behaviours is generally accepted as a preferable alternative to hospital inpatient care (Manuel, Appelbaum *et al.* 2013).

Participants in the current study were resigned to the combination of the monitoring and support function of practitioner home visits. For example, Joyce accepted in Extract 6:52, that she had people 'backing you up and help[ing] you on your way' (1:36:10-11). In Extract 6:53, Barbara felt that the likely visits 'makes it a bit more comfortable being at home' (2:35:7-8), and even without the CTO she would still appreciate visits. Jim, in Extract 6:54, appreciated the input and advice from a cool, positive professional; and Micky felt that help from an

informed worker was very helpful (Extract 6:55). Mary, in Extract 6:56 initially thought her monitoring visits were more of a trap, but later perceived them as positive round-the-clock protection. The data indicates that careful reframing of the construct of assistance may be necessary to emphasise therapeutic intent and minimise the monitoring and surveillance functions.

7.3.7 Therapeutic relationships

References to difficulties with the therapeutic alliance as a consequence of CTOs tended to be generalised and non-specific in the existing qualitative studies. Ridley and Hunter (2013) highlighted the need for collaboration between service-users and professionals, but also acknowledged that in involving people to collaborate in their own detention may be problematic. Gjesfjeld and Kennedy (2011) argued that many service-users would continue to have a mental illness requiring intensive treatment; therefore strong therapeutic relationships need to be maintained to support future partnerships. Canvin, Bartlett *et al.* (2002) found that a therapeutic alliance was necessary for compliance; but Iris Gault (2009) found that the behaviour of professionals had a profound effect on compliance. Clinicians often held the view that compulsion could harm the therapeutic relationship but this was offset by treatment benefits (Gibbs, Dawson *et al.* 2005) although O'Reilly, Keegan *et al.* (2006) found that some service-users remained very angry with their clinicians after the CTO was implemented.

The wider literature reported the importance of therapeutic relationships in mental healthcare and the challenges that coercive treatment can present to those in such relationships (Bliss and Ricketts 2005). Mulver, Geller *et al.* (1987) argued that the basic element of a therapeutic relationship is trust and the negative use of sanctions in CTOs renders this trust unattainable thus reducing the relationship with practitioners to one of monitoring rather than helping. Gilbert and Plant (2010) reported that the nature of the relationship between practitioners and service-users will inevitably change as a consequence of CTO implementation. They suggested that transforming this relationship from coercion to alliance will require a redistribution of power. This redistribution will be more difficult for doctors than for nurses and other workers because of the inherent power hierarchy involved.

However, pursuit of a therapeutic alliance is recommended as supportive clinicians can mitigate the potential negative consequences of perceived barriers to coercive community treatment (Van Dorn 2006). Courtney and Moulding (2014) maintained that the emphasis on therapeutic relationships should not be limited to clinicians but include 'other personal, social, environmental and spiritual connections' (p224) in service-users' lives. By contrast, Gilbert and Plant (2010) reported that the elements of compulsion associated with CTOs could render the establishment of therapeutic relationships unnecessary as compliance could be guaranteed by enforcement. However, Bliss and Ricketts (2005) recognised that the ability to develop and maintain relationships 'lies at the heart of mental health care' (p28). The consensus in the existing literature reports that therapeutic relationships are desirable with CTOs, but that not all clinicians possess the necessary skills to maintain such a relationship (Corring, O'Reilly *et al.* 2017).

The data from the current study suggests that the CTO compromises any potential therapeutic relationship with professionals and practitioners. However, participants refer to professional roles and titles rather than naming specific individuals. For example, in Extract 6:11 John felt that now he is on a CTO he could no longer trust 'the doctor', he felt abandoned apart from sending 'the boys' round twice a week. Micky, in Extract 6:12 felt that 'the doctor' allowed the CTO to be put in place behind his back. Barbara, in Extract 6:20 felt that, as a consequence of her CTO, she no longer needed 'psychiatrists' in her life. This may suggest that personal relationships with individuals can still be maintained but the relationship between service-user and the professional role becomes difficult. Participants may manage any tensions in therapeutic relationships by differentiating between the person and their role or function in implementing or maintain their CTO. Practitioners may find it taxing to maintain a respectful and caring relationship with 'patients who lack appreciation of the need for treatment' (Corring, O'Reilly *et al.* 2017 p5).

7.3.8 Normality

Traditional psychiatric models propose there is a state of 'normality' from which service-users can deviate (Barker and Buchanan-Barker 2005). Often the word 'normal' is used as if well-defined and accepted by general agreement; also the

relativist and temporal character of 'normal' and 'abnormal' is often acknowledged by professionals but rarely implemented (Hollander and Szasz 1957 p602). Other authors have suggested that psychosis-like symptoms should be considered on a 'continuum with normality' (van Os, Verdoux *et al.* 1999 p459). Hollander and Szasz (1957) maintained there was a medical approach to normalcy which was defined by lack of symptoms and may involve treatment, and also a social approach which may involve the service-users' entire social system with judgement, sanction and repressive action used if necessary. Thus, the notions of deviance from a medical norm by way of symptom recognition and treatment; and deviance from a social norm by way of community reaction and censure; is transient, complicated and often requires interpretation, management and intervention from mental health services (Hollander and Szasz 1957).

Some participants in the current study were unable to consider themselves as normal; in fact in Extract 6:27, Joyce stated that she could not refer to herself as 'normal' but was unable to offer an alternative word or phrase, instead substituting a long silence. Adame and Knudson (2007) found that participants attempted to break away from the discourse of the medical model in order to capture their own experience of normalcy but this was extremely difficult for any individual. In the current study, John in Extract 6:19, wanted to be on probation thus more like 'a normal man' (1:19:4) subject to social sanctions rather than medical treatment. Coffey (2012) found that service-users needed to produce viable identity displays that were acceptable in the community. This resonates with data from the current study, for example, in Extract 6:34, Jim simply avoided mental health crises in order to define his 'normal day-to-day life' (1:4:5-6) and Joyce just had to take 'a few tablets' (1:31:18-19) to live life as a normal person. Barker and Buchanan-Barker (2005) argued that there is no 'normal' state and instead focus on the range of feelings, thoughts and behaviours that are part of an ongoing 'normal' experience (p148). This range changes from moment to moment and therefore the important element is more one of paying attention and noticing changes. Service-users can be helped and encouraged to develop this awareness to change and assisting people to respond to the diversity of experience (Barker and Buchanan-Barker 2005). However, according to Whitely

and Campbell (2014) this pursuit of normalcy is a psychological and social attempt to shore-up self-esteem and provide a defence against potential stigma.

7.3.9 Stigma

Many years of well-intentioned public health stigma awareness campaigns have not yet softened the general stereotype of individuals with mental illness as lacking self-control, unpredictably frightening, uncooperative, aggressive or dangerous (Abiri, Oakley *et al.* 2016). Goffman (1968) maintained that stigma was pervasive to the person, marking the person for undue scrutiny, criticism, ridicule and discrimination. Foucault (1977) argued that such people were subjected to increased surveillance from state and community; this additional attention could be internalised by individuals leading to increased self-stigma, self-doubt and loss of self-esteem (Whitely and Campbell 2014). Although stigma is a social construct that shapes public opinion (Abiri, Oakley *et al.* 2016), and although influenced by powerful macro socio-cultural factors, it is experienced at an individual level and can be most acutely experienced by those on CTOs (Livingston 2012). According to Livingston and Rossiter (2011), CTOs may contribute to stigmatising experiences by creating situations where people are likely to feel powerless devalued and oppressed.

The extant literature reports that the actual experience of stigma does not emerge as an overwhelming issue (Whitely and Campbell 2014), and was not identified as significant perspective in a systematic review of qualitative literature (Corring, O'Reilly *et al.* 2017). Stigma was more usually combined with a wider range of stigma-producing factors such as symptoms, social disadvantage and negative experience of the mental health system (Livingston and Rossiter 2011). Individuals on CTOs regularly have personal encounters in the community that can feel stigmatising; they then develop psychological and behavioural strategies to avoid internalised stigma such as avoiding treatment and social isolation (Ricci and Dixon 2015); these strategies can be further stigmatising thus increasing distress (Abiri, Oakley *et al.* 2016). Stigma was mentioned in several of the existing qualitative studies, for example, Brophy and Ring (2004) found that participants viewed CTOs more stigmatising than the label of mental illness, and Schwartz, O'Brien *et al.* (2010), reported stigma was identified by participants as

occurring in the community through labels, scrutiny and isolation as well as in the stigmatising behaviour and attitudes of professionals involved in their care.

For participants in the current study the experience of stigma was expressed more as feelings of social control in Cluster B, Theme 4 where participants felt to be 'labelled a freak' (Elizabeth 1:7:1) and 'marked down as a paranoid schizophrenic' (John 1:18:15-16), with some avoiding social interaction (Gerry, Extract 6:47) and others being ridiculed (Pam, Extract 6:48). Participants in the current study and examples from the extant literature indicate that stigma is increased through contact with mental health services generally, and more specifically, through the implementation of CTOs. According to Barker and Buchanan-Barker (2005), stigma remains a potent force making it difficult for individuals to negotiate re-entry into the community following episodes of mental illness. The consequence of stigma is the sense of alienation from friends, family and wider society. The priority should be to provide the basis for friendship, natural social support and a sense of belonging and membership of some community of others (Barker and Buchanan-Barker 2005). Tentative evidence from the current study indicates that CTOs undermine the basis for this priority of connection with community and others.

7.3.10 Medication

The majority of service-users in the existing qualitative studies were receiving compulsory medication as part of their treatment (Light, Robertson *et al.* 2014; Scheid-Cook 1993; Stroud, Banks *et al.* 2015). Of all the issues raised by these studies, dissatisfaction with medication, associated side-effects and lack of treatment negotiation were the most common complaints (Corring, O'Reilly *et al.* 2017). Service-users expressed a preference for oral medication rather than depot preparations and were generally looking for dose reduction because of major side-effects (Atkinson, Garner *et al.* 2002). Ridley and Hunter (2013) reported an expected ethos of holistic person-centred care but participants complained of over-medication on powerful drug regimens that had a major impact on their quality of life. In only a few cases were medication changes successfully negotiated and in general, non-medical aspects of treatment received little attention (Ridley and Hunter 2013).

According to clinicians, CTOs offer a framework and assistance to ensure stability of treatment (Riley, Hoyer *et al.* 2014), but Canvin, Rugkasa *et al.* (2014) found that many participants felt forced into accepting medication and would not adhere to treatment given freedom of choice. In order to eliminate choice, many participants were prescribed regular injections of anti-psychotic medication (Gibbs, Dawson *et al.* 2005) although some complained about the delay in experiencing therapeutic benefit and the lack of adequate support in the interim (Gault 2009). Brophy and Ring (2004) reported participant dissatisfaction in only receiving medication as a sole treatment option; they expressed a need to be heard and to have access to other therapeutic approaches such as psychology and counselling, as well as the use of alternative therapies. However, Gjesfjeld and Kennedy (2011) found that whether the individuals in their study liked or disliked being coerced, surprisingly, all participants reported personal benefits and life improvements as a result of medical treatment.

Participant responses in Cluster A of the current study were not at all positive about medication and enforced treatment, particularly in Themes 1 and 2. Participants described painful feelings and physical difficulties directly related to enforced medication. They also perceived that medication represented a form of punishment meted out in the name of therapeutic treatment. The perceived misuse of medication resulted in participants losing trust in mental health services in general and doctors in particular. For example, in Extract 6:4, Joyce felt that she was coerced and that 'you've got to take your meds' (1:9:22). Pam did not know what she had been given as medication, in Extract 6:8, she felt that professionals 'could have been giving me dope for all I know' (1:4:5-6). Elizabeth described her side effects, in Extracts 6:9 and 6:10, as 'seizures' (1:1:21-22) and as a consequence of her enforced injection feels like a 'guinea pig for medical science' (1:11:1), even making her feel suicidal.

