The Effect of Community Treatment Orders on Identity

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Abstract

Community treatment orders (CTOs), which allow for involuntary psychiatric treatment of individuals who meet particular legal criteria while they are living in the community, have been in effect in Ontario since 2001. Some similar form of mandated community-based psychiatric treatment exists in every Canadian province and in many other jurisdictions around the world. In the wake of deinstitutionalization, CTOs filled a gap in mental health care, allowing for the treatment of people with serious and persistent mental illness (SPMI) who were otherwise unable or unwilling to access care; however, CTOs brought their own host of legal, ethical and practice dilemmas, as well as mixed results in research about their effectiveness. This doctoral research examines the way CTO policy is situated within a larger historical, social, legal and discursive system; the way it is deployed, operationalized and negotiated in day-to-day practice; and the layered effects that this has on the multiple actors involved. This study gives voice to a small and vulnerable subset of the population who, in addition to experiencing mental illness, have layered experiences of stigmatization and low socio-economic status.

The purpose of this study was to explore the cultural context, beliefs and values underlying the CTO and perpetuated by the CTO, as it was used in community mental health care in Ontario, through an examination of its impact on identity of people living with SPMI. The study was guided by a theoretical framework that brought together the work of Michel Foucault on governmentality and Elizabeth Grosz on body image in order to critically examine the issue of identity from both the outside in (how identity is constructed) and the inside out (how that constructed identity is experienced).
It used a critical ethnographic methodology. Data collection included in-depth interviews with persons with SPMI (N=7), family members (N=5) and clinicians (N=10), observations of health care practices for people with CTOs, and analysis of documents used during the CTO process. Data was analyzed using critical discourse analysis.

This study revealed insights in the into social context of CTOs, that is, the complex social landscape in which CTOs operate; the social practice of CTOs, that is, the many steps and many actors involved in the CTO process; and the social impact of CTOs, that is the effect of CTO processes on both the constructed and the experienced identity of the patient, family member and clinician. The constructed identity of the patient included perceptions of the patient as risky, defective, and in need of surveillance; the experience of this identity was characterized by feelings of being criminalized, disconnected, muted, traumatized and gaslit. The constructed identity of the family members included an idealization of families as responsible and available, and instrumentalization of the family role. This identity experience was characterized as a dissonance between roles, a witnessing of the absurd, and as putting a strain on other elements of life/identity. The constructed identity of the clinician in relation to CTOs included the role of enforcer, fall-guy, paternalistic provider, and the patient's adversary. The experience of this identity was characterized by frustration, powerlessness, distress, and an acceptance of dissonance.

CTOs, while facilitating access to some treatments and services, also act to construct identities for patients that further limit their full integration into communities as valued members. An examination of the constituent parts of the CTO highlights areas in which CTO processes could be changed; research participants conveyed areas in which they thought the CTO could be improved, including changes to methods of police intervention, better collection and use of administrative data, systemic change, the use of specific approaches to care, changes to the timings of renewals, and changes to the Consent and Capacity Board hearings. The discussion highlights ways in which a re-examination of the context in which CTOs are used can lead to the consideration of political and therapeutic means to reduce both the circumstances that lead to mental and emotional distress and to improve our responses to mental and emotional distress when these are experienced by members of our communities.

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Contents

Chapter 1 Research Problem.....1
1.1 Community Treatment Orders.....4
1.2 Identity.....6
1.3 Summary literature review.....7
1.4 Research aims and objectives.....10
1.5 Epistemological stance.....10
1.6 Theoretical framework.....11
1.7 Methodology.....12
1.9 Significance and impact for nursing.....13
Chapter 2 Literature Review.....15
2.1 Community treatment orders.....15
2.2 Identity.....33
2.3 Conclusion.....37
Chapter 3 Theoretical Framework.....38
3.1 Inside out: The role of body image in the experience of identity.....39
3.2 Outside in: The role of governmentality in the production of identity.....47
3.3 Implications for this research.....54
3.4 Limitations.....62
Chapter 4 Methodology.....64
4.1 Background.....64
4.2 Setting, sample, & recruitment.....66
4.3 Data collection.....71
4.4 Data analysis.....75
4. 5 Rigor/trustworthiness.....79

4.6 Ethics....80
4.7 Knowledge translation....80
4.8 Strengths & limitations.... 81
Chapter 5 Results....83
5.1 The social context in which CTOs are used....84
5. 2 The social practice: The CTO process....113
5.3 The social impact: The effect of CTOs on identity....132
5.4 Solutions....197
Chapter 6 Discussion....212
6.1 Step 1: Becoming aware of our own and others' constructed identities ultimately allows us more freedom....214
6. 2 Step 2: Sensitivity to how constructed identities are experienced helps us to establish our values 220
6. 3 Step 3: Owning our agency—As our context creates our action, our actions create our context 224
6. 4 Step 4: Defining our values....226
6.5 Limitations....236
6.6 Recommendations....237
6.7 Conclusion....247
References....249
Appendix A Informed Consent Forms....280
Appendix B Interview Guide....301
Appendix C Sociodemographic Questionnaire....303
Appendix D Ethics Approval....305

List of Tables and Figures

Table 1 Participant demographics..69

Table 2 Documents used in document analysis...74

Figure 1 Structure of Results Chapter..84

Chapter 1

Research Problem

Community treatment orders (CTOs), which allow for involuntary psychiatric treatment of individuals who meet particular legal criteria while they are living in the community, have been in effect in Ontario since 2001. Some similar form of mandated community-based psychiatric treatment exists in every Canadian province and in many other jurisdictions around the world. In the wake of deinstitutionalization, CTOs filled a gap in mental health care, allowing for the treatment of people with serious and persistent mental illness (SPMI) who were otherwise unable or unwilling to access care; often, without mandated services, these individuals cycled through shelters, prisons and hospital emergency rooms (Grunberg & Eagle, 1990; Haney et al., 2017; Scull, 2021; Teich, 2016; Wise-Harris et al., 2017; Yamatani & Spejeldnes, 2011). CTOs had the mixed intentions of reducing violence, reducing hospital visits, reducing time in hospital, increasing medication compliance, and increasing contact with community services (Steadman et al., 2001; Swartz et al., 1999). However, CTOs brought their own host of legal, ethical and practice dilemmas. Although many clinicians report that they are a valuable treatment tool (O'Reilly et al., 2000; Brooks, 2007), twenty years since their inception in Ontario, researchers have been unable to demonstrate proof of their effectiveness (Rugkasa, 2016; Kisley et al., 2014). This has created tension within the psychiatric community: some call for a re-examination of CTO policy in light of this lack of strong evidence, questioning the ethics of continuing a practice that significantly impinges on the rights and freedom of individuals (Dawson, 2016); others have stated that the failure of research to prove efficacy should not keep clinicians from using a powerful tool that has made observable improvements in the lives of some of their most vulnerable clients (Karagianis, 2016; Mustafa, 2016).

Adding to these tensions, the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006), ratified by Canada in 2010, calls for an end to all types of involuntary treatment and substitute decision making. This marks a shift in the global culture of mental health care and demands a re-visioning of the way mental health practitioners approach involuntary treatment, including the CTO. This will require a dramatic change not only in the way practitioners and communities think about mental health care, but the way they envision the psychiatric subject (Wildeman, 2013). Figuring out the practical implications of respecting the individual's rights, will, and preferences while still ensuring adequate access to services requires new ways of thinking about the psychiatric subject and their relationship to the mental health care system (Callaghan & Ryan, 2014).

The psychiatric subject has been a confounding figure in history; CTOs are a modern contribution to a long history of conceptualizations of and treatments for SPMI. What we now call psychotic disorders have, prior to the enlightenment and the rise of psychiatry, been interpreted variably as demon possession, foolishness, enlightenment and madness; these disorders have strained and stressed the individuals who experience them, baffled family members, and challenged religious, legal and medical practitioners as long as they exist in historical records (Foucault, 1988; Shorter, 1997). Those who have suffered from psychotic disorders have been the object of confusion, hopelessness, and fear, and have been controlled using various forms of restraint, ostracization and 'treatment'. Individuals in the throes of psychosis have been buried up to their necks in the ground, kept in cages like animals, sent on grueling 'pilgrimages', banished onto a 'ship of fools', kept incarcerated alongside criminals, and, more recently, kept in asylums, and treated with wet sheets, cold baths, straightjackets, muffs, electric shocks, and lobotomies (Charland, 2007; Foucault, 1988; Moran, 2000; Shorter, 1997).

Throughout the modern history of the treatment of mental illness, there have been many philanthropic campaigns for the rights of the mentally ill, and the tension in the history of SPMI extends into this history of advocacy. Dorothea Dix campaigned for the creation of asylums in America in the 1800's, seeing that psychiatric patients were being mistreated in community settings that did not have the capacity to manage their illness (Muckenhoupt, 2003); in the mid-twentieth century Thomas Szasz, along with the American Association for the Abolition of Involuntary Mental Hospitalization, campaigned for the closing of the asylums, citing abhorrent conditions and the loss of agency (Szasz, 2011). Large scale de-institutionalization led to a dramatic rise in the numbers of mentally ill persons who were homeless, incarcerated, and cycling through hospital emergency rooms (Teich, 2016; Yamatani & Spejeldnes, 2011). The creation of diagnostic classification and the advent of medications for the treatment of psychosis in the 1950's were a dramatic boon in mental health care; half a century later, the Diagnositic and Statistical Manual of Mental Disorders (DSM) and pharmaceutical companies are being critiqued as agents in the medicalization of human emotion, and psychiatry is criticized for over-reliance on pharmaceutical management (Caplan, 2015; Jacob, Gagnon & McCabe, 2014; Kawa, 2012). The consumer led recovery movement empowers psychiatric consumers to take charge of their own care; at the same time, this movement has been critiqued as promoting rugged individualism, and for being a convenient way of shifting the responsibility for care from the community to the person with a mental illness (Corrigan et al., 1999; Deegan, 1988; Henwood & Whitley, 2013; Rose, 2014). Contemporarily, human rights activists call for both more treatments for the mentally ill (that is, an increase in the availability of mental health services), and less treatments for the mentally ill (that is, approaches to managing psychological distress that do not involve the psy sciences), creating clinical and political confusion for those who want to improve the lives of the those with mental illness (LeFrançois et al., 2013; Light et al., 2017). This history draws attention to the danger of being naively attached to a single agenda, and warns the researcher, the practitioner and the advocate that mental health care is part of a complex system whose intricacies must be accounted for in the production of any lasting, meaningful change (Cook, 2000).

Globally, the state of treatment for SPMI is varied. Most western countries no longer rely on long-term institutionalized care for the mentally ill, and many have adopted some form of mandated community-based treatments. There are a few notable exceptions and innovative approaches: In Finland, the Open Dialogue approach involves creating therapeutic communities, involving families, resisting diagnostic language in favour of co-created terminology, and minimizing the use of medication (Alanen, 2009; Buus et al., 2017). In Western Lapland, this approach has been credited with significantly decreasing the rates of schizophrenia (Klapcinski & Rymaszewska, 2015), and some other countries have moved forward in an attempt to integrate Open Dialogue into their own settings (Buus et al., 2017; Gordon et al., 2016). In the United States (US), Dr. Daniel Fisher and the National Empowerment Centre have long advocated for a holistic, person-centred approach to mental illness; they are currently promoting a response to mental and emotional difficulty that they call “Emotional CPR”, and training medical and social professionals, as well as laypeople, in this approach to difference and distress (Emotional CPR, 2020; Fisher, 2003, Ware et al., 2007). In Australia, a group of innovative practitioners trialed a group conferencing method for people with SPMI receiving mandated treatment that employed the principles of restorative justice (Beauport & Vernon, 2011). Psychiatric survivors and mental health advocates have created collaborative international communities which promote approaches to mental health care that involve acceptance of difference, no coercion, and non-pharmacological interventions (Mind Freedom International, 2020; International Mental Health Collaborating Network, 2021). The Soteria paradigm is an approach to creating therapeutic communities that provides an alternative to hospitalization for people experiencing psychosis, including those in acute phases psychosis, which involves supportive care, no coercion and minimal use of anti-psychotic medication (Calton et al., 2008). As clinicians, researchers and health administrators continue to posit new ways to manage SPMI, it is critical that, considering the history of psychiatric treatment and advocacy, we attend to and bear witness to psychiatric practices, attitudes and cultures, and commit to unpacking and understanding the norms of mental health care.

1.1 Community Treatment Orders

Mandated outpatient treatment was first trialed in the US in the late 1990’s. In Canada, Ontario became one of the first provinces to introduce CTO legislation as part of Bill 68, a legislative reform to the Ontario Mental Health Act passed in 2001. This law also goes by the name of ‘Brian’s Law’, as the legislation was brought to review after the murder of the newscaster Brian Smith by a man, Jeffrey Arenburg, suffering from a long-term psychotic illness that was untreated at the time of the homicide.

CTO legislation can only be enacted if an individual meets certain criteria, including a history of chronic mental illness which relapses without treatment, creating a substantial risk for either the individual or those around them (Ontario Ministry of Health and Long-Term Care, 2000).

The CTO acts as a legal framework for enforcing a ‘community treatment plan’ (Malatest, 2012). Although the community treatment plan usually contains a multi-pronged approach, including regular contact with a clinical team, and work on rehabilitation or therapeutic goals, there is general agreement that the main purpose of the CTO, and the part of the plan that is enforceable, is medication adherence, usually in the form of long-acting antipsychotics (Lawn et al., 2015; Canvin et al., 2014). If a client refuses this medication, there are pathways through which their community psychiatrist can mobilize the police and hospital systems, so the client is picked up by law enforcement and brought to a hospital emergency room where they are assessed and may be treated involuntarily (Malatest, 2012).

Another important feature of the CTO is the legislated means through which the clients’ rights are protected. According to Consent and Capacity legislation in Ontario, the client must consent to their CTO. If they are found incapable for providing consent, a substitute decision maker (often a family member, sometimes a public guardian) needs to consent on their behalf. At initiation and at every renewal, a client receives ‘rights advice’, usually over the phone, from a member of the Psychiatric Patients Advocate Office (PPAO, 2016). The CTO must be renewed every six months, with one mandatory and one optional hearing before the Consent and Capacity Board (CCB) yearly. These happen in an adversarial format, with the psychiatrist arguing for the CTO and the client arguing against the CTO to a board that consists of a lawyer, a psychiatrist, and a community member. The client is entitled to legal representation for this hearing should they request it (Malatest, 2012).