Participant responses within Cluster A often focused on medication as representative of the different therapeutic aspirations of practitioners and service-users as well as highlighting other associated constructs such as control by mental health services, service-users' lack of power and freedom of choice. The central themes of dissatisfaction, unpleasant side-effects and lack of negotiation

around medication identified in the existing literature, resonated with the data in the current study. O'Reilly, Corring *et al.* (2016) argue that attenuating the negativity around medication is possible through negotiation and collaboration between service-user and doctor, but also to offer additional services. Some of these potential additional services are identified in the current data. For example: regular reviews, negotiation and discharge planning (John Extract 6:11, William Extract 6:16, Gerry Extract 6:38); social support (Micky Extract 6:55); counselling and psychology (Joyce Extract 6:60). It is clear that participants in the current study would value more flexibility around treatment and medication in order to reduce their perceived negative experience on the CTO.

7.3.11 Dangerousness

Interestingly, there was very little discussion or reference to risk or dangerousness, to self or others, in the extant qualitative studies. There are also very few studies examining the phenomenology of dangerousness from a service-user perspective in the current wider literature. However, strong links have been made between illnesses such as schizophrenia, so-called revolving door service-users, compulsory community treatment and dangerousness (Pinals 2015; Reavley, Jorm *et al.* 2016; Torrey 2015). According to Wolff (2001), mental illness is different from physical illness because it is perceived as both an illness and a risk factor. This puts risk at the 'heart of mental health policy' (p803) and there are fundamental differences in the way service-users, experts and the public assess the risk of dangerousness (Wolff 2001). Often, service-users normalise or minimise risk (Scheid-Cook 1993). Professionals use empirical evidence to demonstrate that the absolute risk of dangerousness posed by persons with mental illness is small (Wolff 2001). However the public, media and politicians cite evidence of the relative risk of dangerousness to create moral panic (Wolff 2001). These differing perspectives compound an already complex ethical and clinical environment (Marty and Chapin 2000).

Two of the existing qualitative studies reported participant responses concerning risk. Gibbs, Dawson *et al.* (2005) discussed discharge from CTOs and one participant with a significant risk history could not understand why he was still subject to the order despite his psychiatrist considering him dangerous. Iris Gault

(2009) reported that participants felt that mental health services, over time, had been encouraged by the media and politicians to become more interested in managing risk than providing care and treatment to service-users (Gault 2009). Participants felt that professionals overestimated service-user dangerousness because the practitioners were 'scared' of the individuals involved (Gault 2009 p510). However, Scheid-Cook (1993) suggested that diverting attention, minimisation and normalisation were strategies used by service-users to distract attention from their potential dangerousness.

When participants in the current study described their perceptions of their alleged violent behaviours, they clearly felt unfairly treated by clinicians. Some of their response could be interpreted as attempts at diversion. For example, in Extract 6:9, Elizabeth felt that she was on a CTO for something she 'might not have done' (1:1:17); and John, in Extract 6:22, reported that 'they' said he was too violent, but he maintained that the accusations of attacking people were just lies. John could also be interpreted as normalising his alleged dangerousness in Extract 6:15 he could not help feeling that he had been provoked beyond his temper threshold. Micky, in Extract 6:24, could have been interpreted as minimising his dangerous behaviours as simply feeling 'a bit aggravated at times' (2:34:18). This could indicate that rather than acknowledge their risk potential, service-users instead expressed their associated feelings of being controlled and powerlessness together with a lack of understanding and inappropriate care from services, which can then lead to aggressive and dangerous behaviours.

7.3.12 The unique status of a CTO service-user

Several strands in the current literature highlight the effect that recent policy changes in mental health service provision have had on the status of service-users. According to O'Brien, McKenna *et al.* (2009) service-user, family and clinician perspectives diverge within and across these groups. Extending the powers of compulsory treatment beyond the hospital into the community is a relatively recent policy change where the service-users are effectively detained in their own environment (Gilbert and Plant 2010). At the same time the concept of recovery became central to mental health policy and practice (Stein, Leith *et al.* 2015). Tensions between the concepts of coercion and control incorporated in

much of the mental health legislation and the collaborative, caring and therapeutic principles embodied within the recovery movement are not new (Jones 1972), but these two recent developments have highlighted the dilemma. Postpsychiatry, where psychiatric practice is developed by engaging with the non-technical dimensions of psychiatry, is a further influence disturbing this maelstrom of competing paradigms (Bracken, Thomas *et al.* 2012).

Service-users are not unaware of these competing and complex developments as they are exposed to media reporting, professional and allied practitioner discourse, peer opinion and service-user network communications (Holland, Blood *et al.* 2009). For example in the current study, Micky in Extract 6:17, felt that the CTO had been imposed in his absence and he was aware this was an infringement of his rights; this knowledge further disturbed him and was compounded by his inability to use this knowledge to rectify his situation. Therefore, although service-users are potentially better informed, they are centrally exposed to competing discourses describing increasingly complex, confusing and potentially distressing scenarios. This provides some insight into the reported ambivalence in the extant qualitative studies as well as the uncertainty generated in the four themes of Cluster B.

In the qualitative literature, service-users consistently report an ultimate preference for no involvement with mental health services because they feel that CTOs restrict their individual liberty but that they are better than being in hospital (Ridley and Hunter 2013; Riley, Hoyer *et al.* 2014; Scheid-Cook 1993). However, the threat of return to hospital if conditions are breached or signs of relapse are evident indicated pessimism from mental health services for service-users to successfully remain in the community. But there was also optimism that community integration and recovery is a possibility, otherwise the CTO would not be implemented. Again, the service-user was placed centrally in this dilemma without clear goals, outcomes or indicators. In the current study for example, William in Extract 6:30, considered the dilemma that if he did not agree to a CTO he would remain in hospital, yet if he did agree to a CTO he was considered well enough to leave. William found this dichotomy both provocative and coercive,

and although he had enough knowledge to question the rationale involved he felt unable to directly influence the outcome.

Discharge dilemmas and outcome criteria were also strands that contributed to the feelings of uniqueness among CTO service-users in other studies (Gibbs, Dawson *et al.* 2005; Gjesfjeld and Kennedy 2011; McDonnell and Bartholomew 1997). The perception that CTOs could be renewed indefinitely without any clearly defined outcome measures or goals was of concern to service-users and added to feelings of insecurity around the orders. This was particularly problematic in comparison to inpatient sections where the parameters of service-users' detention were more clearly defined. In Extract 6:16 of the current study, William felt that his clinicians were over-cautious and were not prepared to take any therapeutic risks. He felt that professionals considered the CTO to be working because he remained stable, but he questioned whether he would be just as stable without the CTO. This resonates with the wider current literature with a focus on risk and media concerns about safety and the implication the mentally-ill are potentially dangerous (Huang and Priebe 2003; Lepping 2007). Repper and Perkins (2003) argue mental health policy is generally replete with conflicting agendas involving risk. On the one hand practitioners are encouraged to involve service-users and adopt their preferences, on the other hand they are required to minimise risk and protect the public. Honesty about the possibilities is necessary together with an appraisal of the value of the service-user perspective. In valuing this perspective, participants in Cluster A Theme 5, could be allowed to voice their version of past incidents in order to negotiate a 'truth' around their risk potential.

7.3.13 Asylum walls in the community

Thomas Szasz (2005) argued that CTOs have 'metastasised coercive commitment' from the psychiatric ward and 'turned all of society into a kind of mental hospital' (p81). Snow and Austin (2009) maintained that the walls of the asylums have been removed and rebuilt in the community, and Fabris (2007 p542) suggested that CTOs qualify as 'chemical incarceration in vivo'. For the participants in the Riley, Hoyer *et al.* (2014) study, their living rooms became institutions outside the institution, with an inherent institutional presence and

gaze. Participants in the Brophy and Ring (2004) study thought that CTOs were the equivalent of 'being in jail without any walls' (p165). All these authors suggest that the old discredited asylum practices of paternalism, coercion, lack of respect and dignity have now become stressful undercurrents associated with CTOs. Although participants felt that CTOs were less restrictive than hospital, they also maintained the identity and the psychological weight of being a service-user (Riley, Hoyer *et al.* 2014). As a consequence this type of reform fails to increase the service-users' responsibility for self-care and accountability for everyday behaviour, even to be legally accountable for any criminal conduct (Szasz 2005).

Some of the findings and analysis from the present study support these contentions; for example, Joyce in Extract 6:4, made links between the CTO and her negative and oppressive thoughts of hospital detentions. These links stemmed from the monitoring she experienced in the community where she realised she was 'not in hospital, like similar' (1:10:24-25). Jim, in Extract 6:5 used his recollections of hospital detention as a frame of reference for the CTO, likening it to a 'prison sentence' (1:12:23). Micky felt that the CTO imposed psychological and physical barriers, like being in hospital, and these were in the back of his mind all the time as a form of invisible control. In Extract 6:21, Micky felt that he would be 'jumped on by the police and shifted off to hospital' (1:32:24-25) if he broke through these barriers. Mary in Extract 6:57, felt that the CTO relieved her of responsibility where she could now do what she wanted and 'nobody could touch' her (1:14:20-21) because she perceived that the CTO insulated and protected her from the threat of hospital or even jail.

Participants often perceived their CTO in terms relative to hospital admission; sometimes an alternative to hospital, or similar to hospital admission, or even a 'softer' version of a hospital admission. Whichever relative comparison was drawn, some of the characteristics of hospital admission were often incorporated into participants' feelings towards their CTO. Corring, O'Reilly *et al.* (2017) maintained that such comparisons should be viewed in terms of 'least restrictive options'. When considered from this perspective, most studies report that service-users do report that being on a CTO is better than hospital and in reality is less restricting (Corring, O'Reilly *et al.* 2017). However, some echoes and dark

memories associated with past involuntary hospital admissions remain. Some of these residual experiences could be referred to as 'sanctuary trauma'.

7.3.14 Sanctuary trauma

There is a growing body of literature indicating that a significant proportion of service-users re-experience trauma as a result of their previous hospitalisation (Frueh, Knapp *et al.* 2005; Paksarian, Mojtabai *et al.* 2014; Robins, Sauvageot *et al.* 2005). Sanctuary trauma refers to incidents in the psychiatric setting that meet the established diagnostic criteria for a traumatic event:

'the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others, and the person's response is intense fear, helplessness, or horror.' (Robins, Sauvageot *et al.* 2005 p1134)

Service-users can experience actual or threatened harm to self or others, seclusion, restraint, noise, overcrowding and insensitive treatment, which not only may be distressing at the time but may cause enduring harm (Pollitt and O'Connor 2007). Participants in the present study described feelings of re-experiencing their inpatient detentions; of re-living the associated pain and distress; and enduring an extension of these detentions in the community under the CTO. Laura Cohen (1994) identified a model for trauma-inducing situations that included inducing fear by enforcement of rules; eliminating victims' autonomy by tight scrutiny and control; limiting communication and isolating the person; as well as depriving individuals of objects of personal importance and significant others. This model resonates with being detained on a psychiatric ward (Cohen 1994) and, according to participants in the present study, by association with the experience of being on a CTO.

Although psychiatric inpatient settings may have evolved into a more 'humane treatment environment' (Cusack, Frueh *et al.* 2003 p454), service-users still report inadequate communication, infringement of human rights, punitive methods of containment and distressing methods of observation as potentially

trauma-inducing (Mayers, Keet *et al.* 2010). All the participants in the present study were negative about their hospital experience, they had a mean of 11 hospital admissions prior to the CTO implementation, and had all been subject to Mental Health Act detentions on numerous occasions, often with admissions to PICUs with additional restrictions and controls. Jim, in Extract 6:5 referred to his 'very bad' (1:12:19) prison-like experience in hospital; and Joyce expressed how she 'hate[s] it so much' (1:19:22) in hospital where she has to abide by the rules (Extract 6:4). A service-user who has high levels of trauma-related anxiety, hypervigilance and irritability, may be at risk of deviant behaviours such as acting out aggressively and disengaging from treatment thus increasing the risks to self and others (Pinals 2015). Community services that are trauma-sensitive and trauma-responsive can provide the necessary sensitivity to the realities of mental health problems in the community (Pinals 2015). There is recognition that interactions across hospital and community settings can influence relapse prevention and recovery as well as minimising the effect of previous hospital admissions (Pinals 2015).