Many individuals are involved in the orchestration of these medico-legal orders. The psychiatrist orders the CTO, the rights advisor and members of the CCB are involved in ensuring that an individual’s rights are upheld in this process. Family members provide consent. The community treatment plan can involve visits with other allied health professionals such as social workers, occupational therapists, peer support workers and registered nurses. Nurses are usually the ones to negotiate the delivery of the injectable long-acting antipsychotic medication, and therefore are also often involved in accessing police and hospital services if the client refuses their medication. In the case that the CTO is activated, and the client goes to hospital, emergency room or psychiatric emergency services nurses see the client and deliver the medication. In my clinical experience as a mental health nurse, I have observed that the CTO, as it is manifested in these processes, produces a series of effects on the client, clinicians, families and systems involved: some of these effects are intended and others are unintended. A major impetus for this study was my own observation of the nuanced, in-situ intended and unintended effects of CTO legislation; in this study, I had the opportunity to examine the everyday processes by which laws became policy, which then led to practice, which then led to “self-evident” conceptualizations of mental health and mental health care (Roberts, 2017, p.2).

1.2 Identity

One way to consider the intended and unintended effects of the CTO is through its impact on identity. For this study, I employed an understanding of identity as an interface between the self and the world, a way of relating to the world that develops in response to a context and has an effect on the experience of subjectivity (Foucault, 1991; Grosz, 1994). Identity can be considered both from the outside in (how it is produced, inscribed, constructed, created or imposed) and from the inside out (how it is felt, experienced, or lived). Identity can also be an avenue through which to understand both the outer world and the inner world: an individual’s identity embodies information both about the nature of their context and the nature of their self. The CTO acts to produce certain identities, both in those with SPMI and in the others—professionals and family members—involved in the process (Fabris, 2011). These produced identities are then experienced, mediated and responded to by the individuals involved. By looking into the CTOs’ effect on identity, I hoped to capture both how the CTO exists politically (that is, how it exists, not in a vacuum, but relationally and contextually, within a particular socio-economic and cultural space), and to capture how the CTO has profound psychological effects (that is, how it affects the experience of the self for those who are involved in its processes). These ideas are rooted in the works of Foucault and Grosz as will be detailed further in the theoretical framework for this study (Foucault, 1991, Grosz, 1994).

1.3 Summary of Literature Review

CTOs have been the subject of numerous international outcomes studies. Of these, the three randomized control trials (RCTs) (Burns et al., 2013; Steadman et al., 2001; Swartz et al., 1999), two meta-analyses (Kisely et al., 2005; Kisley & Hall, 2014), and the Cochrane review, updated in 2017 (Kisely et al.) all fail to find strong evidence in support of CTOs. Each of these studies reports on the outcomes of re-admission to hospital, number of hospital days, and accessing of community services, with some also including social functioning, symptomology, quality of life, perceived coercion, and victimization. There have also been many controlled and uncontrolled before and after (CBA and UBA) studies, and some epidemiological studies (Rugkasa, 2016; Kisely & Hall, 2014), and these include more mixed results. Of these, UBAs are most likely to show reduced rates of readmission, reduced time in hospital, and increased access of community services (Muirhead et al, 2006; Segal & Burgess, 2006; Hunt et al., 2007; Nakhost et al., 2012; Rawala & Gupta, 2014; Taylor et al., 2015).

There are several methodological issues in CTO outcome research that need to be considered in the interpretation of these results. In RCTs, the most ill patients are excluded for ethical reasons, and others are unable or unwilling to participate until the end (Swanson & Swartz, 2014; Mustafa, 2016). Other issues include that the execution of any particular CTO is left to the judgement of individual practitioners, and the way a CTO is administered can vary widely (Mustafa, 2016). Those performing CBA studies struggle to find matched controls; leading to questions about whether the control group is truly equal in psychiatric symptomology (Kisely et al., 2014). That the majority of positive results come from UBAs could be explained by an increase in access to services that occurs simultaneously with the CTO. Adding to this argument, research into the effect of mental health system issues in the use of CTOs (e.g., lack of community mental health services, lack of coordination, lack of continuity in the provision of mental health services, lack of communication between providers, overstretched providers) has found that CTOs are used as a means of accessing community health services in areas experiencing mental health resource constraints (Light et al., 2017), raising questions about how CTO efficacy may be related to why and how CTOs are used and the political, social and economic contexts in which they are employed.

Qualitative research has inquired into the patient experience of the CTO, the clinician and family perspectives, and rationales for and variations in their use. Patient experiences of the CTO are characterized by “profound ambivalence” (Light et al., 2014, p.348); on the one hand, patients see that CTOs have improved their overall health, decreasing hospitalizations and providing more stability in life; on the other hand, they express intense dislike of the CTO and share experiences of stigma and disempowerment associated with the CTO (Corring et al., 2017; Gibbs et al., 2005; Light et al., 2014; Stenstrud et al., 2015; Stuen et al., 2015). Interview studies find that clinicians identify the CTO as an important tool, however, they also have reservations, and feel restricted by the obtuse medico-legal structures surrounding the CTO (Brophy & Ring, 2004; Canvin et al., 2014). Family members have their own unique perspective; interview studies give poignant expression to the difficulties of everyday life with an untreated family member. Family members are most often in strong support of the CTO as something which has allowed their loved one to exit a cycle of chronic relapsing (Canvin et al., 2014). Some studies have looked at the way users and carers attempt to resolve the contradiction inherent in coerced care (Banks et al., 2016; Lawn et al., 2015), others how the clinical approach used with a client on a CTO can increase or decrease perceived coercion (Pridham et al., 2016). There have been limited ethnographic studies, but those that exist provide insight into context specific rationales and processes: an ethnographic study carried out in England looked at variability in the way that CTOs are carried out in practice, examining the practical and ideological motivations behind the way the CTO unfolded in that particular location (Jobling, 2015). An institutional ethnography, carried out from a nursing perspective, studied the unfolding of CTO legislation in Newfoundland, revealing the nuanced political and social motivations for CTO legislation and practice (Snow, 2015).

Overall, the qualitative research is dominated by interview studies which, by their nature, privilege the views and experiences of the most verbal, congenial patients, while they are treated. This means that patients with profound distrust of anyone who represents the 'system', patients who are highly symptomatic despite the CTO, and patients who are unable, due to cognitive or contextual reasons, to articulate their experience of the CTO would not be likely candidates for these studies. The two existing ethnographic studies use a recruitment approach which has the end result of mimicking this sampling bias.

There are very few works that explore identity within the context of the CTO: I have found only two. One of these is an article that analyses the emergence of the concept of the 'revolving door patient' during the enactment of CTO legislation in Alberta (Barron, 2016), and the other is the book *Tranquil Prisons: Chemical Incarceration Under Community Treatment Order*, which explores experiences of CTOs inclusive of their interaction with and influence on "mad identity" (Fabris, 2011, p.178). There is, however, some literature that addresses the experience of identity in the context of SPMI. A number of authors have discussed the impact of a diagnosis of SPMI on identity formation, with a focus on the experience of stigma and self-stigma (Cruwys & Gunaseelan, 2016; Dinos & Lyons 2005; Ilic et al., 2014; Lile, 2013; Onken & Slaten, 2000), as well as the relationship of identity to coping (Corin, 1998), insight (Klass et al., 2017; Williams, 2008) and agency (Lysaker & Buck, 2006). This is balanced by literature that examines the experience of identity in SPMI as a location of psychotherapeutic insight; this literature focuses on unpacking experiences of fractured identity in order to develop cohesion; e.g., working towards an interpretation of hallucinations or delusions that includes them in an understanding of the whole person (Longden et al., 2012; Kingsdon & Turkington, 2005). Much less explored is the relationship of identity to cultural narratives, including the narrative of mental health care itself.

1.4 Research Aims and Objectives

The purpose of this project was to explore the cultural context, beliefs and values underlying the CTO and perpetuated by the CTO, as it was used in community mental health care in Ontario, through an examination of its impact on the identity of patients with CTOs, family members of patients with CTOs, and clinicians providing care to people with CTOs. This has the potential to inform changes to our current approach to mental health care for people with SPMI, and to allow for the envisioning of improved interventions for this very difficult to serve population, interventions that 1) are informed by and address the contextual aspects of mental health, and 2) are sensitive to the psychological impact of the intervention itself.

More specifically, the objectives of this study were 1) to examine the foundational beliefs, guiding values, clinical principles, legal frameworks, and policies that form the context of the CTO in Ontario; 2) to explore how the many steps of the CTO process unfold in everyday healthcare environments, and analyze the impact of these processes on individual identity production; 3) to explore how this identity was experienced by individuals on CTOs as well as by other key players in the enactment of the CTO, for example, family members and clinicians; and 4) to gather participants' ideas and recommendations about ways to improve the CTO, or potential treatment alternatives.

1.5 Epistemological Stance

I came to this study from the perspective of critical theory. Critical theory opens up a way of thinking about mental health that can be both productive and transformative: critical theory understands human experience as shaped by "social, political, cultural and economic, ethnic and gender values" (Guba & Lincoln, 1994, p.109), and a critical lens allows the researcher to "question both the foundation of thought and action in nursing science as well as its genesis or genealogy" (Foth et al., 2017, p.26). I proceeded with the knowledge that, historically (as noted above), both radical critiques and passive acceptance of mental health care practices have led to non-productive—and sometimes disastrous—consequences for patients. With this in mind, I sought multi-faceted evidence and insight into CTO processes that was respectful of the many parties involved, and brought reflexivity and credibility to the layers of meaning and experience present in many voices (Baumbusch, 2011).

1.6 Theoretical Framework

For this research project, I drew on the work of Elizabeth Grosz and Michel Foucault to inform a conceptualization of identity that was both psychologically nuanced and politically charged (Foucault, 1991; Grosz, 1994). Following the work of Grosz (1994), I considered identity both from the outside in, and from the inside out. Like the Mobius strip, these elements lead into each other and proceed from each other: I examined how the CTO works to produce the social and political identity of those with serious mental illness, I investigated how this produced identity is experienced by the person with SPMI, and this experience revealed trace elements of social and political processes as they have been inscribed and transcribed onto the individual.

I used Grosz's reinterpretations of psycho-analytic and phenomenological understandings of the individual in an exploration of identity from the 'inside out' (Grosz, 1994). The identity produced for the individual on the CTO, through the complex machinations of a larger system, has a psychological reality that is experienced by the individual. Grosz considers a psychoanalytic understanding of the individual not as revealing a deep, inherent truth that is contained in the dark depths of the psyche, but as a tool to understand the subjective experience of an inscribed identity (Grosz, 1994). Grosz stresses the importance of understanding the material nature of the self as a critical element of understanding the effects of power/truth on people, individually and collectively (Grosz, 2004). In the case of CTOs, this underlines the importance of considering the experience of the CTO from the individual's perspective: how the individual experiences and mediates this shaping of themselves and their place within their social reality.

I employed Foucault's conception of governmentality in understanding how identity is formed from the 'outside in', and the role of power in the unfolding of the CTO. The concept of governmentality provides an explanation for how power is both acted on and acted by subjects, and how in particular contexts knowledge and power work together to define roles for particular individuals, such as health care providers, that are based in the rationality of the state (Foucault, 1982; 1991). This power is both individualizing and totalizing: that is, the rationale for cultivating particular qualities in individuals is for the purpose of maintaining existing balances or imbalances of power (Gordon, 1991). This speaks to the way that mental health practices define someone as in need of a CTO, and it speaks to the way that a CTO creates a condition of imbalanced power that produces a certain kind of knowledge, a knowledge that maintains the identity of the expert as the expert and the identity of the patient as the patient (Foucault, 1982). However, it also speaks to the way that mental health care and the actions of mental health practitioners unfold according to the logic of a greater system, a complex system in which the actions of individuals are constantly adapting to reduce the threat of hazards to the whole (Mansfield, 2000; Cook, 2000).

1.7 Methodology

I used a critical ethnographic methodology to fulfill these aims. Critical ethnography allows an exploration of culture and meaning with a political purpose. It invokes “social consciousness and societal change” and is thereby “simultaneously hermeneutic and emancipatory” (Thomas, 1993, p.4). This choice of methodology flowed from my epistemological stance and my chosen theoretical framework. It provided the tools to examine the operation of power within the healthcare system, the effect of this power on identity within the context of the CTO, and how this may restrict the voices of vulnerable participants. Further, I sought to strengthen the voices of the vulnerable with this study.

I analyzed the data using Critical Discourse Analysis (Fairclough, 2010; Fairclough, 2013). CDA is a way of examining discourse, in texts or in speech, that reveals the presence of power structures (Mancini, 2011). CDA is not only descriptive, but normative; it provides a way of examining data to generate not just explanatory or causal knowledge but also future-oriented, potential solutions to problems (Fairclough, 2010). This method allowed my data analysis to capitalize on the critical potential of ethnography (Thomas, 1993), and it allowed me to fulfill my research aims of not only examining the effect of current CTO processes on identity, but also using the research process to create space within the community to consider improved or alternative processes.

1.8 Significance and Impact for Nursing

Although nurses are key players in CTO processes, the nursing voice is underrepresented in the literature on CTOs. This study emerged from clinical dilemmas that arose in the course of my nursing practice and has the potential to inform nursing participation in the complex ongoing debate about CTOs. CTOs involve legal professionals, social workers, psychiatrists and families, and they involve ethically, legally and therapeutically complex decisions made as part of everyday nursing practice (Snow & Austen, 2009). Nurses are located at the juncture between different roles and competing priorities and become translators of information from one party to another, and from one system to another. This creates an epistemologically privileged position where nurses have a view into and an understanding of the needs of multiple players: they understand the institutional priorities, the individualized client needs, the family concerns, the medical imperatives and the legal requirements. However, this positioning at the juncture of multiple priorities is also what leads nurses to keenly experience the dilemmas inherent in coercive treatment. This research exposed the work that nurses do to manage these competing priorities in a way that makes care ‘work’ in the context of the CTO: it also explored ways in which this privileged nursing knowledge could be channeled back to the medical, legal and institutional bodies that are shaping and influencing care. In order to successfully act as bridges between these various perspectives, nurses must have language which captures the effect of these interacting powers and unfolding relationships on the individual with the CTO. Evidence of the effects of CTOs on identity will give depth and nuance to nurses’ understanding of the CTO context and experience, allowing them to better fulfill their professional obligations to both provide care and engage in advocacy. It is critical that nurses are equipped for informal and formal leadership roles in the ongoing evolution of CTO policy and practice, and provision of care for SPMI more generally.

The evidence produced by this research project will be disseminated both locally and more broadly. The research process itself facilitated discussion and reflection at the research sites; in addition, I plan to present the findings directly to the research sites. I also plan to share the research results through participation in national and international conferences, and publishing in peer reviewed journals.

Chapter 2

Literature Review

Since the inception of the CTO in the 1990's, a large body of scholarly work on this subject has emerged; these works include outcome research on the CTO's efficacy, philosophical considerations of its ethical soundness, studies that inquire into the experience of CTOs for patients, as well as family and healthcare professionals, and critical examinations by legal scholars. In this review of the literature, I examine current research on CTOs, looking first at the outcome studies, then studies that investigate the CTO experience for patients, family members and clinicians, then works that examine legal and human rights issues, and finally, focus in on nursing literature in this area. I then examine literature that looks at the experience of identity in the context of CTOs; since there is very little literature on this subject, I also consider works that examine identity in the context of care for people with SPMI more generally, looking first at works that examine the experience of identity, and then works that examine the construction of identity for the patient with SPMI.

2.1 Community Treatment Orders

CTOs have been the subject of considerable research interest, and there is a growing body of scholarly work that includes quantitative outcome studies, as well as qualitative analyses of the experience of the CTO from the perspectives of the service user, family carers, and clinical staff. There have also been a number of conceptual and discussion papers published on this topic, as the coercive nature of CTOs, the ethically and logistically fraught nature of the research process, and the contradictory results produced by existing studies have created a lively debate about CTOs within academic, clinical and legal communities. In this review, I summarize and critique relevant empirical studies, both quantitative and qualitative, while also touching upon some of the editorial and conceptual works in order to enliven this research through an understanding of this ongoing discussion.

2.1.1 Outcome Studies

CTOs have been the subject of numerous international outcomes studies, with variable outcomes. Several high-level reviews have synthesized, critiqued and summarized the results of this research: two systematic reviews (Churchill et al, 2007; Maughn et al, 2014); two meta-analyses (Kisely et al, 2007; Kisely & Hall, 2014); and a Cochrane review, updated in 2017 (Kisley, Campbell & O'Reilly). Notably, all of these came to the conclusion that there was no strong evidence to support the use of CTOs. The Cochrane review concluded: "Based on results from this review, there is no strong evidence to support the claims made for compulsory community treatment." (Kisely, Campbell, & O'Reilly, 2017, p.25). On the other hand, several smaller, naturalistic studies have suggested that CTOs have resulted in positive outcomes for patients, for example, reduced hospital admissions (Muirhead et al., 2006; Nakhost et al., 2012; Swartz et al., 2010;) reduced time in hospital (Awara et al., 2013; Hunt et al., 2007; Muirhead et al., 2006; Segal et al., 2009), and increased community service use (Muirhead et al., 2006; Hunt et al., 2007). Clinically, CTO use has continued to rise, and studies that examined clinicians' perceptions of CTOs generally found that they believed them to be a useful clinical tool (Corring et al., 2018a). This has led some researchers to reflect that a focus on the "gold standard" of evidence (as in the meta-analyses and Cochrane review), and the resulting conflict about the efficacy and ethics of CTO use, have generated "passionate disagreements over whether outpatient commitment is effective [which] hobble good-faith attempts to make it work and to evaluate its impact in different service systems and populations" (Swanson & Swartz, 2014).

In a 2016 review of the research, Rugkasa pointed out that all of the randomized control trials (RCTs) have failed to find evidence in support of CTOs on three primary outcomes (readmission rate, time in hospital, and community service use), the controlled before and after studies (CBAs) have had mixed outcomes, and most of the positive results, supporting CTO use, have come from uncontrolled before and after studies (UBAs). Looking closer at this research, there are three RCT's that look at mandated community-based treatment. The first was done in North Carolina, United States, comparing outpatient commitment to community-based case management (Swartz et al., 1999). The researchers randomized 264 mentally ill patients into CTO and non-CTO groups upon discharge from hospital, with both receiving follow-up intensive case management in the community. Patients with a history of violence were not eligible. The primary outcome measure of the study was time in hospital over twelve months; no difference was found between the CTO and non-CTO groups. In addition, this study found outpatient commitment to be highly correlated with perceived coercion and decreased autonomy. The second RCT came out of the United States again, this time from New York in 2001 (Steadman et al.); it was smaller than the first, with 142 randomized patients. Court ordered treatment was compared with voluntary status and followed up over 11 months. For safety and ethical reason, as with the first RCT, patients with a history of violence were excluded. Both groups received intensive case management. Again, in this study there was no difference between the CTO group and the non-CTO group on any factors, including rehospitalization, arrests, quality-of-life and symptom reduction. The authors reflected this might be because this was a pilot project and some of the CTO enforcement mechanisms were not in effect at the time of the study (i.e., the mechanism for police to pick up a patient who refused treatment).

The next RCT took place in England between 2008 and 2013 (Burns et al., 2013). This study included patients with a history of violence; to manage this from an ethical standpoint, the CTO group was compared to a group that was discharged from hospital under section 17 leave, a type of leave, under UK mental health law, which allows involuntary patients to ‘trial’ living in the community, while still being available for recall (unlike the CTO, it does not allow for the provision of mandated medication while the patient is in the community). Both groups received case management and follow up, and both groups had no significant difference in outcomes measured, which included readmission rate, number of days in hospital, symptoms (as measured by the Brief Psychiatric Rating Scale) social functioning (as measured by Global Assessment of Functioning [GAF] Scale), and outpatient clinical contacts (self-reported). Several follow-up studies were done with the participants in this RCT. In one (Vergunst et al., 2017) a subsample of participants from the original RCT were interviewed regarding social outcomes.

There was no relationship found between CTO duration and improvement in patients' long-term social outcomes. Another follow-up study (Rugkasa et al., 2017) used an observational prospective design to evaluate the use of specified conditions and judicial hearings, finding that conditions were mainly used to ensure medication compliance and contact with services, and that there was general agreement between clinical and legal judgments concerning the CTO. Another study compared the economic costs of the CTO and non-CTO cohorts, both the health system costs and informal costs to the family for care and legal proceedings (Simon et al., 2021). This study found no difference in cost to the health system but increased informal costs to the families of those with CTOs.

The controlled and uncontrolled before and after (CBA) studies have had more mixed results. Several of these found a decrease in hospital readmission rates for patients on a CTO (Hunt et al., 2007; Segal and Burgess, 2006; Zanni and Stavis, 2007); whereas some found increased rates of hospital admission with the CTO (Kisely et al., 2004; Segal & Burgess, 2006). Other CBAs found no difference between rates of hospital admission between CTO and non-CTO groups (Castells-Aulet et al., 2014; Preston et al., 2002). Uncontrolled before and after studies (UBAs) also had mixed results, although overall the findings from UBAs tended to lend support to CTO use. For example, several UBAs showed reduction in hospital admission rates (Awara et al., 2013; Christy & Petrila, 2009; Dye et al., 2012; Frank et al., 2005; Muirhead et al., 2006; Nakhost et al., 2012; Rawala and Gupta, 2014; Swartz et al., 2010; Van Dorn et al., 2010), reduction of time in hospital (Awara et al., 2013; Casetlls-Aulet et al., 2013; Muirhead et al., 2006; Rawala and Gupta, 2014; Segal & Burgess, 2006; Swartz et al., 2010; Taylor, 2015), and increased community service use (O'Brien et al., 2009; Dye et al., 2012). In contrast to the CBAs and RCTs, none of these UBAs reported increases in readmission rates or time in hospital, and only one of these UBAs reported no difference between readmission rate and time in hospital.

Studies done in a Canadian context have had mainly positive outcomes. The first published data in Canada on CTOs was a study done in Ottawa in 2005 by O'Brien & Farrell. The clients on CTOs (n=25) had reduced hospital bed days and increased contact with services, and increased engagement with supportive housing. Since this was an UBA, participants acted as their own controls. With this type of study design, participants may have been referred to community services at the same time as receiving the CTO, making it unclear whether their gains were due to increased availability of community supports or their mandated nature. Interestingly, in this study, over 50% of participants were considered capable at the time of the initiation of the CTO, raising the question of whether this was a higher-functioning group within the spectrum of CTO patients. In 2009, O'Brien, Farrell & Faulkner expanded this study, looking at all of the patients from two major urban university-affiliated hospitals put on a CTO in a three-year period (n=84). In this study, 72% of participants lacked capacity. This study focused on the outcomes of access to community supports and housing and found that there was increased access to supportive housing as well as an increase in community supports for those on a CTO. Since these CTOs required monitoring, usually by community teams, it is unclear whether this is a "process or outcome measure" (Kisely, 2016, p.9).

In 2005, Frank et al. performed an uncontrolled naturalistic retrospective study in Montreal, Canada (n=42), finding that the CTO led to decreased time to readmission. This study was later expanded (n=72) (Nakhost et al., 2012), finding that there was a decrease in hospitalization rates and bed days for people on a CTO during the time that their CTO was in force, and that this decrease was then maintained even after the CTO period ended. Because of the different availability of community mental health services in Ontario and Quebec, the patients in these studies did not have access to intensive case management before or after the initiation of the CTO, leading the authors to speculate whether the CTO was an effective way to manage SPMI in the community in the absence of intensive or assertive supports. A naturalistic, mirror-image study was recently done in Quebec (Frank et al., 2020) that also found a significant decrease in hospital days for the patients with a CTO.

The only Canadian CBA took place in Toronto over a four-year period (Hunt et al., 2007). The CTO group had a matched control group (224 CTO clients and 94 non-CTO clients). The groups were demographically similar, with the difference that individuals in the CTO group met the legal threshold for a CTO and those in the non-CTO group did not. All participants were receiving intensive case management services through the Canadian Mental Health Association (CMHA). Both groups had a reduction in length of hospital stays, but for the non-CTO group, this reduction was higher. For the CTO group, there was a reduction in hospital admissions in the 6-12 months period after the CTO was initiated that was higher than the reduction in hospital admissions for the non-CTO group. It is possible that the reduction in bed days for the CTO clients, who had higher number of bed days before CTO initiation, was in fact a regression towards the mean (Kisely, 2016), that is, that any group of patients whose hospital bed days are measured while they are in a psychiatric crisis will be likely to move closer to the mean over the next six-month period, regardless of whether they have a CTO. More than half of the 224 CTOs issued were not renewed at the six-month mark. It is not clear whether this was because these clients no longer met the legal criteria for a CTO, because their care team thought they would benefit more from voluntary treatment, or because the CTO was allowed to lapse for another reason.

International epidemiological studies have had mixed results. An American study, which used administrative data from the assisted outpatient treatment program in New York (Swartz et al., 2010) found that individuals with an order for treatment (n=3609) experienced increased community service use, decreased in rates of readmission, and decreased time in hospital. In an Australian epidemiological study, performed in Victoria (Burgess et al., 2006), compared rates of readmission to hospital for patients discharged from psychiatric service on a CTO (n=16 216) to those not discharged on a CTO (n=112 211). This study found that those discharged on a CTO had increased hospital use and increased time in hospital; the authors hypothesized this was due to demographic differences in this population, such as higher rates of psychotic illness. A Swedish study (Kjellin & Pelton-Piri, 2014) which compared results of patients discharged from a psychiatric hospital from two years before CTOs were introduced (n=524) and two years after CTOs were introduced (n=514). This study found no difference in rates of readmission, and a decrease in total days in hospital for the CTO group. Recently, a large epidemiological study done in Australia found that CTOs increased community care and reduced readmission, delayed time to readmission, and reduced time in hospital (Harris et al., 2019). This study used data from New South Wales, looking at all persons on CTOs (n=5548) and comparing them to a demographically matched control group. There have been no epidemiological studies done in Canada. In his 2016 review of the literature, Kisely comments on this, stating, “this is surprising given that administrative data are collected Canada-wide for the purpose of managing health care services and, in particular, for providing payment for services” (p. 12). The results chapter of this study reveals that such data, at least in Ontario, is incomplete, perhaps leading to a potential explanation for this lack.

Some studies have looked at the efficacy of CTOs with specific populations. In an Australian study, performed in Queensland, Kisely et al. (2020) found that Indigenous people and people from culturally and linguistically diverse backgrounds were more likely to be put on a CTO, but that the effectiveness of these CTOs remained inconclusive. Another study, also in an Australian context, looked at the effectiveness of CTOs for young people being treated for first-episode psychosis (Bardell-Williams et al., 2019). This study used epidemiological data to determine the rates, determinants and outcomes of CTO use with this population. It found that 17.3% of patients were put on a CTO soon after presentation, and that another 69.75% were put on a CTO within three months. The patients on a CTO had worse social outcomes in regard to education and employment than those not put on a CTO. Another study with the same population (young people being treated for first-episode psychosis), done in Quebec, Canada, with an uncontrolled before and after design, found that the CTO led to improved social and clinical outcomes. One Australian study looked at the relationship between Community Care Unit (CCU) bed use (i.e. long term rehabilitations stays) and CTO use, suggesting that longer stays in CCU beds may reduce the need for CTOs on discharge (Parker, 2021).

2.1.1.1 Limitations

The literature on CTO outcomes has limitations. In two of the three RCTs, for ethical reasons, individuals with a risk of violence to themselves or others were not included. This in itself makes it likely that the group studied was a ‘more well’ group than the average group of individuals on a CTO, creating the possibility of falsely negative results. In the 2013 RCT, which did include patients at risk for violence, the randomized group still had some recall measures (section 17 leave, which allows the responsible physician to recall a patient on a leave of absence from mandated inpatient care). Some argue that this also created falsely negative results, and therefore does not represent a strong argument against the use of mandated outpatient treatment (Mustafa, 2016; Swanson & Swartz, 2014). The CBAs offer some evidence in favour of CTOs, but have been critiqued for having poorly matched controls; ethically and legally, it is very difficult to have matched controls on some of the most important criteria (risk and illness history), as the controls generally do not meet the legal or clinical criteria for a CTO. In addition, there is the issue that the participants with CTOs, who are put on the CTO at a crisis point in their illness, are through the course of the study simply regressing towards the mean (Kisely, 2016; Rugkasa, 2016). With the UBAs, which show the most positive results with CTO use, the lack of a matched control group makes it difficult to know whether the improvements were due to the CTO or to other environmental factors; this ambiguity is heightened by the fact that the monitoring of the CTO often results in a marked increase in services at the same time as the CTO is initiated.

In addition to this, quantitative outcome studies do not provide insight into what qualities of the CTO, the attending physicians, the clinical setting, or the character of the patient may play in the CTO outcomes. CTOs are not a standardized intervention but are initiated and maintained with different nuances by different clinicians (Mustafa, 2016); moreover, they may be useful for some populations and not for others. Additionally, the outcome measures themselves can be brought into question, depending on what is considered the primary goal of the CTO; for example, in many studies, ‘hospital bed days’ is the main outcome measure; even so, there is debate about whether increased bed days is a positive or a negative outcome. Although many researchers cite decreased bed days as evidence that the CTO is ‘working’ (Nakhost et al.,2012; Swartz et al., 2010; Taylor et al., 2015), one study argues that an increase in admissions for CTO clients is a positive outcome, in that it is evidence that individuals with a CTO have access to hospital services in a prompt way when needed (Segal et al., 2017). Some studies look to the

CTO as a way to improve care without an increase in community services (Nakhost et al., 2012); others use increased contacts as a positive outcome measure in and of itself (Muirhead et al., 2006; Hunt et al., 2007). It is one of the objectives of this research study to consider why these outcome measures are seen by some to be self-evident, and to consider how this may be related to larger trends and discourses within evolving global perspectives on mental health.