All of the existing qualitative studies report participants' negative attitudes towards hospital admission with little positive reporting and few ambivalent responses. For example, some participants in the Ridley and Hunter (2013) study felt that detention in hospital was 'like going to hell' (p515); being forced to live with mentally unwell people; to endure enforced treatment, inflexible restrictions and depersonalising regimes. Participants also complained of severe boredom, the regimentation of life where, instead of being therapeutic, the detention escalated problems with people feeling they were slowly 'going off [their] head' (p515) and unable to get better as a detained inpatient (Ridley and Hunter 2013). Riley, Hoyer *et al.* (2014) found that during hospitalisation, the participants experienced having to follow rules and procedures, and were also subject to unstable relationships with clinicians which made life more unpredictable. Scheid-Cook (1993) maintained that for many service-users the main objective of their lives was to avoid repeating this negative experience and stay out of psychiatric hospitals. From this perspective, CTOs were considered by virtually all participants as less restrictive (Gibbs, Dawson *et al.* 2005), in principle, they

allowed more freedom, more opportunities and a chance of recovery to adjust to a normal life outside hospital (McDonnell and Bartholomew 1997).

7.3.15 Recovery approaches

According to Davidson and Roe (2007), there is an increasing international commitment to recovery as the major expectation for people with mental illness. However, the construct is increasingly debated and contested with little consensus on what recovery means for people with severe and enduring mental illness (Bonney and Stickley 2008; Davidson, O'Connell *et al.* 2006; Pilgrim 2008). Broadly, the recovery paradigm is founded on the principles of hope, empowerment, healing and connection (Simpson and Penny 2011). Davidson, O'Connell *et al.* (2006) maintain that policy makers, managers and practitioners have an overarching aim of implementing recovery orientated services. Miller, Brown *et al.* (2010) proposed that some international agreement on the definition of recovery has emerged by adopting the American working definition proposed by The Substance Abuse and Mental Health Services (SAMHSA) as:

‘A journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.’ (SAMHSA 2011)

Davidson and Roe (2007) distinguished between ‘recovery from’ and ‘recovery in’ mental illness (p459). The authors reviewed the literature on recovery and the meaning of recovery in clinical community practice to reveal two potentially complementary aspects of recovery. The first meaning of the term derives from over three decades of longitudinal research on recovery from mental illness which has shown that improvement is more common than deterioration (Davidson and Roe 2007). The second meaning of recovery derives from the service-users’ rights to self-determination and inclusion in community life despite ongoing suffering from mental illness (Davidson and Roe 2007). SAMHSA (2011) combine both these meanings into four major dimensions that support community life in recovery:

Health: overcoming or managing one's disease(s) as well as living in a physically and emotional healthy way;

Home: a stable and safe place to live;

Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavours, and the independence, income and resources to participate in society; and

Community: relationships and social networks that provide support, friendship, love and hope.

In the implementation of these dimensions, O'Connell, Tondora *et al.* (2005) found that services were rated highest by providers, practitioners and service-users on aspects related to helping people explore their freedoms and interests. However, Davidson (2003) warns that service-users remain confused and conflicted about recovery which may, in part, be linked to the negative attitude of some professionals and the unstable and unpredictable course of their illness (Barker and Buchanan-Barker 2005). Morgan (2004) described a rich but negative lexicon that health professionals use when dealing with service-users:

'... illness, distress, disability, poor functioning, relapse, deficits, weaknesses, failings, psychotic... It would not be difficult to draw-up a complete alphabet of negativity'. (p126).

There is a traditional pessimistic medical prognosis of chronicity in severe mental illness and it may be a challenge for some professionals to identify and support each person's unique recovery journey while still promoting other, more conventional, forms of recovery such as symptom remission (Davidson, O'Connell *et al.* 2005). Practitioners need to believe that recovery is possible (Kelly and Gamble 2005) and to work collaboratively alongside service-users (Repper and Perkins 2003). This is likely to highlight ethical dilemmas for practitioners as they attempt to balance service-user autonomy with the duty to protect the public as well as protectionist and defensive practice of modern service provision (Bonney and Stickley 2008).

However, there is also service-user confusion and conflict around recovery and community living reflected in participant narratives mainly grouped together in

Cluster B of the present study. For example, Jim's metaphor about the colourful fish tank in Extract 6:26 could describe his reluctance and confusion about moving beyond the boundaries of his safe space and accepting some of the perceived risks involved in his recovery. Jim later, in Extract 6:31, admits that he can 'give up' (1:17:6) easily and would therefore be susceptible to any negative attitudes amongst practitioners, instead requiring positive encouragement and support towards his recovery in the community. There are also examples of participants' attempts and struggles to achieve the four major dimensions identified in the recovery process by SAMHSA. For example, in Extract 6:27, Joyce acknowledged her fluctuating mental health; and Barbara, in Extract 6:28, had problems dealing with her physical and emotional health. Gerry acknowledged the impact of the loss of home and family in Extract 6:33, as well as declaring a determination to regain this dimension of his recovery. Even within the perceived restrictions of the CTO, Micky was able to pursue a purpose in his life where, in Extract 6:30, he described his need to help others less fortunate than himself. Finally, in Extracts 6:41 and 6:48, Pam described her unfulfilled need for support from friends and family; and how she felt that neighbours pestered her with "snide remarks" (1:5:19) and laughed at her because of her mental illness. These dimensional deficits could have contributed to the confusion and conflict perceived by participants as they attempted to engage in their recovery in the community.

7.3.16 Institutionalism

The effect of deinstitutionalisation was discussed in Chapter 3 and the phenomenon of institutionalisation assessed within the context of CTOs. Chow and Priebe (2013) maintained that institutionalised care related not only to conventional institutions but also to restrictive policies and legal frameworks, paternalism in the clinician-service-user relationship, as well as the service-users' adaptive behaviours to institutionalised care. Thus, CTOs can be termed institutional care as they are restrictive legal frameworks where paternalistic care is generally sanctioned so that service-users can respond as if treated in an institution within the community. Wing and Brown (1961) identified three variables that increased the damaging effect of institutionalisation: the social pressure that

temmed from an institution, the length of exposure to these pressures, and the predisposition of the service-user.

However, some authors propose the theory of 'institutionalism' to explain this phenomenon (Chow and Priebe 2013; Liberakis 1981; Ochberg, Zarccone *et al.* 1972) which was conceptualised institutionalism as leading to:

'the impoverishment of feelings, thoughts, initiative and social activity which... manifests mainly in social withdrawal'
(Liberakis 1981 p356)

This adaptive behaviour has been recognised for several decades and initially was observed as a form of social withdrawal and recognised as Social Breakdown Syndrome (SBS) in psychiatric inpatients (Gruenberg 1967). SBS can be characterised by the loss of normal functioning with disassociation from family and community roles (Gruenberg 1967). Other key features of institutionalism are depersonalisation and loss of identity, where over-protection from clinical staff and family members can lead to humiliating, stigmatising and non-therapeutic care (Chow and Priebe 2013). Some years ago, Gruenberg (1967) claimed that some sufferers of SBS compared with Goffman's (1961) patients of total institutions and they accepted the chronic sick role (Parsons 1951).

Participants in the current study displayed some of these behaviours and characteristics with most of the participants in Cluster B exhibiting some similarities with the phenomenon of institutionalism. For example, in Extract 6:26, when Jim used his 'fish tank' (1:28:12) metaphor, he suggested a reluctance to re-engage in normal functioning and community roles following his hospital admissions and subsequent CTO implementation. Depersonalisation and loss of identity were highlighted by Elizabeth in Extract 6:46 where she felt to be 'labelled a freak' (1:7:1) as a consequence of the CTO. Gerry, in Extract 6:47 felt the CTO contributed to him being stigmatised in the community with consequent effects on his relationships with others. Pam also experienced feeling targeted because of her CTO and, in Extract 6:48, humiliated by locals and a neighbour 'laughing her bl**dy head off' (1:6:3-4). Jim, in Extract 6:31, gave-up and withdrew from

addressing his problems and pressures in life; and in Extract 6:34, then described feeling that he 'neglected a lot of [his] existence' (1:4:3-4), failing to achieve success, realise ambitions, finding it difficult to continue 'normal day-to-day life' (1:4:5-6).

However, according to Chow and Priebe (2013) not all institutionalism has negative connotations. Bonavigo, Sandhu *et al.* (2016) analysed institutional dependency on community mental health services and found some positive aspects. They identified different concepts of dependency on community services such as supportive services, promoting independence and security.

There was some evidence of these conceptual perspectives of dependency and the positive consequences of institutionalism for participants, particularly in Cluster C, of the present study. For example, in Extract 6:51, Joyce used her 'safety net' (1:30:14) metaphor to emphasise the palliative effect and security offered by the CTO. Also, in Extract 6:52, Joyce placed herself as a benevolent systems spokesperson who is justifying the CTO to Joyce as a 'lucky break' and 'chance' (1:36:3-4) for which Joyce becomes appreciatively obliged. Barbara also became appreciatively obliged to the beneficial system in Extract 6:53 as she becomes more relaxed in the security offered by the CTO.

Jim described his feelings of obligation and appreciation in Extract 6:54 as he was helped to cope with his schizophrenia by the stress reducing influences of 'cool' and 'positive' (1:8:11) people. In Extract 6:55, Micky described the assistance of a support worker offering meaningful activity as a form of positive dependency. Mary and Jim described feelings of security and protection from dangerous places in Extracts 6:56 to 6:59. Mary also described how the CTO will 'bring [her] home' (2:27:14) as a form of positive dependency if she is ever dislocated from her familiar world. Finally, Barbara (Extract 6:64), Mary (Extract 6:66) and Joyce (Extract 6:67), described how mental health services used the CTO to positively maintain the status quo, maintaining Barbara's status quo in a familiar location and surroundings; keeping Mary 'in step' (1:15:10) with the status quo; and allowing Joyce to remain within her family circle and maintain perceived optimal status quo.

The constructs discussed in this chapter demonstrate how alternative approaches and consideration to implementation can influence a more positive experience of a CTO. Some of the qualitative studies have indicated that some of these constructs can act as modifying elements that can influence both the CTO experience and effectiveness. In order to identify and organise any potential mediating and modifying elements some authors have investigated theoretical frameworks as potential conceptual structures to achieve a more positive and effective experience of CTOs.

7.4 Potential theoretical frameworks

Robson (2002) argued that theory is important, and a theoretical framework to aid understanding can be acquired by interaction with, and analysis of, participant data. The intention of such a framework, according to Robson (2002), is often to assist individuals, groups or organisations to understand, and possibly develop or change, some aspect of the phenomena of study or situation in which they find themselves, and there is significant benefit in remaining close to the concepts and language that participants use.

Reflexive Box The aim of developing a conceptual model moves beyond the main aim of describing and interpreting. Why not do Grounded Theory (GT)? GT lacked the flexibility for interpretation and analysis of experience, also IPA allows for the development of theory – placing the work in a wider theoretical context (Smith, Flowers *et al.* 2009). This section of the discussion links the analysis to the extant literature – which includes existing theory – and exploring the implications of those links for furthering understanding of the lived experience of CTOs

Robson's (2002) basic claim is that the use of principled, theoretical enquiry can gain understanding of human situations and its manifestation in specific situations in order to initiate sensible change or development. According to Bowling (2002), theory at the lowest level can be an *ad hoc* classification system, consisting of typologies which organise and summarise observations. Much of the extant

qualitative literature reviewed in Chapter 3 falls under this category; there are some attempts in the literature at developing taxonomies which are more descriptive categorical systems of CTO responses constructed to fit participant perceived experiences. However, this stage of the thesis is intended to propose the application of a higher level of theory, described by Bowling (2002), as consisting of a conceptual framework and structure of propositions that summarise, simplify and offer additional insight into participant responses.

7.4.1 Freedom, control, threat and restoration

Several classic texts have outlined basic dilemmas involving many of the previously reviewed constructs. For example the dualism between freedom and control (Rose 1999; Szasz 2002), and the power to exercise that control or restore the freedom (Miller and Rose 1986; Scheff 1984). Some of the extant literature has suggested that existing theory could be used to synthesise the complex dichotomies and competing influences involved in CTOs into basic concepts using straightforward terminology. This section will briefly review some of those alternative theories and explore the application of Reactance Theory to further understanding, and potentially improve the CTO experience for service-users.

According to Brehm and Brehm (1981), freedom and control have become popular concepts in the behavioural sciences and the proposition holds, generally speaking, that to have freedom or control is good and beneficial to the individual, while not having control or freedom is bad or potentially harmful.

‘Though this assertion is practically a truism and could hardly be refuted on logical grounds, it fails to be an accurate representation of the major thrust of the experimental evidence. Rather, what much of the evidence shows is that threat to control or freedom has important psychological consequences, and these consequences may be either beneficial or harmful’ (Brehm and Brehm 1981 p2-3).

Several theoretical perspectives have been proposed in the extant literature as potentially valuable in explaining responses to compulsory community treatment.

Sociological approaches have been suggested, such as Conflict Theory (Giddens 1997) where conflict and change arises between groups of unequal resources; and Social Control Theory in psychiatry (Miller and Rose 1986) which examines the use of power by psychiatry to control problematic individuals in the name of therapy. Psychological perspectives have also been considered, such as Reinforcement Theory (Hayes 1994), where behaviours are reinforced through reward or punishment; and Self-determination Theory (Valimaki 1998) attempts to explain how individuals vary between active involvement and passive involvement in determining outcomes.

An example of a conceptual emphasis towards control and freedom was reflected in the extant CTO literature where Canvin, Bartlett *et al.* (2002) argued that self-determination theory may be a model to examine circumstances 'likely to display a wide range of fluid responses and behaviour' (p367). Unfortunately, this self-determination approach, like other frameworks, can explain the reasons for applying a CTO and, although does predict varying responses, it does not fully explain or analyse the wide range of motivational reactions both before and after a CTO has been applied. These proposed theoretical approaches do not provide a coherent framework which explains the diverse range of service-user response to CTOs.

Tentative results from the current study, and much of the extant literature, indicate that a negative response to a CTO was often as a consequence of a perceived controlling and coercive threat to a previously held freedom of choice. The service-user, prior to the CTO and associated conditions was, for example, relatively free to refuse or accept medication, treatment and engagement with the care team. The threat attached to failure to comply with a CTO takes the form of a possible return to hospital and enforced treatment. In his classical theory, Jack Brehm (1966) argued that people are continually surveying their internal and external states of affairs and making decisions about what they will do, how and when they will do it. Their behaviour is not always freely selected, but most of the time people *feel* that they are free to engage in a variety of different behaviours, and the individual can choose behaviours that maximise need satisfaction (Brehm 1966 emphasis in original).

According to Brehm (1966), it is reasonable to assume that if a person's behavioural freedom is reduced or threatened with reduction (as in a CTO), that individual will become 'motivationally aroused' (p2).

'Since this hypothetical motivational state is in response to the reduction (or threatened reduction) of one's potential for acting, and conceptually may be considered a counterforce, it will be called "psychological reactance"' (Brehm 1966 p2).

This theory of psychological reactance outlined a set of motivational consequences expected to occur whenever perceived freedoms are threatened or lost (Brehm and Brehm 1981). In general, Reactance Theory holds that a threat towards or loss of a freedom motivates a person to restore that freedom either directly or indirectly.

7.4.2 Psychological Reactance Theory and CTOs

Reactance Theory is proposed as a potential explanatory structure to enhance understanding of the service-user reaction and response to the implementation of a CTO. The essence of the proposed theory, as applied to CTOs, is that the greater the level of service-user reactance, the greater the requirement for a CTO; conversely, as reactance is reduced, so is the need for a CTO. According to Dillard and Shen (2005), there are four essential elements to the theory: freedom; threat to freedom; reactance; and restoration of freedom. When considering the phenomena of CTOs, these essential elements would generally equate as follows:

- Freedom – perceived as the freedom to choose non-compliance or engagement with treatment team.
- Reactance – service-user reaction to enforced treatment.
- Threat to freedom – the explicit threat of a return to hospital and enforced treatment.

- Restoration of freedom – either by modifying the conditions of the CTO or anticipation of discharge from the order.

As reactance reduces so the motivation to re-establish freedoms diminishes and the need to maintain the CTO moderates. Individuals could become motivated towards direct restoration which would simply involve continuing the forbidden acts of non-compliance and non-engagement. The result would be a need for a CTO; and once a CTO is introduced, such non-compliance and non-engagement is no longer an option under threat of a return to hospital. People then resort to indirect methods in an attempt to restore freedoms by three main methods (Dillard and Shen 2005):

- by increasing the liking for the threatened choice;
- by derogating the source of the threat; or
- by exercising an alternative freedom.

All these direct and indirect restoration strategies are attempts by the individual to reduce reactance, mainly by increasing feelings of control or choice (Wicklund 1974). Arguably, before a CTO is put in place, a service-user often responds to a CTO by exercising their freedom to refuse medication, treatment and engagement, in spite of efforts by mental health services to persuade them to accept such treatment. In this way reactance is induced by the attempted persuasion, leverage and coercion applied by mental health services and the service-user is motivated to respond using direct restoration to continue the forbidden act, namely non-compliance and non-engagement. It could also be argued that when a CTO is then implemented, the service-user cannot continue with direct restoration because of the threat of a return to hospital and enforced treatment. The contention is that service-users will then resort to various indirect methods attempting to reduce reactance.

For example, participants in the current study voiced increased desire and amplified indirect pursuit of the perceived lost freedom. William in Extract 6:16,

indirectly challenged the CTO by implying that, given his previous preferred freedom, he may comply with treatment, saying 'Well how do they know if I wasn't on a CTO, it still wouldn't be the same' (1:10:14-15). John, in Extract 6:19, was prepared to pay a fine or be put on probation 'like a normal man' (1:19:6), rather than remain on the CTO; and in Extract 6:33, Gerry emphasises the past importance of 'a car, house and wife', where he emphasises the attractions of previous freedoms. Service-users also derogated the source of the threat often by demonising doctors or treatment or the CTO itself. For example John, in Extract 6:7, likened his injection to "snake venom" (1:21:17); Pam, in Extract 6:8 accused doctors of being 'the drug squad, could have been [giving me] dope for all I know' (1:4:8-9); and in Extract 6:10, Elizabeth amplified the perceived experimental nature of her treatment by feeling 'a guinea pig for medical science' (1:12:25-26). These examples resonated with the predicted responses proposed by Reactance Theory.

Participants also searched out and emphasised alternative freedoms, for example, in Extract 6:5, Jim emphasised the freedom from hospital because he 'didn't like it in there, it seemed like a prison sentence' (1:12:22-23). Similarly, in Extract 6:52, Joyce emphasised that the CTO provided freedom from 'another six month section' (1:35:19-21) in hospital; and Mary, in Extract 6:57, found an alternative freedom in 'a new lease of life which did me good' (1:14:25-26). Barbara, in Extract 6:53, was able to identify alternative freedoms of accessing practical help from visiting clinicians who, she perceived, acted as a surrogate 'family' (2:35:26) offering assistance and advice. By utilising and combining these strategies, it is probable that service-users attempted to reduce reactance and the associated unpleasant feelings, again, resonating with the responses predicted by Reactance Theory.

Reactance Theory can also enlighten understanding of the clusters of the current study. Cluster A, which has been determined as a generally negative response, outlines the perceived pain and powerlessness experienced by participants. The detailed descriptions suggest that the negative implications of the responses have been emphasised and perhaps amplified by participants in order to reduce the strength of threat to freedom. Reactance Theory predicts that service-users

would employ indirect methods to reduce reactance, one of which is derogating the source of the threat to freedom. Thus, participants compared the use of a CTO with an inpatient section when they felt *Sectioned in the community* (Theme 1). They also attempted to undermine the therapeutic nature of the intervention and the status of the professionals involved when participants felt *Sentenced by the drug squad* (Theme 2). Participants also attempted to derogate the authority of the processes involved in implementing the CTO when participants perceived that *They stuck me on it* (Theme 3). Participants also attempted to derogate the therapeutic motives of practitioners involved in the CTO towards aims that indicate persecution when they felt *Bullied and intimidated* (Theme 4). Finally, participants pursued this negative approach by attempting to derogate and invalidate the supporting evidence by suggesting *It's written down wrong* (Theme 5).

Cluster B is generally an ambivalent group of responses which outlines uncertainty around alignment and reconnection between mental health services and independence in the community. This cluster also resonates with Reactance Theory by variously describing how participants attempted to balance reactance induced by the CTO as a threat to freedom of choice with the alternative freedom of greater independence in the community. On the one hand, participants demonstrated an increased liking for that independence, and on the other hand they were unsure about that independence as an alternative freedom. This uncertainty gave rise to a feeling that *My head's screwed-up* (Theme 1). Sometimes, because of the episodic nature of mental illness, the alternative freedom of independence became difficult to maintain and participants found that they had to recommence the pursuit of that freedom by *Dusting yourself off* (Theme 2). Participants also had to maintain the increased liking for independence throughout the episodes of illness and recovery by *Just get[ting] on with it* (Theme 3); even maintaining this liking in the face of adverse responses from others when they were *Labelled as a freak* (theme 4).

Cluster C has been determined a more positive group of participant responses and, in Reactance Theory terms, can be interpreted generally as the identification and pursuit of alternative, consolatory and compensatory freedoms. It is argued

that by exercising these freedoms can give participants a perception of increased choice and control, thus reducing reactance in response to the CTO and the threat of a potential return to hospital. Also, whilst identifying these alternative freedoms, participants were able to maintain their increased liking for the threatened choice of independence in the community. Thus merely remaining stable and balanced in the community *On an even keel* (Theme 1) was perceived as an alternative freedom; the safety and protection associated with a CTO meant that *Nobody can touch me* (Theme 2); and the CTO brought comfort from the perception that *It'll bring me home* (Theme 3) from difficult situations.

Considering the conceptual constructs associated with CTOs identified from the extant literature from a Reactance Theory perspective, can also enlighten and make sense of the service-user experience. For example, the negative constructs such as service-user feelings of powerlessness, perceived stigma, dangerousness and sanctuary trauma can all be interpreted as increasing the strength of threat to freedom and therefore increasing reactance. The more ambivalent constructs such as assistance, structure, relationships, normality, medication, uniqueness and institutionalism can either be perceived by service-users as increasing the strength of threat or offering alternative freedoms, thus variously increasing or reducing reactance. The uncertain and ambivalent nature of these constructs suggests that they may be susceptible to influence from practitioners in helping to increase or reduce reactance as necessary. Finally, the more positive constructs identified in the extant literature such as living at home and, particularly, the promise of recovery could offer restoration potential which, according to Reactance Theory, could significantly reduce reactance for CTO service-users.

Critics of Reactance Theory argue that the nature of reactance remains largely undetermined apart from a brief reference to the possibility that individuals 'may be aware of hostile and aggressive feelings' (Brehm 1966 p9). This is certainly the case for Micky in Extract 6:24, where he admits to getting 'aggressive, shouting (...) 'cos I want to get my point across' (2:34:21-22); and, in Extract 6:3, John voices mild hostility, feeling that twelve months on a CTO 'upsetting is that, I find that upsetting' (1:6:24-26). When revisiting Reactance Theory 40 years later,

Miron and Brehm (2006) confirmed that reactance arousal can result in 'a great deal of hostility' (p5) but caution that this is not always present. Brehm and Brehm (1981) also acknowledged that reactance cannot be measured directly but does allow for the prediction of various behavioural effects (p37). However, Dillard and Shen (2005), maintained that measurement is possible as reactance is comprised of cognition and affect, both of which can be measured using self-report scales.