2.1.2 The CTO Experience

The main focus of the qualitative literature has been the experience of CTOs for patients, families and clinicians; the majority of this research is in the form of interview studies. In addition to this, there are a few quantitative studies that inquire into the CTO experience, mainly in the forms of questionnaires or surveys. Finally, there are two ethnographies that examine aspects of the CTO from multiple perspectives.

2.1.2.1 The Patient Experience

Individuals with CTOs view these treatment orders with “profound ambivalence” (Light et al., 2014). The CTO experience is full of complex and contradictory impressions; patients reported feeling stigmatized and embarrassed by the orders (Light et al., 2014) and of feeling appreciative of the safety and security their CTO provided (Gibbs et al., 2005). In 2017, Corring et al. carried out a systematic review of the international qualitative literature that dealt with patient experiences of the CTO. The themes they unpacked across 22 studies included both feelings of being coerced, and a preference for the CTO versus being in the hospital. Individuals on CTOs reported improved symptom control, and yet resented the CTO processes and the feeling of being controlled. They also noted reports of stress on relationships with family and professional carers brought on by the CTO, and dissatisfaction with a lack of self-efficacy.

A quantitative survey study into the subjective experience of CTOs provides further evidence of this ambivalence (Newton-Howes & Banks, 2014). In this study, more than half of the respondents (n=79) stated that they were better off with the CTO; at the same time, there was a strong negative association with the court proceedings associated with the CTO. An interview study that included some numerical data (n=42) also showed that over half of the clients saw their CTO in a favourable light, with only 3 (7%) being totally opposed (Gibbs et al., 2005). Advantages of the CTO perceived by participants included safety, security and increased access to services, while disadvantages included feelings of restrictions, stigmatization and being under the control of unwieldly medical professionals. A study by Strenstrud et al. (2015) reported on Norwegian patients' experiences of being on a CTO; these patients felt that monitoring of medication compliance was the main reason for the CTO, and that the decisions to both prescribe the medications and monitor them through the CTO were based on a remote medical process that was unmoved by patients' individual preferences.

Several studies arose out of Canadian contexts. One of these, done in Ontario, reported on patients' experiences of CTOs, noting several tensions in patient responses (Pridham et al., 2018). Patients acknowledged some clinical benefits to the CTO, while at the same time seeing it as detrimental to long-term recovery and therapeutic goals. Patients expressed feelings of coercion while on the CTO, while still preferring it to mandated hospitalization; they also reported that, in general, therapeutic relationships were preserved while on the CTO, even though they found they struggled with the enforcer role taken on by the involved clinicians. This study also reported on the double bind that patients feel when facing coerced psychiatric treatment: "But if I stand up for myself they may take it as I am sick, and then put me into the hospital" (p.125). A quantitative study done in Ontario looked at the relationship between perceived coercion and CTOs; it found that patients on a CTO were much more likely to perceive their care as coercive than those not on a CTO; this was increased for patients who had previous histories with the justice system and decreased in patients who felt there was a sense of procedural justice to the decisions made and processes used in the course of the CTO (Nakhost et al., 2018). A further study done in Ontario (Paul et al., 2020) looked specifically at patients' experiences of the Consent and Capacity Board hearings; overall, patients perceived the process as not procedurally fair; this view was shared by many of other relevant stakeholders. Mfoafo-M'Carthy (2014) used a phenomenological approach to understand the experiences of minorities on CTOs in Ontario, finding that individuals on CTOs had positive experiences of the mental health system and of their clinical teams, and increased medication compliance, while also experiencing feelings of stigma and coercion. A 2019 study out of Toronto (Nakhost et al.) used a matched-control design to assess CTO clients' understanding of CTOs, finding that participants in the CTO group knew significantly more about CTOs than the control group and that the control group had more optimistic views of the potential of the CTO to improve physical health through increased monitoring and access to services. The CTO group was "significantly more optimistic about the potential positive impact of CTOs on other service users' quality of life and mental health compared to themselves" (p.726), that is, when they were asked to rate the potential for the CTO to a have a positive effect generally on someone with a mental illness, their responses were much more positive than when they were asked about the positive effects of the CTO in their own experience. Burstow (2015), summarizing two studies which drew on the methods of Institutional Ethnography and Critical Discourse Analysis, notes that patients with CTOs experienced the power of the psychiatric institution following them into the community, where psychiatric 'rules' were able to constrain and regulate their everyday life.

A few studies have looked at CTOs within the context of Assertive Community Treatment (ACT) teams, a common context for CTO use in Ontario. Assertive Community Treatment is a model for community-based tertiary care for individuals with SPMI that combines intensive case management, psychiatric services, and other allied health services in one outreach team. A Norwegian study looking at user satisfaction with the mental health services of patients of an ACT team, contrary to the hypothesis of the researchers, found that the clients on CTOs reported more satisfaction with their care than those not on a CTO (Lofthus et al., 2016). A Canadian study, done in Ontario, looked at how ACT teams reconcile recovery principles with the use of CTOs (Mfoafo-M'Carthy et al., 2018). Although clients associated the CTO with a loss of dignity and respect, they still saw ACT services as being of benefit overall and saw clinicians as individuals who had a genuine interest in helping them.

2.1.2.2 The Family Experience

Families are often integral caregivers to individuals with SPMI; in some jurisdictions, including Ontario, consent and capacity legislation means that the CTO requires consent, and in cases where the individual with the CTO is incapable (the most common scenario), a family member often fulfills the role of substitute decision maker (SDM). Although the formalized systems for collecting data on CTOs are inconsistent, the 2019 legislated review in Ontario noted that 47% of requests for rights advice to the Psychiatric Patients Advocacy Office (PPAO) were for SDMs; since the provision of rights advice to patients and to their SDMs is a mandatory part of the CTO process, this indicates that almost all CTOs involved an SDM (Malatest, 2019).

Family views, as they are represented in the CTO literature, are predominantly in favour of CTOs. In an American study which used an RCT design, family members whose loved ones were on a CTO reported decreased subjective caregiver strain compared to those with loved ones who were not on a CTO (Groff et al., 2004). An Australian survey study found that most caregivers of individuals with CTOs found the CTOs to be of benefit. In the qualitative arm of the OCTET trial, the UK-based RCT (Burns et al., 2013), family carers found the CTO helpful because it “carried legal authority that the carers did not or could not apply themselves, at least not without risk of damaging their relationship with the person they cared for (Canvin et al., 2014, p.1877). In Ontario, a qualitative study which used in-depth interviews to explore various stakeholder’s experiences with CTOs included six family members who were acting as SDMs. Their accounts highlighted that they mostly followed the advice of the physicians regarding the CTO, that many of them found that the CTO did not have a detrimental effect on their relationship with the patient, and that the CTO had a positive impact on the patient’s symptoms. On the other hand, some also reported strain on their relationship with the patient, frustration from working with a mental health system that saw them as passive participants, and a wish that their family member would have more opportunity to express their views of the process (Pridham et al., 2018).

Family members also identified practical, logistical and personal concerns with the CTO process. Family carers felt like they were included when it came to legalities and liabilities (i.e., acting as a SDM, signing documents) but less so in decisions about nuances of care; although they were included in the CTO process, they had not achieved a balanced or a collaborative relationship with the care team (Strensrud et al., 2015). Family carers also reported on the indignities of dealing with the mental health system, a system which they found circuitous and difficult to navigate and in which communication was neither straightforward nor respectful (Light et al., 2014).

A systematic review of family views of the CTO (Corring et al., 2018b) found that families overall saw the CTO has having more positive than negative impacts, and that the CTO increased their involvement in care. However, they also reported dissatisfaction with several aspects of the CTO process, including finding the processes cumbersome and overly focused on medication compliance, finding follow up was “insufficiently rigorous” (p.7), and that the mental health system in general was adversarial and insufficient.

2.1.2.3 Clinicians’ experiences

The literature dealing with clinician experiences contains both positive and negative views of the CTO. It is dominated by psychiatrists’ perspectives, with some nursing and allied health perspectives also. Two survey studies, one done in Canada (O’Reilly et al., 2000) and the other in the United States (Brooks, 2007), showed that psychiatrists generally felt that CTOs were a helpful tool, but that the legal parameters surrounding their use were cumbersome and obtuse. The qualitative arm of the OCTET trial (referenced earlier in regard to patients’ experiences), showed that psychiatrists, much like patients, felt that conditions of the CTO were only useful when they could be enforced, and were therefore often minimal, and centred around medication and contact with the team (Canvin et al., 2014). This study also reported that psychiatrists felt the legal and ethical parameters of the CTOs were unclear, and further, that they capitalized on this in interactions with patients, allowing the CTO to take on a vague and blanketing authority.

Outside of this empirical research, some psychiatrists have spoken out loudly within the academic literature both for and against the CTO. For example, Newton-Howes & Ryan (2017) found it ethically paradoxical that patients well enough to be living in the community could be found incompetent of making treatment decisions and be subjected to CTOs. Therefore they urged lawmakers to recognize that legislation allowing CTOs was outdated and must be changed in light of current evidence. Dawson (2016) also suggested that we need to reconsider this legislation in light of current research outcomes. Karagianis (2016), on the other hand, argued that the failure of researchers to find clear evidence regarding the efficacy of the CTO did not discredit its effectiveness from a clinical perspective. He argues that there is evidence that a core group of individuals with serious psychotic disorders chronically disengage from treatment, and that for this group, the CTO remains an invaluable treatment tool. He makes the point that the success of the intervention depends on “patient selection, the strength of the treatment plan, and the many variables involved in its implementation” (Karagianis, 2016, p.433), implying that the issue of concern is not whether the CTO works or does not work, but when and for whom. Segal (2013), Swanson & Swartz (2004) and O’Reilly (2004) have all published editorials, discussions or review articles in favour of CTOs.

Other studies examined the views of other professional carers (nurses and allied health professionals). Professional carers saw the CTO as a necessary element of mental health care that they used to the client’s benefit, and believed that even the harsher elements of the CTO were ultimately for the good of the client (Brophy & Ring, 2004, Mfoafo-M’Carthy et al., 2018; Pridham et al., 2018). A study out of Australia (Brophy & Ring, 2004) found that clinicians had positive views of the CTO’s efficacy, that they were knowledgeable about CTO processes, and that they felt that clients had input in the care plans and care processes. One interview study in Ontario found that clinicians believed that the CTO, in combination with intensive supports, allowed for fewer hospitalizations and overall improvements in quality of life (Mfoafo-M’Carthy et al., 2018).

Another Australian interview study looked at the intersection of recovery-oriented practice and CTOs (Edan et al., 2019). Clinical staff found integrating recovery-oriented practice into the context of CTO enforcement to be challenging; they also identified a lack of buy-in from organizations and social services, which increased their practice challenges. Similarly, another study, using a modified grounded theory approach, looked at the experience of clinicians within an Assertive Community Treatment setting (Stuen et al., 2018), finding that most clinicians saw the CTO as beneficial for securing long-term treatment for their clients, while at the same time struggling to balance coercive practices with an overall treatment philosophy that promoted patient autonomy.

One study looked specifically at the experiences of nurses. Lawn et al. (2015) discussed how nurses managed the moral framings that surrounded the CTO experience in their daily practice. For example, a nurse made a point of shaking clients' hands, noting that because patients with CTOs were often seen as 'dangerous' or 'bad', nobody touched them. Lawn also noted that the tendency to believe that the CTO was "for the good of the patient" (p.10) became a way that nurses justified situations borne by the CTO that stigmatized or brought indignity or hardship to the patient.

A 2018 systematic review of clinicians' perspectives on CTOs (Corring et al., 2018a) found that, overall, clinicians saw the CTO as having a positive effect on patients although they also saw room for improvement in the CTO processes, finding the current process to be "excessively cumbersome" (p.793). Clinicians generally agreed that medication compliance was the central purpose of the CTO, although there was some confusion around what other conditions should be included in the orders. There were also concerns about the availability of broader services from the mental health and social systems to support people on CTOs, such as availability of adequate housing.

2.1.2.4 Ethnographies

In addition to these survey studies and interview studies, two ethnographies have investigated CTO experiences and practices. Jobling (2015) conducted an ethnography examining CTOs in an English mental health team from a social work perspective. Her aim was to discover how, for whom and under what conditions CTOs worked or did not work. She noted that service users responded to the CTO very differently, and that this depended on varied factors, including the clinical team's ability to maintain some negotiation and reduce levels of perceived coercion, as well as the patients' attitudes towards and previous experiences with mental healthcare. She concluded that CTOs cannot be premised on a single policy aim or they lose the flexibility that can make them potentially useful.

Snow (2015) performed an institutional ethnography that looked at CTOs in Newfoundland, Canada. She found that CTOs prioritized legal issues of risk and public safety above the therapeutic goals of treatment and recovery, and that this changed the way that the labour of living with a mental illness, and accessing mental health and social services was organized both for family members and for nurses. For example, family members became the day-to-day monitors of the CTO, formalizing a role that they may have had informally for some time; nursing roles also changed to take on reporting and enforcement related to the CTO.

2.1.2.5 Limitations

The majority of qualitative research into CTOs is in the form of interview studies; the most pressing methodological issue arising from this research is the likely sampling bias: it is likely that the most congenial, articulate patients would be the ones who agreed to participate in in-depth interviews. It is then possible that the views of some types of patients and patient experiences are not represented in these studies. We can also question the ability of the interview, as it relies on participants' memories and the quality of their relationship with interviewers, to represent all the nuances of the CTO experience. Yet most of these studies are generic, qualitative interview studies, and do not push their data collection or analysis past the spoken reports of the participants. The two existing ethnographies have not corrected for the above sampling bias: Jobling's ethnography used a case study method which meant that participants were chosen based on their ability to manage a certain number of interviews and follow up observations. Snow's study recruited using a letter sent out to potential participants; the individuals who read and followed up on this letter likely represented a higher functioning subset of CTO patients.

2.1.3 Legal and human rights issues

CTOs involve the intersection of medical and legal systems, and as such there exists a body of legal literature regarding them. Some authors have explored how the CTO challenges traditional conceptualizations of human rights from a standard bioethical standpoint, showing the complex balancing act between rights such as autonomy and rights such as wellbeing (Snow & Austin, 2009; Donnelly, 2008; Banks et al., 2016). Others have discussed the UN Charter of Rights and how this calls into question the use of the CTO; the Australian committee on interpreting the charter interpreted it as calling all mandated care, including CTOs, into question (Callaghan & Ryan, 2014). In 2006, the UN Convention on the Rights of People's with Disabilities (CRPD) called for an end to coercive care and substitute decision making and began to envision alternatives; legal and medical scholars have critiqued the CTO in light of this legislation (Minkowitz 2011; Newton-Howes et al., 2019) including critiques that consider specifically a Canadian legal context (Dhand & Joffe, 2020; Sheldon & Spector, 2019). Another study looked at the amount of legal information that clients are given and actually understand; Rolfe & Davidson (2008) found that while some information was given consistently (for example, the right to review by a mental health board), other information (for example, the right to a second opinion) was not provided to the majority of consumers. In Canada, Pallaveshi & Rudnick (2017) compared Ontario mental health legislation pertaining to CTOs to British Columbia laws that govern a similar process called Extended Leave. These authors found that mandated outpatient treatment can be very different, legally, between jurisdictions, further complicating interpretation of outcome studies.