Arguably, reactance primarily acts as a mediator in the persuasion process by mediating between threat to freedom and outcomes such as attitudes and behaviours (Dillard and Shen 2005). However, this mediation process is conditional on other factors, which are not explained by the theory, such as individual personality traits and social as well as cultural influences. Miron and Brehm (2006) reviewed attempts to address these issues whilst examining the 'determinants of the magnitude of reactance' (p5). Determinants include trait reactance, where individual differences in reactance have been assessed using a Therapeutic Reactance Scale (Dowd, Milne *et al.* 1991), although the accuracy of this scale was not fully developed and therefore the explanatory power of the scale remained low. Also, the evidence for the existence of 'group reactance' (Miron and Brehm 2006 p9) was reviewed but, again, the predictive power of any conceptualisation was low as reactance was dependent on other individual variables such as perceived value of the threatened freedom and the perceived strength of any specific threat.

The phenomenology of reactance is, again, largely dependent on two of the antecedent variables and essential elements identified earlier. These are the strength of the threat to freedom and the restoration potential of the freedom. Threats to freedom, and consequent reactance, could be reduced by identifying alternative compensatory freedoms (Dillard and Shen 2005) and the concreteness of the language used (Miller, Lane *et al.* 2007). The restoration potential of freedoms could be increased by offering time limits on threats or elimination of freedom and some indication of when the freedom may be re-introduced (Brehm and Brehm 1981). For the participants in the current study, participant responses in Cluster A represent high levels of reactance and display

strategies of indirect restoration such as derogating treatment, providers and the CTO itself. Participants in Cluster C display lower levels of reactance and indirect restoration strategies such as identifying alternative freedom in the form of compensatory benefits. Participants in Cluster B are often described in the literature as ambivalent, with variable levels of reactance, perceived strength of threat to freedom and efficacy of restoration strategy.

7.5 Discussion summary

The key findings and analysis from the present study resonate with the extant qualitative literature by incorporating negative, positive and ambivalent types of responses. The combined data and literature also identify important and interconnected constructs which feature in participant responses throughout the corpus. Examination of the data from the current study together with responses from the extant literature and subsequent discussion suggest that the featured constructs, although essential components in fully understanding the service-user experience of CTOs, inform but do not fully explain the wide range of participant responses. The discussion identified a need for an explanatory theoretical model. The theory of psychological reactance was proposed as a framework for examining the relationships between more complex emergent constructs closely associated with CTOs and explaining the participant reaction to CTO implementation.

Reactance Theory is composed of four essential elements: perceived freedom; reactance; threat to freedom; and restoration of freedom. Reactance could serve as a mediator and motivator for a CTO service-user to restore the freedom of choice around treatment and engagement. Service-user responses and perceptions of their CTO experience can be examined using Reactance Theory to explore how service-users make sense of the constructs that emerge from the current study data as well as resonating with the existing literature. This sense-making activity involves consideration and reaction to more negative constructs such as: powerlessness, stigma, dangerousness, asylums and trauma; together with more positive constructs such as: living at home and recovery; as well as ambivalent constructs including: assistance; structure and relationships;

normality; medication; unique status; and institutionalism. Service-users strive to optimise the competing influences of these conceptual constructs which can be examined using psychological Reactance Theory as a guide and framework for further analysis and understanding.

Chapter 8

Conclusions, the way forward and evaluation

8.1 Introduction

The extensive body of literature examining CTOs is inconclusive in terms of clinical effectiveness, ethical justification or stakeholder validation. The weight of research and expert commentary cannot fully support or condemn the continued use of CTOs. This thesis maintains that in-depth analysis of the service-users experience of CTOs therefore becomes increasingly important in understanding the impact of the legislation on their daily lives. Examination of the wider literature also suggests that contextual influences are a major determining factor in the ongoing use of CTOs and explains why compulsory community treatment remains in regular use in all the jurisdictions that have adopted this form of mental health care. In short, contextual indicators, rather than clinical outcomes, suggest that CTOs will continue to be used and it is therefore increasingly important to understand how service-users make sense of CTOs.

8.2 Conclusions

CTOs were introduced in England and Wales in 2008 and over 14,000 have been issued with their proportionate use increasing each year. Although they have been used in many countries for over 30 years, they still remain clinically contentious and ethically controversial. CTOs are usually used for so called 'revolving door' service-users and have conditions attached such as compliance with prescribed medication and engagement with the service-user's care team. Failure to comply with the conditions of a CTO may mean a compulsory return to hospital and enforced treatment. Professionals generally accept that CTOs can infringe service-users' civil liberties but this is often justified by the assumed clinical benefits. However, a wide range of research designs have been extensively employed over a three decade period, including three systematic reviews, and all have been vulnerable to conceptual, methodological and practical problems. This has resulted in a lack of robust evidence of either positive or negative clinical outcomes which have included measures for hospital

readmission, length of hospital stay, improved treatment compliance or patient quality of life.

Over the same period, 20 qualitative studies have been undertaken investigating the service-user experience of, and response to CTOs. A variety of methods were used and variously identified and described three broad typologies of response – positive, negative and ambivalent reactions. Ambivalence was, confusingly, the most common and recurring theme within the three typologies of the extant literature. The views of other stakeholders and experts were also researched including nurses, occupational therapists, social workers and associated practitioners. Psychiatrists, as the main decision makers, generally considered that CTOs were necessary for certain patient groups to maintain treatment adherence, engagement and improved insight. The general consensus across the existing literature suggested that CTOs will continue to be used despite the lack of clinical evidence. In fact, some commentators argue that the pursuit of definitive clinical evidence may be beyond the scope of current research paradigms and the extant qualitative evidence may not have revealed the necessary in-depth, rich detail of the service-user experience.

The current service-user experience is coloured by historical and contextual developments which date back to the earliest periods of recorded madness. From the horrors of the madhouse through Foucault's great confinement, incarceration was the western response to mental disorder. This response was characterised by the rise of the asylums and the dominance of psychiatric practice. However, a conflicting view also developed that madness was socially constructed and gave rise to the contradictory challenge of therapeutic treatment and social control. But the reliance on the asylum system as a convenient solution to the problem of inconvenient people continued until World War II. There was then a shift towards community services that began a transformation that ran counter to all the previous years of incarcerating the mentally ill. Around the same time there were significant pharmacological developments in psychoactive medications that further enabled and accelerated this process.

The rate of change caused an imbalance where community care facilities were unable to accommodate the rising number of mentally ill rendered dispossessed

secondary to the closure of the asylums. This caused critics to question the causation of deinstitutionalisation as economically driven rather than therapeutic progress. This crisis of the system occurred at both national and international levels and gave rise to famous political declarations that community care had failed. This failure was evidenced by high profile homicides committed by individuals suffering from untreated mental illness in the community. This, in turn, triggered an overhaul of mental health legislation, crisis intervention and support for the seriously mentally ill. CTOs were introduced and expanded throughout the English speaking counties as a reaction to public and political attitudes assuming that mental illness predicts violence. This assumption was fuelled by media amplification and the spread of social media so that risk remains at the heart of mental health policy today. These contextual and historical influences could explain why CTOs have remained active in all the worldwide jurisdictions where they have been introduced, why their proportionate use worldwide is increasing, and also indicates that their ongoing use is likely to continue for the foreseeable future. This is particularly relevant within the continuing debate concerning therapeutic intent and social control.

Given the absence of clinical evidence and the influence of contextual indicators, it is increasingly important to establish the experience of service-users subject to CTOs in order to determine and understand the effect of this legislation. The current study sought an understanding of this experience; in-depth, individually and collectively, using IPA. Ten active CTO service-users were recruited to undertake two interviews each, variably using simple diaries and photo-journals to support their narrative. The interviews were transcribed and analysed by the researcher (LM) and supervisors, identifying codes, sub-themes and themes for each individual case, then combined in a cross-case analysis to develop clusters for comparison with the existing literature and further discussion.

The findings and analysis from the study generated three clusters of responses from participants. These resonated with the extant qualitative studies which identified broad typologies of negative, ambivalent and positive responses. Cluster A – *Pained and Powerless*– was the majority negative response and detailed how participants confused and conflated traumatic hospital detentions

with their CTO, and often described their perceived cruel and unpleasant experience in punitive criminal justice terms. Cluster B – *Alignment and Reconnection* – was a significant ambivalent response and detailed how participants were uncertain about their ability and opportunity to detach from mental health services to recover in the community. Cluster C – *Consolation and Compensation* – was a minority positive response and detailed how participants identified more helpful elements of CTOs but these were limited and restricted in their nature and value. These findings differed from the existing studies in certain areas, mainly that the extant studies identified a majority and profound ambivalent response whereas the current study found a majority strong negative response. The current study was also able to provide rich, in-depth and detailed analysis because of the methodology selected and the range of methods employed.

The data from the current study enabled further discussion, comparison with the existing literature and the identification of emergent constructs. These constructs and the subsequent discussion further informed understanding and sense-making from the wide range of participant responses. Overall, the analysis and discussion indicated that participants experienced negative feelings of coercion and control under the CTO, rather than positive perceptions of a therapeutic approach. However, this negative experience was, at times, modified by significant feelings of ambivalence and uncertainty towards dependency on mental health services and increased independence in the community. The exploratory power of theory was also investigated and the theory of psychological reactance was examined as a potential framework able to ‘make sense of service-users making sense of CTOs’ – a declared summary intent of the study. Reactance Theory proposes that individuals are motivated to restore an eliminated or threatened freedom; for CTO service-users, this comprises the freedom of choice around treatment from, and engagement with, mental health services. The theory identifies four essential and variable elements: perceived freedom, reactance, threat to freedom, and restoration of freedom. Reactance serves as a mediator and moderator as service-users employ direct or indirect methods of restoration.

Direct methods involve continuing to exercise the freedom, thus pre-CTO 'revolving door' service-users would therefore continue with non-engagement and non-compliance. Indirect methods of restoration employed post-CTO include increased liking for the previous freedom, derogating the source of the threat, identifying and exercising alternative freedoms. The theoretical framework, essential elements and methods of restoration combine to explain the wide range of responses from participants in the current study. The constructs emerging from the body of literature also provided an understanding of how service users make sense of CTOs. Thus, the theory enables the study aims and objectives to be achieved and provide an answer to the research question. Further, Reactance Theory may offer additional analytic insight into formulating a more therapeutic and effective approach to the use of compulsory community treatment, providing a way forward to redress the balance and challenge of therapeutic treatment and social control associated with compulsory community treatment.

8.2.1 Revisiting the study aims

This exploratory study had specific stated aims and objectives (see section 3.5); these can now be reviewed in the light of the presented study:

Aim 1.

To explore the meaning, understanding and purpose of CTOs for service-users and the felt impact of CTOs on their daily lives.

The combination of data collection methods employed and the interpretative potential of IPA meant that the meanings, understandings and perceived purposes could be extensively explored. The richness and detail of the data enabled a descriptive exploration of the daily impact of a CTO to be captured along with detailed examination of the feelings associated with lived experience for each participant.

Aim 2.

To examine the service-user story, account and description of their mental health journey up to the implementation of the order as well as their current experience.

The semi-structured nature of interviews combined with a basic timeline, diaries and photo-journal opportunities allowed each service-user to detail their own story and journey within mental health services.

Aim 3.

To assess the influence of historical and current social context of CTOs on participants' experience.

Comprehensive, critical examination and review of the extant CTO-specific literature combined with the wider contextual and historical information to allow the data from the current study to be considered within the current mental health landscape.

Aim 4.

To generate analytic outputs, through Interpretive Phenomenological Analysis (IPA), that may help service providers and service-users in achieving more effective CTO support.

IPA data has been presented from transcripts of participant interviews together with an audit trail of supporting extracts. This data from the current study has been compared with previous studies and assessed within the current context of mental health provision. A useful theoretical framework for understanding the impact and service-user experience of CTOs was identified. This framework could also guide service providers in developing more effective future theory, practice and policy.

8.2.2 Answering the research question

How do service-users make sense of their Community Treatment Order experience?

The rich and detailed data from the current study describes and interprets how individual service-users attempt to understand their life on a CTO. When this data is compared with the existing literature and further informed by a comprehensive contextual and historical background, the theory of psychological reactance emerges as a useful framework for further exploring how service-users make sense of their CTO experience.

8.3 The way forward

Critics of CTOs maintain that the coercive and controlling nature of the legislation far outweigh any clinical benefit. Reactance Theory may provide a key for unlocking the therapeutic potential of CTOs without compromising their social

significance or effectiveness. By reducing reactance the need for restrictive and controlling conditions may diminish; indeed, the need for a CTO at all may be lessened or eliminated. If reactance is reduced, service-users may not be motivated to re-establish eliminated or threatened freedoms either by direct restoration or by indirect methods. There are various ways in which reactance may be reduced for individuals; the profound ambivalence identified within the literature and the current study indicates there is potential for persuasion and shifting of attitudes and reactions to CTOs. By influencing these elements in the most appropriate way for each person's circumstances, a specific formulation may be developed in order to reduce reactance as a service-user responds to persuasion, leverage and coercion associated with a CTO. Figure 8.1 illustrates these elements and the following introductory review briefly examines how each variable could contribute towards a reactance model and therapeutic formulation for CTO service-users, with worked examples based on the cases of Elizabeth and John.

8.3.1 Reactance

Although Reactance Theory comes from a tradition in social psychology that does not emphasise individual difference, there is a strong implication in the theory that reactance potential is determined by characteristics of the situation, with a temporal instability (Dowd, Milne *et al.* 1991; Miron and Brehm 2006). This concept of reactance potential has immediate practice implications for CTO service-users because reactance would be expected to mediate compliance with CTO conditions such as treatment concordance and engagement. Fundamentally, the reduction of reactance could improve

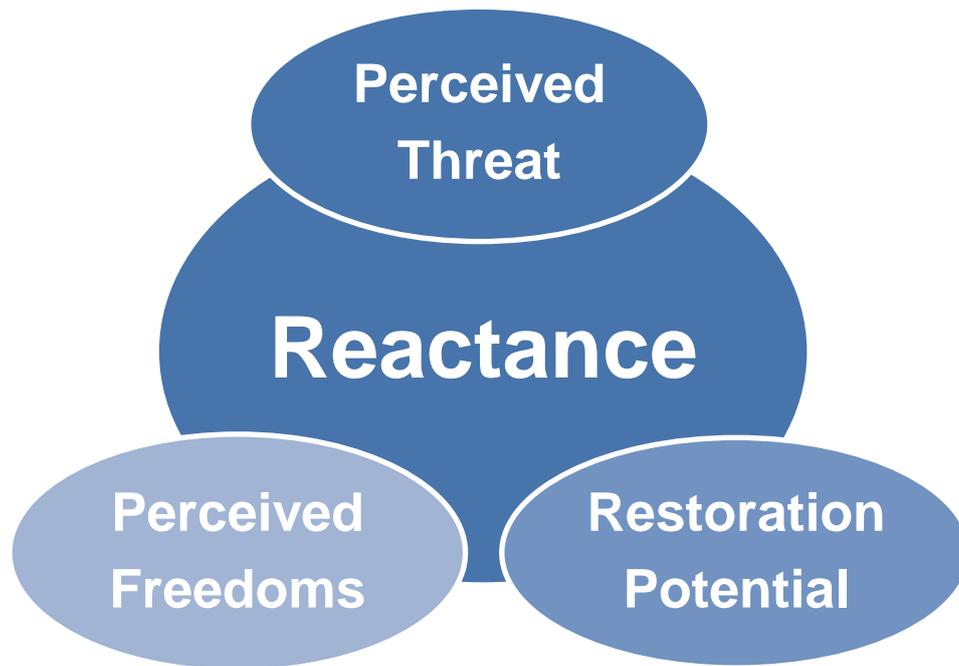


Figure 8.1 A reactance model

service-users' experience and quality of life on a CTO. It follows that influencing the elements that, in turn, affect reactance would be of value in reducing the motivation to restore threatened or eliminated freedoms. Therefore, reducing the liking for a threatened freedom; reducing or softening the perceived threat to a freedom; increasing the value or choice of alternative freedoms; or increasing the likelihood of restoration of an eliminated freedom; would all potentially, reduce reactance.

8.3.2 Perceived freedoms

The perceived value of freedoms could be reviewed and explored with the service-user. For example, the power of the threatened or eliminated freedom to refuse medication and decline contact with services could be analysed to investigate any ambivalence or associated uncertainties. Also the value of alternative freedoms could also be examined, so that for example, the value of additional practical help and additional social contact associated with engagement with services could be explored. In this way, practitioners could work with ambivalence to loosen the liking for an eliminated freedom and affirm the value of alternative freedoms, thus reducing reactance. Participants in Cluster C

of the current study were able to identify and value alternative freedoms associated with their CTO and these were indicative of potential freedoms available for CTO service-users more generally.

8.3.3 Perceived threats

In his original theory, Jack Brehm (1966) argued that using non-directive language would soften perceived threats to freedom. This approach could be extended to use therapeutic language and intent to soften the perception of threat associated with the conditions of a CTO. Thus such phrases as “you must ...”, and “you cannot ...”, could be replaced with phraseology such as “some service-users find that ...”, which could also be linked to evidence of therapeutic benefit in order to further soften, without removing, the threat. Softening of perceived threats could be applied to more than language in a reframing of perceived control into an evidence-based therapeutic approach. For example, a counselling approach which could guide service-users is much less threatening than a directive approach which could feel much more authoritarian. Participants in the current study would feel less bullied and intimidated with a softening of the language used and could feel less controlled if a more therapeutic approach was perceived to be offered.

8.3.4 Restoration potential

Reactance is also reduced when a threat to freedom is removed or a freedom is restored. This also applies to a variable extent when restoration is imminent or indicated at some point in the future. Thus, if a service-user can estimate when they will be discharged from a CTO or can perceive movement towards that discharge point, their levels of reactance may decrease and their present experience may become less problematic or distressing. Therefore negotiated dose reductions of medication or frequency of engagement may be, for the service-user, an indication of progress towards that point. Such changes in treatment and contact may become more of an attractive incentive, so that the need for leverage or coercive legislation is reduced along with the levels of reactance.

8.3.5 Brief application examples

Using the data from the current study as brief hypothetical examples, the following basic applications may be illustrative.

Elizabeth was generally very negative about her CTO and could be described as displaying highly reactive traits which motivated her to restore eliminated freedoms through indirect methods. Elizabeth felt that threats to her freedom forced her to accept injections which induced seizures (Extract 6:9); the need for this medication implied, to her, that she did not care for her children (Extract 6:10); and that she was subject to experimental science (Extract 6:10). This threat could be softened for Elizabeth by offering education around medication effect; evidence about improved caring capabilities in recovery; and the use of evidence-based practice in medicine rather than the use of 'Guinea Pigs'. Elizabeth also felt that her freedoms were limited by injustice (Extract 6:18); no opportunity for holidays (Extract 6:18); and feeling stigmatised and different (Extract 6:47). Perceived freedoms could be increased by offering the support and experience of other service-users; holiday opportunities between medication administrations; and also emphasising support with the legal appeals process.

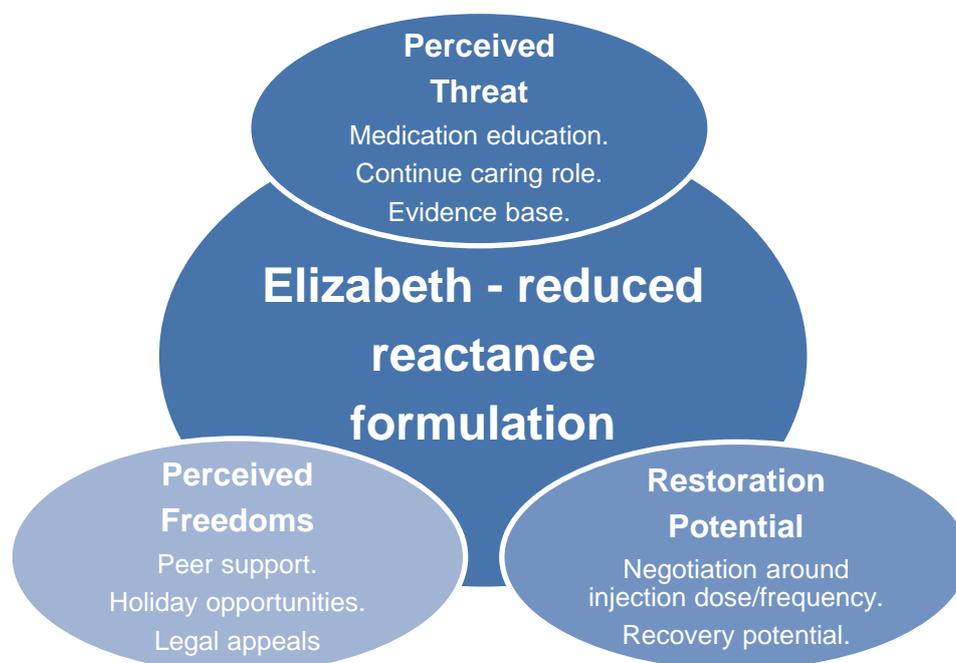


Figure 8.2 Elizabeth – a potential application

Elizabeth also felt that there was little negotiation around her medication (Extract 6:14); and that, generally, she could not see an end to her current situation. Therefore, restoration potential could be increased by offering negotiation linking medication dose and frequency reductions to compliance targets and recovery potential, moving away from the need for a CTO in the future.

John was also generally very negative about his CTO and could also be described as displaying highly reactive traits which motivated him to restore eliminated freedoms through indirect methods. He felt that medication was not only a threat but actual poison (Extract 6:7); he also felt that he could not trust doctors (Extract (6:11); and that the threat of enforced treatment was based on false reports (Extract 6:23). John could be offered education and evidence around medication effect; he could also be offered increased contact with his doctor to develop a personal relationship; and this relationship could be used to review the reports that he finds so distressing. John felt stigmatised and different from his peers (Extract 6:49); that he was subject to injustice (extract 6:19); and that he could not display any anger or strong emotion (Extract 6:15).

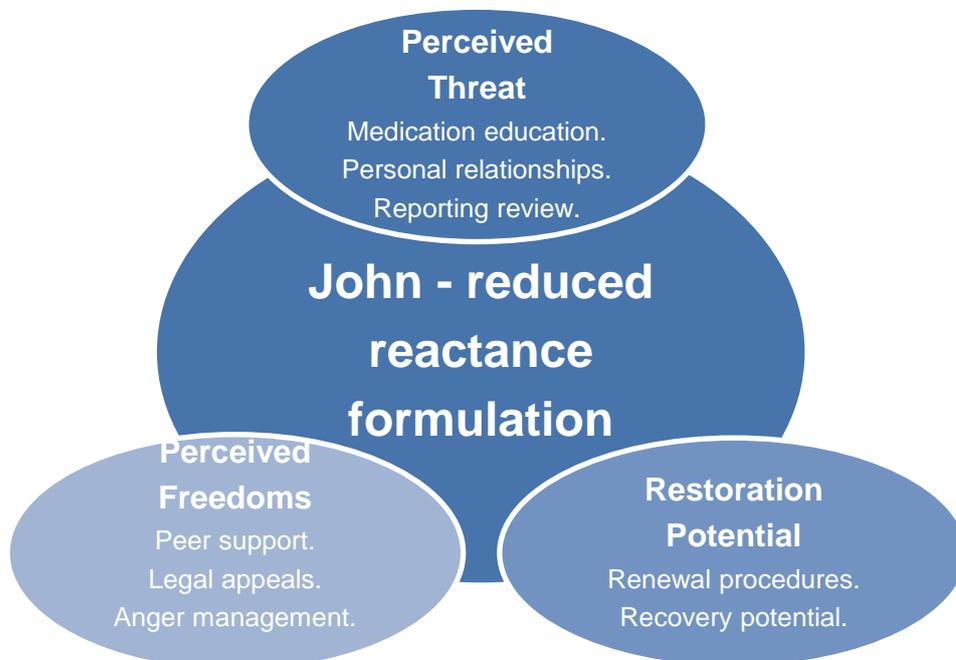


Figure 8.3 John – a potential application

John could explore additional freedoms through peer support groups; the legal appeals process; and the offer of emotional support groups including anger management. He felt a lack of restoration potential because of the perceived length of the 'section' and also a general inertia associated with his CTO; therefore John could be offered education and review of the renewal process for CTOs as well as emphasising the recovery potential for people with a diagnosis of schizophrenia in the community.