Legal scholars have examined the CTO or portions of the CTO process through the lens of therapeutic jurisprudence (Abisch, 1995; Ferencz & McGuire, 2000; Perlin, 2003; Winick, 2003).
They have also examined the hearings/tribunals which are required as part of mental health law (in Ontario these are called CTO hearings, and involve the Consent and Capacity Board) (Boyle & Walsh,

2020; Carney & Tait, 2011; Jobling, 2019; Tait, 2003; Thom & Nakarada-Kordic, 2014; Weller, 2020; Williams, 2009), looking at access to representation, the clinical or therapeutic value of the hearing, the failures of dignity inherent in the hearing process, and the potential for non-adversarial processes.

2.1.3.1 Limitations

There is a dearth of literature that attempts to reconcile the legal and the medical perspective on CTOs. When legal processes are examined in literature by clinicians (such as Paul, 2020), legal processes are characterized as confusing and non-beneficial; when the medical perspective is discussed in legal literature, it is characterized as paternalistic and inconsistent (Boyle & Walsh, 2020; Carney, 2008). There is no literature that looks at using a therapeutic jurisprudence model for CTO hearings in a Canadian context.

2.1.4 Nursing literature

Nurses play an essential role in making CTOs work; yet their voices and their perspectives are underrepresented in the CTO literature. O'Brien, a New Zealand nurse, has written several articles about coercion in mental health generally, including an analysis of regional variability in CTO use in New Zealand (O'Brien, 2014); she has also published a study that explored the relationship between CTOs and capacity to consent (Milne, O'Brien and McKenna, 2009). Cullen-Drill and Schilling (2008) review the literature on CTOs for a nursing audience, supporting its use. Galon, an American nurse, contributed to an article regarding an ethical justification of CTOs (Munetz et al, 2003), as well as an article that assessed literature that provided methods of ameliorating perceived coercion in CTO use (Galon & Wineman, 2010). Jansson, a Swedish nurse, led a phenomenological study focusing on the creation of therapeutic relationships within the CTO context (Jansson & Fidlund, 2016), finding that relationship building in this context was challenging, and that without strong therapeutic relationship, patients experienced greater vulnerability. Canadian nurses Snow & Auston (2009) published an article looking at the bioethical implications of CTOs for nurses. Snow, referenced earlier, went on to do a PhD that examined the nature of the "work" of mental health and mental illness, and how this was affected by the (then new) CTO legislation in Newfoundland (Snow, 2014). Norwegian nurses Strensrud and Granerud collaborated on a study that examined family carer perspectives of the CTO (Strensrud et al., 2015).

2.1.4.1 Limitations

Nursing work forms an essential step in the actualization of medical and legal orders and objectives; it is nurses who come face to face with the patient at the moment of medication administration. Nurses are often the ones who manage the tensions intrinsic to the CTO, as they manifest both in the patient and in the nurse themselves at the point of care. In addition, nurses often act as managers of the outpatient teams which monitor and maintain patients on CTOs. Yet, the nursing literature on CTOs is limited in its scope, and within the available literature, very little addresses the particularities of nurses' roles and experiences.

2.2 Identity

As will be discussed in further detail in the next chapter, the work of Elizabeth Grosz and Michel Foucault act as the foundation for the examination of identity in this research. Drawing on their work, I define identity as an interface between the self and the world, a way of relating to the world that develops in response to a context and has an effect on the experience of subjectivity (Foucault, 1991; Grosz, 1994). Although the focus of this study is identity within the context of the CTO, a search of the literature found only two works that addressed this directly (Barron, 2016; Fabris, 2011). Therefore, I looked at literature that dealt with the subject of identity within the context of SPMI more broadly. In line with the theoretical framework for this study, I looked first at literature dealing with the experience of identity within SPMI, that is, from the 'inside out' (Grosz, 1994). This was by far the more common way to address issues of identity in SPMI in the literature. I then looked at literature that speaks to the way that the identity of someone with SPMI is constructed or produced by their social and cultural position, that is, the way that identity is produced from the 'outside in' (Grosz, 1994).

2.2.1 Inside Out

Psychotic illness can be seen as a failure of identity integration. Grosz (1994) speaks about psychosis as a breakdown of identity—where one's thoughts and feeling are perceived as being outside of oneself, or as controlling, messaging, or haunting oneself. This interplay between identity and psychosis arises in several ways within the literature. Corin (1998), performed a study in Quebec which used psychological phenomenology and hermeneutics to unpack the lived experience of people with schizophrenia who had experienced de-institutionalization; she looked at differences in how they constructed their identities, noting that certain patterns in identity related to the person's ability to cope in the world. One interview study, done from a nursing perspective in Spain, examined how individuals with schizophrenia had trouble ordering their life story, and how this affected their personal identities, leading to experiences of isolation and alienation (Saavedra et al., 2009). A quantitative study out of Switzerland looked at the relationship between insight, defined by the researchers as a social-identity process, and social functioning, finding that, for patients with schizophrenia, insight had a positive impact on social function as measured by the Social and Occupational Functioning Assessment Scale (SOFAS) and the GAF scale (Klaas et al., 2017). Another quantitative study, done from a psychology perspective and performed in Maryland, measured the stigma sentiments of patients with a diagnosis of schizophrenia against a control group; both groups had strong stigma sentiments related to schizophrenia, and for the group with a diagnosis, this correlated with their self-identity (Aakre et al., 2015). A qualitative study, done in New Zealand from a psychology perspective, used taped therapy session with patients with bipolar disorder to examine the impact of the disorder on the development of self; they found that the disorder created discontinuity and confusion which made it difficult to establish continuity in their sense of self (Inder et al., 2008). A quantitative study, done in the US, looked at the association between a number of factors, including self-stigmatized identity and self-efficacy (Waynor et al., 2020). The authors found that a self-stigmatized identity had a significant impact on patients' self-efficacy, while recent hospitalization did not.

There is also a body of literature that suggests how to therapeutically manage issues of identity in SPMI. One study, done in the UK, looked at how men with psychotic illnesses could find a positive identity through sport and exercise (Carless & Douglas, 2008). A study done in Israel used standardized scales to measure self-concept clarity, self-stigma, meaning in life, and recovery in patients with schizophrenia (Hasson-Ohayon et al., 2014). The researchers found negative correlations between self-concept clarity and self-stigma, self-stigma and meaning in life, and meaning in life and recovery; in discussing these results, they suggest that a diminished self-concept leaves the patient vulnerable to internalizing stigma, which leads to hopelessness and low motivation, which in turn affects their recovery. Some authors have considered the therapeutic benefits of unpacking experiences of fractured identity (e.g. auditory and visual hallucinations, delusions of control) and including them in an understanding of the whole person (Longden et al., 2012; Turkington & Kingdon, 2005). A UK study found that when mental health professionals responded to and were sensitive to issues of power, safety and identity, it increased service users' perception of quality of care (Bacha et al., 2020). A US study looked at the use of continuous-identity cognitive therapy in the context of SPMI, finding that it reduced clinical symptoms of hopelessness and suicidality, and had a positive effect on future self-continuity (Sokol et al., 2021).

2.2.2 Outside in

Fewer studies examine the relationship between identity and context: to see not only how a fractured identity can affect one's experience of the world, but also how one's experience of the world can lead to a fractured identity. Researchers have examined the tendency of certain populations to have higher rates of schizophrenia after they immigrate, for example, Surinamese migrants in the Netherlands, or Caribbean migrants in England (Anglin et al., 2016; Beards et al., 2013; Bhugra et al., 1997; Boydell et al., 2001). McIntyre et al. (2016) used grounded theory to explore the possibility that the social disconnection experienced by migrants, and the effects this has on social identity, could help explain the higher rates of psychotic illnesses in this population. Selton and Cantor-Grae (2005), examining this phenomenon, developed the social defeat theory of schizophrenia which proposes that permanent neurochemical changes can happen in relation to being in socially defeated positions, where one occupies an outsider status. In her ethnography of life on the street for people in Chicago, Luhrmann (2007) utilized this theory to explain the identity construction of marginalized individuals seeking mental health services, arguing that social defeat was a common feature of many of the contexts in which people with SPMI live.

Two works look at identity construction within the context of the CTO. Barron (2016) examines how a certain identity is produced, socially and culturally, for the CTO patient through discourses that arise in political, social, media-driven and therapeutic environments. He used critical discourse analysis to look at the legal proceedings and media articles that arose in Alberta, Canada during the lead-up to CTO legislation, and observed the creation of the identity of the "revolving-door patient" (p.290). Fabris, a self-identified service-user, also spoke of identity in his book *Tranquil Prisons: Chemical Incarceration Under Community Treatment Orders* (2011). He discussed the constructed identity of the CTO patient, how this was in conflict with a 'mad' identity, and how neither of these were sufficient to capture his subjective experience of self.

Other scholars have considered the impact of mental health care environments on identity. For example, Roberts (2005) speaks of how mental health care ties the user to a vulnerable identity that increases the control of psychiatric power, while Larsen (2007) writes about the identities that are conferred by notions of curability versus chronicity in treatment of psychosis.

2.2.3 Limitations

Studies that examine identity within the context of SPMI show the relevance of this concept to the care and treatment of individuals with psychotic disorders, yet there have been very few studies that look at the impact of the CTO on the identity of those involved in the CTO.

2.3 Conclusion

Although there have been extensive studies in many jurisdictions internationally, the research on CTOs remains divided and unclear. Many researchers argue that due to the lack of clear evidence showing the benefits of CTOs, their use should be minimized. Nonetheless, CTO rates continue to increase around the world, and many clinicians argue that for some populations they have distinct therapeutic benefit. Whereas most of the literature about CTO experiences shows that clinicians and families are in favour of CTOs and see their benefits as outweighing the negatives, patients are deeply ambivalent about CTOs, at once recognizing that they have had a stabilizing effect and recounting experiences of stigma and coercion. Issues of identity, as related to CTO use, have been underexplored in the literature, although many research studies confirm that this is a relevant and essential issue in the understanding and treatment of SPMI. The nursing voice is also under-represented in the literature on CTOs, despite nurses' essential role in the CTO process.

Chapter 3

Theoretical Framework

Global discussions about mental health to some degree acknowledge that people are shaped by their contexts (Felitti et al, 1998; World Health Organization, 2004; McCrory & Viding, 2015), however, mental health care still overwhelmingly revolves around an understanding of individuals as discrete units, with the origin and cure for disease located within themselves (Rose, 1990). This reliance on neurobiological and, to some extent, psychotherapeutic solutions to the problem of mental illness can distract from a conversation about the political causes and solutions to mental distress, and to the importance of psychological interventions that are inclusive, kind, and aimed at collective problem-solving. If we perceive mental distress through a social and cultural lens, while remaining attuned to individual experiences, then we open up the possibility of new political and ethical responses (Chapman, 2013).

Through the work of Foucault and Grosz, I present a conceptualization of identity as produced within a political context and inscribed onto a psychological actuality. I then apply this understanding of identity to the context of CTOs. The CTO is a politically forged construct that acts to shape identity, and this identity is written onto and experienced as the psychical actuality of individuals with SPMI and, to a lesser extent, others involved in the process, such as family members, community actors, healthcare providers and law enforcement. The CTO, by its nature, locates the cause and the solution to mental distress within a discrete individual, thereby potentially disconnecting a psychological experience of identity from the larger, political context which it may explicate. By studying the CTO through an investigation of how it acts to shape identity, and how this identity is experienced by individuals, individual experiences of identity may in turn act to reveal something about the nature of the CTO and the larger political structures within which it exists.

In her work *Volatile Bodies* (1994), Elizabeth Grosz draws on psychoanalytic theory, neurobiology, political theory, and philosophy to build an understanding of the subject as a body that is at once produced by contextual factors and lived and negotiated through self-knowledge and self-understanding; she labels these two viewpoints for understanding the forces at play in subjectivity as “inside out” and “outside in”. These two directions are like the two sides of a Mobius strip, endlessly affecting each other. Here, I will use Grosz’s exploration of the role of body image in the creation of subjectivity to illuminate the subject’s experience of identity from the “inside out”. I will then use Foucault’s concept of governmentality to look at the production of identity from “outside in”. In Grosz’s examination of identity from the outside in, she utilizes the work of Foucault as well as the work of Nietzsche, Deleuze & Guttari, and Kristeva; I have chosen to focus on the work of Foucault, and specifically his work on governmentality, because this work is particularly applicable to the CTO, as will be discussed in detail later in this chapter. This approach is consistent with the perspective of critical theory: it considers the way that social and political forces have shaped the present (Guba & Lincoln, 1994), and how knowledge construction can act to resist oppressive forces (Weaver & Olsen, 2006).

3.1 Inside out: The role of body image in the experience of identity

Grosz was interested in understanding the experience of a subject that was the site of “economical, political, sexual and intellectual struggles” (1994, p.19). In this way, she rejected the idea of a ‘tabula rasa’ and a dualistic conceptualization of mind-body and advocated instead for a layered understanding of the self that drew on multiple perspectives, was non-essentialist and was non-reductive. This subject was inscribed by a complex web of causation and was itself a part of this web: a subject that was both “signifying and signified” (1994, p.18). In order to understand this subject from the ‘inside out’, Grosz explored the subjective development of body image through the lens of psychology, neurophysiology and phenomenology. Herein, I will consider how each of these areas contributes to a formulation of what it means to experience identity, and then consider how this formulation can be applied to the experience of a patient with a CTO, as well as those involved in their care.

Grosz used psychoanalytic theory to explore “psychical topographies” (Grosz, 1994, p.27): the way in which mental representations of bodies are inscribed and re-inscribed with meaning through childhood and other significant experiences. These tracings have concrete social and cultural meaning and are created through an individual’s relationship with their environment and with other people. Psychical representations of the body, for example, those represented by the homunculus, give value and meaning to areas of the body; they do not represent a projection of the physical self, but a projection of meaning, of data points, of areas in which the subject meets and receives information from the exterior world. It is the subject’s ability to hold in mind a sense of themselves—an identity—that brings sense to a vast array of sensual data, and which allows the subject to assert “some kind of propriety over those experiences...of taking responsibility for them” (p.31). But this image of the self, crucial for a stable identity, is derived “vis-à-vis others” (p.48); it is through experiencing the boundary between the self and the world that one comes to have a self-image. The self is “mapped socially” (Lacan (1977) cited in Grosz (1994), p. 45). A cohesive identity brings together information and understanding of the self in relation to one’s environment, and is necessary for a subject to have “activity and agency....mobility and social space” (Grosz, 1994, p.19). Alternatively, a fractured identity diminishes a subject’s ability to successfully direct their actions and navigate interactions within their environment.

Through the theories of Freud, Lacan and Collois, Grosz presented an explanation of the symptoms associated with psychosis as the result of the fracturing of identity. The person experiencing psychosis is no longer able to identify whether thoughts and sensations come from inside themselves or from outside themselves; thoughts with which the subject does not identify are perceived as auditory hallucinations. Others experience autoscopy, where the subject sees itself as if it were outside itself. In this state, a sense of autonomy and agency are lost, and an individual experiences delusions of being controlled. One’s ability to form and to identify with a self-representation—in other words, the cohesiveness of one’s identity—is critical to being able to function in the world; interruptions and disruptions to this mapping can have critical consequences. Within a cognitive model of treatment for schizophrenia, “hallucinations are conceptualized...as automatic thoughts that are perceived by the client as originating externally, that is, from outside the mind.” (Kingdon & Turkington, 2005, p.119); this model also recognizes the psychological vulnerability that comes from externalizing tendencies; in this view “paranoid thinking may be defensive or functional (effective) in reducing discrepancies between the ‘actual self’ and the ‘idealized self’” (Kingdon & Turkington, 2005, p.6). Linking this externalization to a fractured sense of identity—an incomplete or inconsistently held image of the self—as proposed by Grosz, provides a potential mechanism for how psychological and social vulnerabilities combine in the etiology of psychotic thinking.

Grosz turns to neurophysiological phenomenon to further explore the relationship between self-concept, the subject, and their environment (Grosz, 1994). She explores the way the concept of ‘body image’ has been critical to the way that psychologists and neurophysiologists have approached phantom limb experiences, hypochondria, depersonalization, and postural schemas. She uncovers a brain that has an understanding of itself that is “mobile, changing” (1994, p.67), based on ongoing input from itself and its surroundings, and which has “extreme pliability”, noting “the inherent amenability of the body image to immense transformations, upheavals and transcriptions according to psychical, behavioral, biological, social, and signifying changes” (1994, p.85). This body image is critical to understanding sense data, to combining sensations such as tactile and visual data, and to the bodies kinesthetic sense of itself, which is necessary for coordinated movement.

Body image disturbances “may affect either the ways in which the subject perceives and experiences his or her own body, sensations, or movements, or may affect the ways in which the subject is able to relate his or her present postural position to wished for goals or action” (Grosz, 1994, p.70). Body image disturbances can have a physical cause, such as phantom limb pain, where the body retains a sense of a limb that is no longer physically present, or hemiasomatognosia, in which a cortical lesion makes an individual unable to recognize half of their body. However, these disturbances can also have a psychological cause, such as in depersonalization, in which the subject is detached from experiences of the body, or apersonalization, which involves “a transfer of the meaning which other people’s body parts have for them onto the subject’s own body image, resulting in the treatment of one’s own body as an outside object” (p.84). Grosz points out that in psychotic disorders “the subject’s sexual life is transposed from its socially expected locations, aims and objects to elsewhere, either to different erotogenic sources or to different objects with different aims” (p.78). Interestingly, recent research has shown that individuals with schizophrenia, who can experience self-disturbances such as “depersonalization, fuzzy demarcation between one’s own body and others, feelings of body disintegration or dislocation, the feeling of a distance between oneself and the world” (Giersch, 2019, p.106), also have anomalous bodily maps of emotion, with “less discrete and less clear bodily sensations across emotions” (Torregrossa et al, 2015, p.1060).

Using the phenomenological approach of Merleau-Ponty, Grosz considers the body as a phenomenon experienced by the subject, and the implications that this has for self-identity. She describes Merleau-Ponty’s position that a sense of oneself—one’s identity—gives one access to, and mediates one’s understanding of, the rest of the world. She then connects this to the subject’s sense of agency, their ability to act in the world; it is being aware of oneself as being in space that allows one to take up an active role. A sense of identity is what gives the self an understanding of how it can be at once both a subject and an object, “a single ‘thing’ folded back onto itself” (Grosz, 1994, p.95). It is a sense of identity that allows one to perceive, but it is perception, both of the self and of objects, that allows one to develop an identity. In this Grosz adds another layer to her argument that we cannot reduce or binarize our understanding of the subject; a subject must be “situated in space” (p. 91), and is the “point of central organization of perspective, the point which organizes a manifold into a field” (p.91).

In a paper examining phenomenological approaches to self-experience in schizophrenia, Grosz (2015) considers the characteristics of “diminished self-experience...feelings of ‘unreality’, and a sense of rupture between mind and body" (p.3). Schizophrenia is considered as a condition of disturbed ipseity, where the subject no longer feels ownership of their presence in the world, which then leads to disruptions in the "feeling of being an agent or locus of action" Grosz, 2015, p.4). She points to research that demonstrates reduced anterior cingulate activation in schizophrenia, which is thought to reduce the ability to hold a body image, reduce the sense of "mine-ness" of the body, and lead to diminished self-experience. The proposed antidote to the lack of "realness" is a relationship with someone who is able to emotionally engage the individual and acknowledge and confirm the individual's experiences and perceptions. A powerful first-person account of therapeutic treatment provides an example of how the therapeutic presence of a clinical professional can potentially ameliorate this experience:

> I cannot feel my being anymore. I cannot feel myself. I cannot have control over an action. If I cannot feel myself, I cannot feel. I cross the street, and I don't realize it, and I must cross it again...I am not aware of the presence of my own person...I cannot say 'I' in relation to myself, but only in relation to others. But when I am here talking with you all this does not happen. (Staghellini, 2004, p 123-124)

Through theories of psychoanalysis, neurophysiology and phenomenology, Grosz conceives of a corporeality for the individual subject that is closely tied to an immaterial context—that is, to the sense and meaning that they give their experiences. She posits that the "increasing complexification" (2017, p. 251) of the material world that resulted in life, happened in parallel with the increasing complexity of the immaterial, of "ideality or conceptuality" (p. 2017 p. 251), that is, the "emergence of...sense, whose elaboration through language and collective cultural and political practices is the condition of thought or the concept" (p.251-252). This immaterial world of sense, or meaning, allows material to find patterns, order and direction; it is separate from the material world but also complex, layered and ever changing through its interactions with itself and with the material world. "As an incorporeal frame, the world of meaning or sense enables living beings and their chemical and biological constituents to orient themselves in relation to objects and each other, to direct their own actions, to give meaning and value to things, including themselves, and to develop languages and design systems that refer to, address, signify, or express things, relations, events, and the universe they inhabit" (2017, p.253). In this conceptualization, the meaning given to social experiences, including stigmatizing or deprecating, or devaluing experiences have real and lasting consequences in the physical world. For the subject, self-perception—the meaning that the individual assigns to their physical being located in space—can have physiological consequences that are lasting, and themselves the pre-condition for other consequences and lasting effects. Within this framework, experiences which increase or damage an individual's self-worth are creative, generating experiences with an organizing power that can affect individual identity. It is sense and meaning that "connects material things together, enabling ...identities to emerge" (Grosz, 2017, p.253).

3.1.1 Applying this framework to the experience of the CTO

CTO's are most often used for patients who have psychotic illnesses; as we saw above, this may mean that they already have a disrupted sense of identity, and are suffering from the effects of these disruptions on their agency and their relationships with others and with the environment. The social defeat theory of schizophrenia provides a potential heuristic mechanism by which to understand the processes that underlie this disruption in the ability to form a cohesive identity. This theory, developed by Selten & Cantor-Grae (2005), grew out of research into the increased rates of schizophrenia among migrant workers in European countries (Boydell et al, 2001; Cantor-Grae & Selten, 2005). Selton and Cantor-Grae were looking for a way to understand the common elements in characteristics that increased risk for schizophrenia, including migration, low IQ, deafness, autism, and perceived discrimination. Their theory was that social defeat, defined as "subordinate position or 'outsider status'" (2005, p.101) could lead to neurobiological changes that led to psychosis: "chronic exposure to social defeat may lead to sensitization of the mesolimbic dopamine system and/or overactivity of the system, and thus further the development of psychosis" (2005, p.102). They pointed to animal studies that showed that rats who were put in a position where they were at a disadvantage and forced to display submissive behaviour, showed changes in brain activity. Repeated experiences of defeat led to behavioural sensitisation "in which the animal displays an enhanced behavioural response to dopamine agonists" (2005, p.102). Of potential relevance, they also noted that "lengthy isolation after defeat amplified the changes in dopaminergic activity, whereas return to the group mitigated the changes" (2005, p. 102).

The theory of social defeat provides an illustration of Grosz's analysis: it links a psychological experience (defeat) with a neurobiological response, making the argument that together these form the foundation for a phenomenology of the untenable, of the unbearable. Repeated subjection of the self, for the sake of survival, without the mediation of a community of belonging, creates an experience of the self—an identity—that is "shut up within itself yet persecuted by alien entities endowed with their own agency", and "exiled from relationship with others" (Grosz, 2015, p.17).

In a 2007 paper, Luhrmann, a psychological anthropologist, applied the theory of social defeat to her observations of homeless mentally ill persons navigating the social systems in Chicago. Reflecting on the social judgments people needed to endure just to eat, urinate, and sleep, Luhrmann writes, "It may be because of these humiliations, large and small, that homelessness becomes such a corrosive, punitive identity" (p.159). She goes on to explore how within this dis-enfranchised culture "being crazy is the worst possible identity you can assume" (p.160), synonymous with being "isolated, disliked, unreachable" (p.162). She points out the cultural trend in psychiatry to favour biological over psycho-social causation for mental disorders, theorizing that this is partially a backlash from the theory of the schizophrenogenic mother which was popularized in the 1970's, and which caused unnecessary and unhelpful distress to families (Luhrmann, 2007; Slipp, 1973; Seeman, 2002). However, by linking the identity of "crazy"—a mental health label that people necessarily assumed in their quest for adequate services—to the theory of social defeat, Luhrmann forces us to reflect on not only how difficult social experiences can lead to psychotic disorders, but how cultural and systemic responses to mental illness can influence the course and outcome of the disease. These can include labelling, and broad cultural stigmas around mental illness, but they can also include the types of attitudes expected to be taken by those seeking mental health services, and the behaviours expected of them, such as an acceptance of monitoring (Furedi, 2004), openness about their inner life (Roberts, 2005), the time, effort and discomfort of keeping multiple appointments, and the tolerance of medication side effects (Light et al, 2014; Canvin et al, 2014). In some instances, this can also be inclusive of the expectation that they take part in what their care team determines to be ‘recovery’ activities (Henwood & Whitley, 2013).

This has distinct relevance for this inquiry into the effect of CTOs on identity. The CTO as a clinical intervention is intended to reach people who are at risk, either to the community or to themselves, and mediate that risk. It is therefore one of the tools that mental health clinicians use to lift people out of difficult circumstances—poverty, homelessness, repeat use of emergency services and inpatient experiences, loss of relationships—and assist them with reaching a level of stability where they are not experiencing these daily humiliations. However, being on a CTO includes a host of new experiences, such as being informed by a physician or health care team that one will receive medication whether one agrees to it or not, of being picked up by police if one refuses, of standing before a Consent and Capacity Board to argue one’s side of the case, and of having a family member act as one’s health care decision maker. Beyond these, there is potentially a host of other, more nuanced and individualized experiences related to being on a CTO that have a wide range of impacts on the individual’s experience of themselves. These experiences have the potential to impact an individual’s sense of themselves, the meaning that they ascribe to their body in relation to its environment, their ability to maintain a cohesive self-image, and to their feeling of wellbeing or safety in the world. This in turn has the potential to impact their sense of agency—their ability to understand themselves as a location of action on and in the world. By inquiring into these effects, we consider, as Luhrmann did, whether the conditions of treatment may themselves “enhance the severity of their illness, and exacerbate its course and outcome” (2007, p.163). This then opens up the possibility of designing interventions that are protective of individual identity: that are designed to value the individual’s experience, be conducive to a cohesive self-image, and allow for continuity between the individual and their environment.

3.2 Outside in: The role of governmentality in the production of identity

In an interview conducted by Becker, Fornet-Betancout and Gomez-Müller in 1984, Foucault reflected that, “The concept of governmentality makes it possible to bring out the freedom of the subject and its relationship to others—which constitutes the very stuff of ethics” (Foucault, 1997a, p.300). Here, Foucault highlighted not only the value of the concept of governmentality for understanding the construction of the subject, but also the value that reflection on governmentality may have in allowing one to act and form oneself outside of relations of oppression and domination (Foucault, 1997a). Foucault’s concept of governmentality provides a means of understanding the CTOs effect on identity from the “outside in” (Grosz, 1994, p.xiii). Herein, I consider how the concept of governmentality applies to mental health care settings through an exploration of the ways in which governmentality influences knowledge and relations of power in a pervasive way that involves both overtly political structures, pastoral agents (such as the church, health and social services), inter-individual relations, and even individual conscience. This will become the framework for understanding how power is disseminated through the processes used in the course of initiating and maintaining CTOs, and how the rationality of the state acts to inscribe subjects, becoming a force in the production of their identity.

The concept of governmentality provides a means of understanding the objectives and modes of the modern Western state, and in so doing, provides a way of conceptualizing the way that certain types of knowledge and relations of power came to have a diffuse and substantial impact on social and political life. Foucault traced the object of government from a period in history where it had the circular purpose of protecting the interests of a sovereign (the purpose of the rule of the sovereign was to protect the rule of the sovereign), to the modern-day, where the purpose of government is more broadly focused on the population (Foucault, 1991). Along with this change in focus came a change in the understanding of what it meant to ‘govern’: good governance required both upward and downward consistency. Upward consistency required that the one who governed must also employ self-governance; downward consistency required that good governance extended to the wealth and behavior of each individual, and the minutiae of everyday life, in the same way a patriarch would give attention to maintaining the economy of a family. This downward line was enforced by the police, by "apparatuses of security" (Foucault, 1991, p.102), and it was also the impetus for the development of bodies of expert knowledge that allowed for the understanding and control of populations.

The power of the state, removed from an individual (the monarch), became a "scandalous and all-powerful reality whose nature escapes the intelligence and constitutes a mystery" (Thau, 1966 cited in Gordon, 1991, p.9), and at the same time, becomes focused on an increasingly broad and complete regulation of life. Foucault (1991) defined governmentality as three things:

> 1. The ensemble formed by the institution, procedures, analyses and reflections, the calculations and tactics that allow the exercise of the very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security.
> 2. The tendency which, over a long period and throughout the West, has steadily led towards the pre-eminence of over all other forms (sovereignty, discipline, etc.) of this type of power which may be termed government, resulting, on the one hand, in the formation of a whole series of specific governmental apparatuses, and, on the on other, in the development of a whole complex of saviors.
> 3. The process, or rather the result of the process, through which the states of justice of the Middle Ages, transformed into the administrative state during the fifteenth and sixteenth centuries, gradually becomes governmentalized." (p.102-103)

The governing of individual and collective conduct involves a form of power that affects all subject relations in a society. This is executed in large part through governmental institutions or agencies, like the police, the military, or the courts; however, it is also more insidiously implemented through a diffuse web of subject relations, through the transmission of values and ideas that are supportive of the rationality of the state (Golder, 2007). Churches, schools, health care agencies and families all become vehicles for governance, a governance that is concerned "at the level of consciousness of each individual who goes to make up the population" (Foucault, 1991, p.100). Along with this shift of the focus of power towards the details of individual and collective life (the general economy of population) grew a multitude of types of expertise: bodies of knowledge that had the aim of better understanding and better maintaining the population on both the individual and the collective level, that implicitly or explicitly supported this rationality (Mills, 2004). These knowledges worked to expose, normalize, explain and express the minutiae of human experience (Foucault, 2010a).