8.3.6 Future research

Using Reactance Theory as a framework for investigation, opportunities for further qualitative studies begin to emerge so that the effect of different elements associated with the theory can be examined from differing stakeholder perspectives. There is also opportunity for further quantitative investigation using existing outcome measures in combination with developing reactance rating scales such as the Therapeutic Reactance Scale (Dowd, Milne *et al.* 1991) and physiological measures such as changes in autonomic arousal (Miron and Brehm 2006). This potential future research would be aimed at increasing the therapeutic effect of CTOs rather than attempting to justify the use of CTOs within an environment of increasing social control.

8.4 Evaluation of the present study

According to Brocki and Wearden (2006), qualitative research in general can be 'somewhat mysterious' (p100), and Giorgi (2010) has claimed that IPA is unscientific, therefore it is important that this type of research is fully evaluated. Lucy Yardley (2000) maintained that it has become increasingly important to assess the value of novelty and diversity in qualitative research. She therefore proposed a series of open-ended, flexible principles that could act as a guide when evaluating the quality of a qualitative study. However, Jonathan Smith (2011) argued that IPA, in particular, should be subjected to more specific criteria in order to evaluate its contribution. For the purpose of assessing the quality of the current study these two evaluative frameworks will be combined in order to assess the validity of qualitative approach as well as identifying core features and specific markers of high quality IPA research.

Yardley (2000) listed four 'essential qualities' (p219) as characteristics of good qualitative research:

- Sensitivity to context
- Commitment and rigour
- Transparency and coherence
- Impact and importance

Smith (2011) supplied a list of criteria as guidelines for evaluating good quality IPA studies; the studies should have:

- a clear focus.
- strong data.
- a rigorous approach.
- an elaboration of each theme.
- analysis that is interpretive not just descriptive.
- pointers to both convergence and divergence.
- well-wrought, sustained narrative, carefully written.

If qualitative research is to be useful, quality claims need to 'legitimated by criteria that are meaningful for whose benefit the research was intended' (Yardley 2000 p219). IPA is concerned with the 'meaning of lived experience to participants and how participants make sense of that experience' (Smith 2011 p9). Therefore evaluative claims of the current study need to be meaningful to participants and those attempting to understand that experience.

Sensitivity to context (and a clear focus), is the first essential quality identified by Yardley (2000). According to Smith, Flowers *et al.* (2009), this starts with paradigm, philosophy and methodology selection, which then translates into appropriate methods and analysis. This was particularly important for the current study as IPA had not been used previously in the examination of CTO experience, and sensitivity to the needs and considerations of vulnerable service-users was of paramount importance. This sensitivity towards service-users was

evident in the idiographic approach, the recruitment process and the data collection techniques together with support for the narrative such as using diaries and photo-elicitation. The extensive use of verbatim extracts and the attention to metaphor ensured that the descriptions, interpretation and analysis remained focused on the service-user experience. However, careful review and evaluation of the existing literature and contextual background behind the development of CTOs was always considered throughout the research process. The phenomenological and hermeneutic principles of IPA allowed participants to relate their story, communicate their experience and highlight important understandings, feelings and perceptions in their own words and in a safe environment. Participant descriptions of their experience on a CTO could be credibly taken to be indicative of the experience of CTO service-users more generally. Such claims about potential generalisation are consistent with Smith, Flowers *et al.* (2009) who argue that IPA establishes generalisations by locating them 'in the particular, and hence develops them more cautiously' (p29).

The second of Yardley's (2000) essential qualities relates to commitment and rigour (using strong data and a rigorous approach). Attention to detail and a reflexive approach to the data collection demonstrated this quality in the current study with the use of reflexive boxes. The use of empathic interviewing skills, multiple interviews and supporting elicitation techniques ensured thoroughness in the data collection process. Careful recruitment and an ethical approach to participation appeared to help participants to fully engage with the research process despite the inherent difficulties associated with severe mental illness. The potential importance and development possibilities of the research was recognised and endorsed by participants, the researcher and supervisors which maintained enthusiasm throughout the process.

The need for transparency and coherence (an elaboration of each theme, analysis that is interpretive not just descriptive, pointers to convergence and divergence) was also recognised as essential by Yardley (2000). In the current study, this was primarily represented by the flow and development of conclusions from the literature review, through the study design, analysis and subsequent discussion. All of the generated codes, sub-themes, themes and clusters were

supported by an audit trail of extracts which demonstrated a sensibility to the philosophical foundations of the study. By attending closely to the service-users' CTO experience, the double hermeneutic (making sense of service-users making sense of CTOs), became apparent in the claims about the meanings represented in the data. Yardley's (2000) final essential quality concerned impact and importance (well-wrought, sustained narrative, carefully written). This was demonstrated in the current study by the proposed explanatory theoretical framework and model to guide practice. The extant literature and the current study have shown that CTOs can be distressing for service-users and difficult for practitioners to understand. A framework that can aid formulation and assist in the development of a more therapeutic approach could improve the future effectiveness of CTOs and improve the service-user experience.

8.4.1 Limitations

Potential limitations of the study are focused on two fundamental elements of the research – the participants and the researcher. Whilst recruitment was of a purposeful sample from an AOT and AOT service-users are, generally, representative of individuals likely to be considered for a CTO. That is, people who are generally non-compliant with treatment, described as having minimal insight, difficult to engage with services, susceptible to frequent relapse and readmission to hospital. However, there are other types of service-user often subjected to CTOs, namely, those with a significant forensic history. This type of service-user may perceive their experience differently as they may make comparisons with more restrictive Home Office sections and possible prison sentences. However, investigation of the CTO experience with this type of service-user may be better examined by a separate investigation using a small specialist sample. The other potential limitation involves the dual role of the researcher as investigator and mental health nurse.

The participants that were interviewed all had extensive and intensive experience within the mental health system and would probably be able to recognise the investigator as also a nurse and therefore a care provider within mental health services. It is acknowledged that this may have affected responses from participants to provide the 'correct' answers to general questions posed. In order

to recognise this potential influence, a reflexive position was adopted wherever possible throughout the research process with regular supervision throughout to access independent oversight and scrutiny.

Reflexive Box On commencement of this study, indeed part of the reason for undertaking it, my thinking was unclear about the justification for continued use of CTOs. I now feel that the cautious and limited use of CTOs is justified, but only if their positive impact and effectiveness is enhanced by a more structured therapeutic approach. Such an approach (using, for example, Reactance Theory) could improve the service-user experience, reduce the duration of the order and may avoid the need for a CTO in the first place. This enhanced therapeutic approach would make more sense to a service-user who is trying to make more sense of their proposed treatment experience. It would also make more sense to a mental health nurse in pursuit of their primary caring role.

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Appendix 1.

Ethics approval



Health Research Authority

NRES Committee North East - Northern & Yorkshire
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29 March 2012

Mr Lee Marklew
Case Manager & PhD Student
Leeds Partnerships Foundation Trust
Assertive Outreach Team
St Marys Hospital, Armley
Leeds
LS12 3QE

Dear Mr Marklew

Full title of study: Making sense of Community Treatment Orders: the service-user experience.
REC reference number: 12/NE/0060

Thank you for your e-mail of 29th March 2012. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 09 March 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	Version	Date
Covering Letter		
Other: Interview 2 - Schedule	Appendix 2	
Other: Interview 1- Schedule	Appendix 1	
Other: Photography Consent Form	Appendix 3	
Other: Diary Sheet no.1 - Week beginning April 9th 2012	Appendix 4	
Other: Photography Release Form	Appendix 5	
Participant Consent Form: Research Participant Consent Form	Version 2.0	21 March 2012
Participant Information Sheet: Research Participant Information	Version 2.0	21 March 2012
Protocol		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/NE/0060 Please quote this number on all correspondence

Appendix 2.

Participant information sheet

Faculty of Medicine and Health – University of Leeds

Research Participant Information

An Invitation ... Hello my name is Lee Marklew – a researcher at the University of Leeds, and I would like to invite you to take part in my research study...

Making sense of Community Treatment Orders: the service-user experience

Please read this information before you decide if you want to participate or not, it should answer some of your questions. If you are at all unsure, please talk to others about it such as family, friends or your mental health team. Take your time, there's no rush. If you want to ask any questions or want more information you can contact me on 07985 803973; email hcs712m@leeds.ac.uk or School of Healthcare, University of Leeds, Baines Wing, Leeds, LS2 9JT.

At a glance ...

- A study about people on CTOs.
 - You can help.
- You don't have to take part if you don't want to.
- All information is confidential and anonymous.
 - The results may help others on CTOs.
- Study sponsored by University of Leeds and funded by Florence Nightingale Foundation.
 - Ask your care team for advice.

In more detail ...

What's it about?... Community Treatment Orders (CTOs) were introduced in November 2008 to help people like you make the most of treatment. However, it's not clear how people feel about their CTO and what the CTO means to them. I would like to hear how people make sense of their CTO; listen to their stories, accounts and descriptions of life before and after a CTO.

Why me?... You can help. You are a person on a CTO. Your consultant and care coordinator have given me permission to contact you and explain the study.

What are the potential advantages & disadvantages? ... Many people find that being able to express their thoughts and feelings about their experience with mental health services to an independent person is helpful. It's good to have someone hear and understand what's happened as well as being able to report your experiences. Some people may find that they remember unpleasant, upsetting or difficult times in their lives during the interviews but your care team will be on hand to offer extra support if you need it.

Do I have to?... No, it's entirely up to you whether or not you want to take part. You will be free to stop at any time without having to give a reason. Whether you decide to take part, or stop once we have started, your treatment, your rights and your relationship with your care team will not be affected in any way.

What happens if I agree?... If you agree to take part, you will opt into the study by agreement with me and sign the necessary consent form. The whole of the research process will be undertaken with me. None of your care team will be present unless you want someone to be there. I would like to interview you twice; each interview should take 60-90 minutes to complete and in between the interviews you will be asked to keep a diary and photo journal for 2- 4 weeks. I will supply diary sheets and a disposable film camera(s). You will receive £20 Argos vouchers for the first interview and £30 vouchers for the second to repay you for the time and effort it takes to participate in the research.

Interviews are very informal and although they both have a different focus, they can take place in your home or where you feel most comfortable. In the first interview you will be free to tell me your recent experience with mental health services and anything you want to talk about regarding your CTO. The second interview will be a little different as we will discuss your diary sheets and photo images and how the CTO affects your daily life. I would like to audio-record the interviews, if you agree, so I can recall exactly all the important things you say.

Photo-Journals will help us to discuss your everyday activities and other life events under a CTO. For example, visits to friends or family (you must obtain photo consent on the slips provided) or even just going out to the shops. You will be given a short training session at the end of the first interview to explain the ethics and mechanics of photographic research. Then you'll be able to just click away in your daily life. I will process the films and prints but copyright will always remain with you. However, if any of the images give cause for concern, for example, showing dangerous, illegal, inappropriate or provocative behaviour, we may have to consult with your care team about the photos. The negatives and a set of prints will be returned to you before the second interview and I will retain a copy of the photos in case supervisors or examiners need to see them. All retained copies will be deleted at the end of the study. If any of the images are to be used in the final report or published in any associated articles, specific written consent will be obtained from you and all others concerned, facial features will be blurred and other identifying details will be digitally removed using specialist computer software. A copy of the actual print to be published will be given to you with the photograph release form.