One of the means by which governmental power becomes diffused throughout all subject relations is ‘pastoral power’. Pastoral power began as a power exercised by religious institutions, where “the pastor must really take charge of and observe daily life in order to form a never-ending knowledge of the behavior and conduct of the members of the flock he supervises” (Foucault, 2007, p 181). However, in the modern Western state, pastoral power shifted from a focus on saving souls to a focus on health and wellbeing, and in so doing, this power diffused through a multiplicity of institutions (Golder, 2007; Mills, 2004). The goal of pastoral power, as part of a system of governmentality, was to cultivate the strengths of the individual in such a way that it also cultivated the strength of the state (Gordon, 1991). In this way, governmentality wielded a power that was at once individualizing and totalizing (Foucault, 1982). That is, this power extended deeply into the private life of individuals and extended its ideology to the totality of subject relations. It is this “tricky combination” (Foucault, 1982, p.782) that gives it such pervasiveness and strength.

Pastoral power “cannot be exercised without knowing the inside of people’s minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it” (Foucault, 1982, p. 783). As power shifted from religious institutions to health care systems, psychiatry developed a special and important role in the totalizing and individualizing power of governmentality (Rose, 1990; Foucault, 1982). Foucault was interested in how the birth of psychiatry represented a new kind of subjugation of the subject: one that was not just physical, but that required observation and judgment of thoughts and emotions (Leoni, 2013). Foucault did not conceive of insanity as a self-evident condition, but one that emerged alongside a focus on rationality that characterized enlightenment values (Foucault, 1988). He traced the development of psychological sciences and methods, as used in maintenance of well-being for the general population, as a technology for constituting the subject (Dreyfus, 1987, Rose 1990, Roberts, 2017). The experts and expert bodies of knowledge that have proliferated around the psychiatric conceptualization of the subject (diagnosis, pharmaceutical management, psychotherapeutic techniques, administrative approaches, and legal apparatuses) begets and substantiates an imbalance of power. Foucault questioned the self-evident nature of professional knowledge, looking at what conditions emerged to make certain things knowable (Mills, 2004). He stated “it is impossible for knowledge not to engender power” (Foucault, 1980, p.52). Conversely, imbalances of power act to engender knowledge (Mills, 2004). An example of this is the power gained when an expert (for example, a mental health nurse) gains knowledge about a patient. Mental health care, in this conceptualization of power, creates the conditions under which one person becomes powerful, and therefore authorized to speak truth, and another person becomes less powerful, and their voice becomes meaningless, disregarded, and/or silenced.

Another relevant concept that helps in explicating the relationship between governmentality and mental health care is that of ‘biopower’. Modern western governmentality consists of “a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them” (Foucault, 2010, p.259). The modern state developed two ways of managing human life, the first being the “anatomo-politics of the human body” and the second being the monitoring and regulation of information such as birth rates, mortality rates, and longevity, a “bio-politics of the population” (Foucault, 2010, p.262). Through both elements, control of the body and control of the population, individuals are identified and managed according to their usefulness to the state. Others have argued that biopower is evident in mental health care in the sterilization of the mentally ill (Perron et al., 2005) and in making mentally ill people more docile through the mandating of treatment through the use of forensic mental health courts (Nordburg, 2016). Roberts (2005) draws attention to the role of psychiatry in exercising power such as restraint, seclusion and locked wards, but importantly also points to the “more refined and subtle forms of power” (Roberts, 2005, p.36) used in mental health care, such as analysis, monitoring and other ‘panoptic’ strategies.

Panoptic strategies form another way of understanding the totalizing and individualizing effects of governmentality. The panopticon is an image that Foucault employs to illustrate the relationship between the subject and power (Roberts, 2005). It is based on a prison design described by eighteenth century philosopher Jeremy Bentham: this prison is a circular tower in which a guard, invisible to the prisoners, is positioned in the middle. This allows for the possibility that the guard may be watching any cell at any time, but it also means that the prisoners are never aware of when it is their cell being watched (Mills, 2004). This leaves them in a position of constant self-monitoring; in this way, “a new form of internalised disciplinary practice occurs: one is forced to act as if one is constantly being surveyed, even when one is not” (Mills, 2004, p.45). Foucault uses this image as a metaphor for the pervasive way in which the state codifies relationships of power, which at their most powerful and most subtle, enters into the consciousness of individuals. Psychological sciences have a powerful role in this development of constant monitoring. For example, the use of the ‘confession’ in the practice of psychotherapy: “the client is invited to observe and monitor their own thoughts and feelings, and on the basis of the psychotherapist’s theoretical framework, adjudicate for themselves which are to be understood as ‘normal’ and ‘abnormal’” (Roberts, 2005, p 37).

Governmentality, through its use of pastoral power (such as mental health care), and the technologies and expert knowledge of the psychiatric sciences, changes the way that individuals relate to themselves and to the world. Mental health care constitutes a subject, and produces “psychiatric identities” (Roberts, 2005, p.34). Foucault proposed two meanings of the word ‘subject’: “subject to someone else by control and dependence; and tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to” (Foucault, 1982, p.781). Governmentality is not something that may or may not have some impact on an otherwise complete, cohesive subject; it is a diffusion of power that runs through all relationships in society in a such a way that it is productive of a subject. This subject is beholden to the state both explicitly, through regulatory apparatuses, and, more insidiously, by the way their own identity has developed in relation to the values and logic of the state. Psychiatric discourses, diagnositic categories, psychotherapeutic approaches, practices of documentation, pharmaceutical technologies, and mental health law all play a role in the production of subjective identity both through direct observation and control, and through the development of norms and values that become part of individual conscience (Roberts, 2005).

“The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated Self (adopting the illusion of a substantial unity) and a volume in perpetual disintegration” (Foucault, 2010c, p.83). The subject is a vehicle for history, a vehicle for power, a site of conflict between warring rationalities. By applying the concept of governmentality, Foucault posits, we are able to understand individual struggles for freedom within a larger context, within a “government of individuation” (1982, p.781). These are struggles against the ways certain knowledges are privileged (e.g. psychiatric knowledge) but also against the “mystifying representations imposed on people” (1982, p.781) (e.g. psychiatric identities). Mills (2004) suggests that Foucault, through his focus on the diffusion of power, also provides a clue to the means for resistance to this power: namely, that resistance must be multi-directional and multi-tiered, and that it may take place at the level of subject relations. In the case of the power diffused through mental health care, then, this gives impetus to examine the way that this power plays out in the day to day practices of care, and the routine interactions between psychiatric patients and psychiatric care providers.

3.2.1 Application of governmentality to the CTO context

By framing an inquiry into the impact of CTOs through the lens of governmentality, we can see how this practice, within the context of mental health care, may allow the exercise of a “very specific albeit complex form of power” (Foucault, 1991, p.100), with a logic that is based in the governance of populations, through the application of complex clinical knowledge, highly developed technologies (e.g.

long acting injectable psychotropic medication) and the apparatuses of security (police). Moreover, CTOs particularly, more than other elements of the mental health act, reach state powers, through the pastoral agents of the mental health system, into the private life of the individual, so that they are under sustained observation and control, not within a state institution, but while they go about their day-to-day life. This application of governance works not only through institutions and agencies, but by permeating inter-individual relationships; the provision of care practices related to the CTO are marked by a clinician-patient relationship which is both profoundly intimate and a location of drastically imbalanced power. The intimacy of this relationship—its incursion into personal feelings, thoughts and ideas—allows this power to enter into the very conscience of the individual. In this way, it inscribes identities onto the involved parties—both clinicians and patients—by creating norms and imperatives for self-monitoring thoughts and behaviours that seep into the subject's understanding of themself.

Looking at the impact of CTOs on identity through the lens of governmentality allows for reflection on the cultural values that are transmitted and reinforced through the 'rituals' of this process, the manner in which power relations and power structures are present in the way that the CTO is designed and enforced, and the way that this is manifested in the construction of psychiatric identities. Ultimately, this reflection leads to opportunities to conceive of approaches to SPMI that explicitly acknowledge that structural and political forces play a role in individual well-being, and which are designed to mediate the inscriptive power of psychiatric care on subjective identity. An examination of what appears to be self-evident with the practices of mental health care, opens us up to new ways of seeing problems (Roberts, 2017), and new ways of seeing problems has the potential to impact inter-individual relationships and individual identity. As Foucault stated, the purpose of the concept of governmentality is to "bring out the freedom of the subject and its relationship to others" (Foucault, 1997a, p.300), that is "to liberate us from the type of individuation which is linked to the state" and thereby "promote new forms of subjectivity" (Foucault, 1982, p.785).

In this way, this study joins an international project of increased critical reflection on “psych” techniques within mental health care. Overall, there has been an increase in the degree to which mental health care has experienced examination and change, both internally and externally (Roberts , 2017), as well as international calls for a fundamental change to mental health practices, specifically ones that involve coercion practices or substitute decision making (United Nations, 2006). Remarkably, amid this climate, and despite a lack of evidence supporting its efficacy (as seen in the previous chapter), CTO use is on the rise in Ontario (PPAO, 2016). This demands our attention and our critical reasoning; as a critical researcher and mental health nurse, I grapple with the competing priorities inherent in the CTO: to help and to control; to free and to constrain. By using the lens of governmentality, nurses and other health care providers can engage in a fundamental part of their task as health care providers, that of “bringing into question power relations...a permanent political task inherent in all social existence” (Foucault, 1982, p. 792).

3.3 Implications for this Research

The work of Grosz and Foucault act in combination to form a theoretical foundation for this research project. Here, I will consider the challenges in combing these perspectives, and how they work together to form the conceptualization of identity that is central to this research project. I will then consider how these approaches to identity combine to create a consideration of agency and ethics that enrich a critical research methodology.

3.3.1 Compatibility

Grosz and Foucault have differing but not incompatible notions of the subject. Foucault rejected taking a firm position on the ontology of the subject, as this would be antithetical to his overall project (Gordon, 1999), and Grosz purposely drew on multiple theories of subjectivity, finding consonance in the way that each illuminated the non-reductive materiality of the subject, even if this non-reductive materiality was outside of the project of the original thinker (Grosz, 1994, 2017). Combining these two perspectives relies on an understanding that Grosz remained critical of the theories she mined; for example, a Foucauldian subject is ontologically in opposition to the subject of psychoanalysis, but Grosz's interpretation of psychoanalysis allows it to illuminate the complexities of the inscribed body postulated by Foucault, as I shall argue next.

Foucault's subject is more than simply the passive product of power relations and yet less than self-creating (Gordon, 1999). He states: "The individual is an effect of power, and at the same time, or precisely to the extent to which it is that effect, it is the element of its articulation." (Foucault, 1998, p.689). Foucault saw philosophies which prioritized analysis of the self-consciousness of humans as obscuring the way in which individuals are not agents of but the vehicle and the material of power (Mansfield, 2000). In this way, Foucault seems possibly incompatible with Grosz, who looks deep into the human experience, privileging the body as the primary vehicle through which we come to understand the world (Grosz, 1994). However, there are aspects of both Foucault's and Grosz's theories which draw them closer together. Foucault, in his later works, delved deeper into the subject and freedom, focusing on the nature of the subject—particularly, its agency—as a precondition for power (Foucault, 1982). This conceptualization of the subject, which some think represents a significantly different ontology of the subject from his earlier work (Gordon, 1999), becomes the impetus to his focus on ethics— "what is ethics if not the practice of freedom, the conscious practice of freedom?" (Foucault, 1997a, p284). Whether or not this is an ontological shift, the idea of the body as the site of power is threaded throughout his work.

This idea is also highly relevant to Grosz's conception of the subject. In Grosz's reading of Foucault, "the body is that materiality, almost a medium, on which power operates and through which it functions…the body itself functioning almost as a 'black box' in this account: it is acted upon, inscribed, peered into…yet its materiality also entails a resilience and thus also (potential) modes of resistance to power's capillary alignments" (Grosz, 1994, p.146). Although she privileges self-experience as a vehicle for understanding ourselves and the world, Grosz carefully demonstrates how the body is inscribed on by contextual forces and, in fact, becomes a political site for action (Beasley & Bacchi, 2000). She acknowledges the contradiction between the theories she employs, in their original form: some seeing individuals as meaningful depths, the others as surfaces inscribed on by history (Grosz, 1994). She freely reinterprets and uses them to inform the inside out/outside in Mobius strip of subjectivity, reconciling these alternate perspectives with the statement, “All the effects of depth and interiority can be explained in terms of the inscription and transformations of the subjects’ corporeal surface” (Grosz, 1994, p.vii). By combining the work of these two philosophers, I am carrying on in their respective traditions of using philosophical reasoning with the intent of improving understanding of complex phenomena, without attempting to reduce these phenomena into neat and simple absolutes.

3.3.2 Identity

The works of Grosz and Foucault combine to form a conceptualization of identity that informs this research project, and this conceptualization of identity has certain features, namely: 1) identity is formed through contact between exterior and interior forces, 2) identity gives cohesion to a subject made up of disparate forces, 3) identity is changeable, and 4) identity is linked to a sense of agency. Each of these features will be further discussed next.

Identity is formed during contact between interior and exterior forces. In Grosz’s exploration of the role of body image in the formation of identity, she considers the translation of exterior events into interior meaning, considering how the social and political world form the contexts for the mapping of the self. The body is “a point from which to rethink the opposition between the inside and outside, the private and the public, the self and the other” (Grosz, 1994, p.20). For Foucault, identity is formed when political and social events are inscribed onto the body through relations of power (Foucault, 2010c). For this research project, this provides an impetus for an examination of how individuals interact with social and political events to create the data points which allow for the mapping of their identity.

Identity gives a sense of cohesion to a subject made up of disparate forces. Grosz speaks of “the production of an identity for what is always varying” (2017, p.102), and speaks about the role of identity in drawing together the bits and pieces of experience, creating cohesion in the image of the self as an active agent in space (1994). Foucault speaks of the self as “a volume in perpetual disintegration” (Foucault, 2010c, p.83), alluding to an identity inscribed by historical events, but able to be dismantled into parts, and also speaks of care of self as a struggle between competing forces (Foucault, 1997c). The process of transforming social and political discourses into subjective identity—what the subject understands itself to be—is productive of the self, the subject (Foucault, 1982; Mills, 2004). For this project, this provides an impetus to look specifically at what may create and threaten cohesiveness in identity, such as the CTO and associated practices; it also prompts a consideration of what contextual factors lead someone to choose an oppressive or burdensome cohesiveness over a fraying, or disintegrating experience of freedom.