Diaries can record daily activities, events, thoughts, feelings, hopes and aspirations affected by the CTO. *For example, some find that they feel less freedom under a CTO whilst others think they are more independent and yet others feel controlled in their own community.* Simply make an entry every day. I will supply diary sheets and clear instructions, it doesn't matter how it comes out – it's not a writing or spelling test!

Who will know?... Just you, me, my supervisors and possibly examiners will know any personal details. All information about you will be kept confidential and anything you say will only be reported anonymously. I will transcribe the audio recordings personally, leaving out any names, addresses or identifying details. The recordings and any photographic images will be stored securely with access only available to the researcher, university supervisors and examiners. The responses from you and the other participants will be analysed and the results presented in report form. Word-for-word direct quotes will be used a lot in the report but nobody will be able to identify who said them. A short summary of the report will be sent to you for your comments if you wish.

What will they know?... The results will bear witness to your experience; it may help others like you on a CTO and will form the basis of my PhD research degree. As a consequence the results will be seen by academic supervisors and examiners from various universities. Recommendations will be made that may improve service-user's experience of CTOs and guide care teams in providing extra help. I would like to publish the results in scientific journals and in magazines for mental health service-users, carers and health professionals. Remember, you will not be identified in any report or publication. Direct quotes may be used but only you and I will know they are your words.

Who is sponsoring and funding this research?... This research is sponsored by the University of Leeds and supervised by senior academics and experienced researchers. The study is funded by The Florence Nightingale Foundation with full NHS ethical approval.

Who do I contact if there's a problem?... Your Care Coordinator is aware of this study. If there are any aspects of the participation that you find at all difficult we can approach them for support. If you have any private concerns you can discuss them in confidence with any member of your care team.

Thank you so much for reading this information.

With very best wishes,

Lee Marklew

Appendix 3.

Interview schedules

INTERVIEW 1 – SCHEDULE

Opening

My name is Lee Marklew and we met some time ago to discuss your participation in this study. You agreed to take part in these interviews as part of a study investigating how people feel about their CTO and what the CTO means to them.

I would like to ask people how they make sense of their CTO, listen to their stories, accounts and descriptions of life before and after the CTO is in place.

Are you still happy to participate?

Is it OK for our conversation to be recorded?

THIS IS A TIMELINE

Past-----Present-----Future

Mark any significant events/responses with rough dates and comments if appropriate – use timeline to visually stay focused

Initial Question selection (guidance only)

How did your contact with mental health services start?

Were there any memorable/significant events that stand out for you?

Why do they stand out?

When was your first detention under the Mental Health Act ... and how was that?

When was the CTO first mentioned to you?

What were the circumstances?

Where were you?

How did that feel at the time?

Did you know about CTOs?

What does the CTO require you to do?

Do you feel it helps you?

What difference does it make?

Do you feel the CTO improves your life/health?

Did you feel any different when the CTO was in place?

Tell me how you're feeling about your CTO right now?

Imagine, if you woke up tomorrow and the CTO had been removed, how would I know, what would be different in you/for you?

How does the future look to you?

INTERVIEW 2 – SCHEDULE

Opening

My name is Lee Marklew and we met a couple of weeks ago to complete a first interview as part of this study. You agreed to take part in these interviews as part of a study investigating how people feel about their CTO and what the CTO means to them.

I would like to ask a little more about how people make sense of their CTO, listen to their stories, accounts and descriptions of life under a CTO.

Are you still happy to participate?

Is it OK for this conversation to be recorded?

Questions (guidance only) – **Try to build a picture/glimpse into the service-user's life**

Can we discuss your photographs?

How do these photos fit into a typical day/week?

Why did you include this photo?

How does the CTO affect you and this image?

Are there any photo opportunities like this one you left out?

Would your CTO affect you and that missing photo?

Are there any photos like this one that you would like to have taken but didn't?

Would your CTO have affected those photos?

Can we look at your diary entries?

Use specific entries to build a daily/weekly schedule or routine – **how does the CTO affect your day/week?**

Use any out-of-the-ordinary entries to build a picture of ordinary v special events – **how does the CTO affect these special occasions?**

Use each specific photo to add further detail to the diary schedule – **how does the CTO affect your relationship with these people/places/spaces during your day/week/month/years**

Appendix 4.

Example of diary sheet - Pam

Petula.

Diary Sheet No. 1

Week Beginning 20th June 2013

Please complete each box each day for two weeks if you can

Date	What I did today	Thoughts & feelings about my CTO today
Thursday 20th June 27 th June.		
Friday 21st June 28 th June.	Got up phone Mother (well I have no one here) the em tied Bin HA) Dinner washed Dishes. Played a bit of music, LAYED in chair (THEN BACK STARTED) SO WENT ON TO P.O.F (BED) HAD TEA (TOOK PILLS) Just RELAXING ON BED now.	well I can if I WANT I FEEL I COULD. DO MOST THINGS LOVE GET UP GO FOR A WALK ETC. (BUT AT THE MOMENT) I AM UNABLE TO DO LOTS OF THINGS, I WISH THAT I WOULD ENJOY MY ILLNESS STEPS
Saturday 22nd June 29 th June.		
Sunday 23rd June 30 th June		

Appendix 5.

Example of transcription sheets - Elizabeth

TRANSCRIPT FOR INTERVIEW 1 – 16/01/13 WITH 'Elizabeth'

Codes	Original transcript	Exploratory comments
<p>Sentenced to punishment</p> <p>By injection</p> <p>Death sentence</p> <p>Unknown effect</p> <p>With side effects</p>	<p>I: I think it's recording now... this is like er, what we call a time and when we look back in the past, when did all this start with mental health services, was it a long time ago</p> <p>R: My mum says I was 12 years old when she first got in touch with someone</p> <p>I: 12 years, right and have you been...</p> <p>R: But I don't agree to this injection, I feel as though I've been sentenced</p> <p>I: Yea, you said that before</p> <p>R: For something I might not have done and I've been injected and it feels like it's a death sentence, you don't know what this injection's doing, I take seizures now I have this injection</p> <p>I: Oh right, right, so you get lots of side effects do you</p> <p>R: Yea</p> <p>I: Oh dear, and how long have you been having to have the injection</p>	<p>Refers to mum getting in touch with MH services – no hostility or resentment</p> <p>Straight into <u>injection as punishment – been sentenced</u></p> <p>For something <u>MIGHT</u> have done – unsure</p> <p>Refers to <u>injection only - no mention of medication</u></p> <p>Feels like a <u>death sentence</u></p> <p>Don't know what <u>effect</u> it's having</p> <p>May be inducing seizures as a <u>side-effect</u></p> <p>Confirms <u>side-effects</u></p>

<p>Blackmail and coercion to remain at home</p>	<p>R: Well It's like blackmail" cos they say I can't stay at home unless I have the injection I: Right R: So I say, you're making me feel suicidal I: Oh dear, right, is that what people have said to you then. R: Doctor I: Right, so he said you... R: It's labelling people, they should label a tin of beans and feed someone's fucking brain instead of injecting 'em with drugs, practicing the science, 'cos that's what they're doing, practicing the science. I: Right R: Medical science. That's what it's all for</p>	<p>Blackmail – coerced into injection Has to have injection to stay at home – re-frame CTO rationale</p> <p>Blackmail/coercion making her feel suicidal</p> <p>Confirms it is the doctor blackmailing her</p> <p>Labelling her – labelling metaphor?? 'They' should label a tin of beans [rather than her] and feed brains [rather than starving? her brain] with drugs. Just 'practicing' science on her – experimenting?? Repeats – 'practicing the science' – science fiction – media portrayal Mad scientist – science of the mad??</p> <p>It's all about practicing medical science – experimental science</p>
<p>Feeling suicidal</p>	<p>I: So this community treatment order, does this mean that you have to do certain things R: Well I have to be here for nurses all the time and let 'em in me house even if I don't want to I: Oh right, right, so people come and</p>	<p>Has to be at home all the time for nurses – prison at home? <u>Has to let nurses into her house even though she doesn't want to</u> <u>No privacy – no choice</u></p>
<p>Doctors blackmailing</p>	<p>Practicing science Experimental Medical science</p>	<p>Has to be at home all the time for nurses – prison at home? <u>Has to let nurses into her house even though she doesn't want to</u> <u>No privacy – no choice</u></p>
<p>Prison at home – has to allow entry</p>		

Appendix 6.

Example of codes and sub-themes analysis sheets - Elizabeth

ELIZABETH SUB THEME ANALYSIS (Page in transcript)

Devalued and labelled	Depersonalisation	Abnormal experiments	Powerless against enforcement	Ruthless response	Angry at experience
<p>Label tin of beans (2) Labelling, not feeding (5) Labelled because she's skinny (11) Just label and inject her (12) No rights so may as well not exist (16) So don't listen to the mother – she's labelled (21)</p>	<p>Labelling (2) No privacy, no choice (3) Labelled a freak (7) Stigma of freak label (7) Can't trust labels now (10) Restrictive and invasive (13) Feels like a parrot – repeating the same thing (15) Nobody listens just – just labels you a freak (15) No listening to the mother because she's been labelled (16) Labelling affects family (19)</p>	<p>Death sentence (1) Unknown effect (1) Feed the brain (2) Instead of street drugs (2) Practicing science (2) Experimental (2) Medical science (2) CTO no help at all (3) Unclear causes (4) Linked to visual hallucinations (4) Very traumatic (4) Auditory and visual hallucinations (5) Resulted in admission (5) Fakes being well so they don't take her away (5) Unknown effect of experimental medicine (6) CTO first mentioned in hospital (6) Started with trauma (11) Worse than rapist/killer treatment (11) Worse than Peter Sutcliffe treatment (11) Guinea Pig for experimental science (13) Why inject someone who's well (14) Why roasting me (15) Friends and family help (18) Frightened of doctors and experimental science (20) Staff don't care beyond the injection (23)</p>	<p>Blackmail and coercion (2) To remain at home (2) Prison at home – has to allow entry (2) Only alternative hospital (3) Inducing seizures, dizziness, and falls (6) Doctors say it's good as she can stay at home (6) No option, no choice, no dialogue (8) Sentenced to punishment by injection (9) Doctors maintain it's doing good but does physical damage (9) Doctors got it wrong (12) No future, no life on injection (13) No justice in coercion and threats (14) Makes her fall, feel tired and gormless (14) Nothing good about CTO (17) Reduces quality of life (18) Unfair – she's done nothing wrong (21) Not a lawbreaker so why punish (24)</p>	<p>Sentenced to punishment (1) By injection (1) With side effects (1) Doctors blackmailing (2) Injections unfair – could go on for years (3) Iatrogenic seizures (4) By injection (4) Nurses don't care (7) Poor care under CTO (7) Injection makes body and muscles hurt (10) Medicines mean dying younger (10) Injection treatment (11) Injecting people turns them into freaks (14) Turned her into a freak (14) So affects family (15) The problem will spread (17) Injection makes her suicidal (20) Is it all worth it (24)</p>	<p>Past admissions very negative (3) Not her fault (3) They don't listen (7) No respect for nurses (8) Nurses have nothing to offer (8) Nobody listens (12) Makes her very angry (13) She wasn't given a choice (17) She is not heard – listen to doctors (20) Taken everything – no power (21) No privacy, no security (21) Feeling suicidal (2) Doesn't agree – keeps herself well (6) Threat to disappear from family (8) Feels very strongly (9) May lash out (12) Doesn't care (12) Injection will make her leave her family (15) CTO reflects on her mothering ability (21) Feels like disappearing (23)</p>