Identity is changeable. There are two elements to this: first, the types of political, cultural and social interactions a subject encounters over the course of their life continue to mold and shape their identity. Foucault speaks of subjects’ engagement with culturally-derived procedures that “determine their identity, maintain it, or transform it in terms of a certain number of ends” (1997b, p. 87). Second, a socially and politically forged identity can be transformed through acts of critical reflection. Foucault states “the purpose of history, guided by genealogy, is not to discover the roots of our identity, but to commit itself to its dissipation” (Foucault, 2010, p.95), an understanding of history that is “against identity” (1997b, p.160). Grosz speaks of resisting the “stasis of an identity” (2017, p. 113), and a body that is “capable of being rewritten” (1994, p.60). The implication for this research is therefore twofold: healthcare practices such as the CTO have ongoing influence on a subject’s identity, and reflective practices have the potential to dismantle oppressive or oppressing identities.

Identity is linked to a sense of agency, an agency that can be diminished or enhanced. Grosz (1994) links a cohesive sense of identity to a feeling of being able to act in the world, to a sense of agency and control. Moreover, she links a subject (who is reflective about their identity) to a sense of ethical action. Foucault, speaking of the freedom of the subject in relation to ethical practices, speaks of "how the subject constitutes itself in an active fashion through practices of the self" (Foucault, 1997a, p. 291); however, he also acknowledges that:

> when an individual or social group succeeds in blocking a field of power relations, immobilizing them and preventing any reversibility of movement by economic, political or military means, one is faced with what may be called a state of domination. In such a sate, it is certain that practices of freedom do not exist or exist unilaterally. (1997a, p. 283)

Here he acknowledges that practices of the self or practices of freedom are not accessible when subjective identities have been constituted in such a way that a group has ended up in a state of domination. For this project, this prompts an investigation into what contexts may create a state of oppression that in turn limits agency for some groups and, conversely, what contexts enhance the potential for agency.

This framework guided my choice of methodology, my choice of data analysis, my approach to data collection, the types of observations I made, and the questions that I asked. I sought out complex, varied data about how relations between individuals during the course of psychiatric care for people with CTOs impact clients' (and the surrounding subjects') identity: I looked for experiences of identity cohesion or identity fracturing, the creation of norms that enter into individual conscience, infiltration of state ideologies and expectations into personal spaces, and experiences of social defeat, or social mediating, and effects on personal agency. This conceptualization of identity allowed for research that is politically charged and psychologically nuanced. Like the mobius strip, these outer/inner elements led into each other: an examination of how the CTO worked to produce the social and political identity of those with serious mental illness led into investigations of how this produced identity was experienced by the person with SPMI; these experiences, in turn, revealed trace elements of social and political processes as they had been inscribed and transcribed onto the individual. This has the potential of opening up new ways of thinking about SPMI, highlighting the potential for changes to social, economic and political circumstances to prevent or relieve mental distress. Focusing on identity allows the measure of any new solution to be the degree to which it creates space for a re-articulation of subjects as sites of knowledge-power, the way in which it allows the subject to be rewritten, and the extent to which it is an act of liberation which opens up the potential for acts of freedom.

3.3.3 Agency

Finally, from a critical research perspective, this multi-faceted, layered understanding of identity offers a way of reconciling the tension inherent in critical research between drawing attention to the constructed nature of injustice while also maintaining a commitment to radical and transformative social change. That is, to finding a balance to which we understand the subject—both research participant and researcher, patient and clinician—to have identities constructed by social and political forces, and the degree to which we understand the subject to have the freedom—the agency—to act ethically in the pursuit of social good. Critical researchers are invested in the first—in the understanding of the constructed subject—because it offers an understanding of injustice and inequality that is based in a misalignment of resources and in discrediting experiences and not in the ‘nature’ of the marginalized subject. However, critical research is also strongly grounded in an ethical pursuit; critical ethnographers study culture not only to describe it but also to “change it” (Thomas, 1993, p.4). Critical researchers make explicit their goal of strengthening the voices of the vulnerable and having an emancipatory purpose (Foley & Valenzuela, 2000; Bransford, 2006).

Both Grosz’s and Foucault’s conceptualizations of the identity of the subject inform their works on the nature of agency and how this relates to ethics. Grosz explicitly sets out to explore how the nature of the inscribed subject is connected to the possibility of ethical pursuits, reasoning a complex relationship between identity, agency and ethics. In agreement with Foucualt, she sees ethics not as a constructed morality, but as the seeking for “a life which regulates itself, develops its own style, its own modes of self-enhancement and expression in the world” (Grosz, 2017, p. 133). For Grosz, an ethical life is a life in which the subject is able to achieve self-expression, an “immanent ethics to adequately address ways of living, styles of life, made possible in and of this world. Such an ethics....seeks ways to act and be acted upon in both collective life and its cultural and natural milieus". However, there are certain circumstances—political, social or cultural circumstances—which either enhance or diminish this ability to engage in ethical action. Moreover, she saw the agency of this ethical subject as creative in and of itself, and she sought to understand how one can "live in the world, act in the world, make things and oneself, while also creating values that enhance oneself and one's milieu, not through pre-existent values but through acting, making, and doing that generate new values" (2017, p.255). This process she called 'onto-genesis' or 'onto-ethics'.

> If ethics is the reasoned reflection on the conditions under which living beings and their milieus of becoming can be understood and made otherwise, can have new directions and energies liberated from beings and their infinite connection in relation to all that is 'something', then ethics is not just embedded in and relies upon an ontology: it requires an ontogenesis, a thinking of the processes that engender all kinds of becomings, within which values, mnemic themes, goals, are themselves in the process of becoming and may be able to direct some of becomings in material, natural and social directions that facilitate more and greater reasoning and more and greater connections. (2017, p.261)

For Grosz, then, not only does agency beget ethics, but ethics begets agency. When a subject's ability to act ethically is diminished by their natural or cultural circumstances, they lose not only an opportunity for self-expression, but the opportunity to be a creative agent in the ongoing formation of the world of themselves and their milieu.

Foucault also considers the nature of the relationship between freedom and the subject. He states that there is no power outside of "power relations", and that "in power relations, there is necessarily the possibility of resistance because if there is no possibility of resistance (of violent resistance, flight, deception, strategies capable of reversing the situation), there would be no power relations at all" (Foucault, 1997a, p. 292). He argues that although he has proposed a constructed subject, whose conscience and identity has been formed through manifestations of governmentality, this subject yet retains, by their nature and by the nature of relations of power, some degree of freedom. Foucault therefore puts forth a "genealogy of ethics" (Foucault, 1997d, p.253); as part of this genealogy, he considers freedom in relation to his explorations of ancient Greek "care of the self"

(Foucault, 1997a, p. 287), which he relates to living an ethical life. Foucault also comments on the impact of ethical life not only for the subject, but for their milieu. “The care of the self is ethical in itself; but it implies a complex relationship with others insofar as the ethos of freedom is also a way of caring for others” (Foucault, 1997a p.287). Further to this, he states, “freedom is the ontological condition of ethics. But ethics is the considered form that freedom takes when it is informed by reflection” (Foucault, 1997a, p284).

Speaking of power relations and freedom in the construction of the mentally ill subject, he states, “if it indeed is true that the constitution of the mad subject may be considered the consequence of a system of coercion—this is the passive subject—you know very well that the mad subject is not an unfree subject, and that the mentally ill person is constituted as a mad subject precisely in relation to and over against the one who declares him mad” (1997a, p.291). Foucault does draw attention to the fact that even so, this freedom is limited, due to circumstances that serve to diminish freedom: “in a great many cases, power relations are fixed in such a way that they are perpetually asymmetrical and allow an extremely limited margin of freedom” (1997a, p.292). Of further relevance to this project and to much of critical research more broadly, he states that although power will always be there, “liberation paves the way for new power relationships, which must be controlled by practices of freedom” (1997a, p.293-294).

Together, these complex interplays between identity, agency, and ethics form a way of conceptualizing the mandate of the critical researcher. In the case of this research study, I set out to unmask the ways in which political and social environments construct identities for participants in particular health care processes (CTOs): identities which act to enhance or diminish their agency. I engaged in this project with the aim of enhancing my own freedom and the freedom of my milieu to act ethically—in ways that enhance the freedom of others, specifically and especially those who are marginalized or diminished by their social and political position. This is critical not only for the benefit of these few, but for engaging in the cocreation of a future in which we can participate in “a generous and productive collective existence—lives that resist oppression, coercion, and prevailing social constraints—that enhance and produce values, that expand social and collective existence and lives of non-human things" (Grosz, 2017, p.4).

3.4 Limitations

Grosz has been critiqued for using scientific or biological concepts in a way that is not empirically grounded (Trappes, 2019). Alternatively, considering the political and ethical project in which she is engaged, her use of biological concepts has been criticized for being inappropriate for a feminist ontology (Trappes, 2019); and for focusing on theories of change that lead feminist discussion in a direction of "explanation not intervention" (Pulkkinen, 2017, p.280). With agility, Grosz employs a wide array of historical, scientific, psychological and philosophical thinkers to support her philosophical projects; layering, building and contrasting ideas in a way that reflects the process of human reflection itself. This is consistent with the genealogical approach established by Foucault; it is a way of understanding the world through the stages and phases of humanity's project of self-understanding. This non-reductionist approach gives her work depth and relevance. Unlike Foucault, Grosz explores art, philosophy and science, and she explicitly considers the ontological implications for the material and non-material world. However, she connects her focus on 'what is' to the potential for beings to have an effect on a world that is constantly shifting and changing, both conceptually and materially. In this way, her ontological interest does not distract, but rather ties her to a political and ethical project (Grosz, 2017).

Some critics have found Foucault's understanding of the history of psychiatry to be factually inaccurate, and fuelling misrepresentation of psychiatric interventions (Shorter, 1998, Charland, 2007). Others question whether "introducing discontinuity…[does] not remove all basis for progressive political intervention" (Foucault, 1991, p 53); one could argue that a Foucauldian deconstruction of the CTO is incompatible with the development of progressive psychiatric interventions and policies. It is my goal to inform positive changes to the mental health system, and so I turn a critical eye to the CTO with caution, keeping my sights on a practical, positive goal, not an abolishment or reduction in services that leaves vulnerable individuals without care. Foucault, when asked whether his project was incompatible with progressive politics, answered that a progressive politics “recognized historic conditions”, “sets out to define a practice’s possibilities of transformation”, and “does not make man into the universal operator of all transformation” (Foucault, 1991, p 70). His response has relevance for this project; by turning a critical eye to the CTO and its context, my aim was to become aware of possibilities of transformation; to “deprive some practices of their self-evidence, and extend the bounds of the thinkable to permit the invention of others” (Burchell et al., 1991, p.x)

Chapter 4

Methodology

This research project aimed to examine the CTO's effect on identity through three strategies: understanding the CTO as a technique deployed within a certain social, cultural and political context; unpacking the CTO into its constitute parts; and understanding how these 'parts' effect identity. To achieve these goals, I employed the methodology of critical ethnography. Critical ethnography allowed for the use of multiple data points and the integration of a variety of perspectives within a naturalistic setting; it also fostered the time investment needed to capture sensitive and sometimes contradictory information. Critical ethnography also provided a way to address issues of power and justice that are inherent to this subject matter and to the epistemological stance and theoretical framework through which I approached it. Herein I detail how this methodology informed recruitment, sampling, data collection and data analysis.

4.1 Background

Ethnography has its roots in cultural anthropology, where researchers have historically been described as collecting facts and evidence using detached observations of a culture under study (Dharamsi & Charles, 2011); it was re-invigorated in the last century by researchers from the Chicago School, who used ethnographic methods to turn inward and examine local culture (Jaynes et al., 2009). This was an inherently critical project, intended to bring to light taken-for-granted aspects of "the social and cultural organization of everyday life" (Waring & Jones, 2016, p.556). Although modern ethnographers have in practice adopted a variety of epistemological perspectives, including critical realism (Jobling, 2014) and post-positivism (Bruni, 1995), nonetheless, the project of modern ethnography—that of exposing the tacit elements of social life—gives it a naturally critical bent (Rudge, 1996; Thomas, 1993). The goals of ethnographic research include making insider knowledge of a culture explicit, with the researcher's presence having the potential to reveal the mechanisms of phenomena within a cultural group (Roper & Shapira, 2000).

Critical ethnography makes this ‘bent’ unambiguous, emphasising the role of ethnography in not only creating knowledge, but in employing knowledge for social change (Thomas, 1993). As I focused my lens on understanding how assumptions embedded in mental health care created the underlying logic of the CTO, critical ethnography, with its emphasis on researcher reflexivity, and on understanding how structures of power are translated into day-to-day practices (Streubert, 2000; Thomas, 1993), was a natural fit with my epistemological position and my chosen framework. Critical ethnography opened up the possibility that as a researcher, I could push past the limits of observation and critique and use my position to advocate for solutions to material problems (Foley & Valenzuela, 2000).

A critical ethnographic methodology helped to manage the issues inherent in ‘sensitive research’. Lee & Renzetti (1990) define a sensitive research topic as one “which potentially poses for those involved a substantial threat, the emergence of which renders problematic for the research and/or the researcher, the collection, holding and/or dissemination of research data” (p.512). This research study can be considered sensitive first, because it deals with deeply personal and emotionally laden topics, for example, serious psychotic episodes, the use of restraints, involuntary admissions to hospital, effects on family members and relationships, mistrust, paranoia, and stigmatizing experiences with the police (Corring et al,. 2017; Lawn et al., 2015; Pridham et al., 2018). Second, this research deals with subject matter that may impinge “on the vested interests of powerful groups or people” and addresses “the exercise of coercion” (Lee & Renzetti, 1990, p.512); since the CTO has become the status quo in many jurisdictions, and because it has become tied to deeply held beliefs (e.g., regarding the biomedical nature of mental illness) and established systems (e.g., mental health law, the Consent and Capacity Board, the Psychiatric Patients Advocacy Office), questioning it could be seen as deviant and threatening (Anderson, 1990). The flexible and naturalistic approach of critical ethnography, as well as its sensitivity to issues of power, allowed me to approach my research site in such a way that I was able to build trust with participants over time, become sensitive to the internal power dynamics of the research sites, and vary my interactions with participants according to their particular needs.

Critical ethnography is an appropriate way to address health issues that have complex cultural aetiologies and manifestations. Culture has a larger impact on health than is often acknowledged in busy healthcare environments, where the priority is managing the current issue, not a broad understanding of the social, economic, legal, historical and political background of the health problem. In addition, culture can influence the types of solutions that are sought out, and can influence how a problem is defined or who is seen as ‘to blame’ for the problem (Napier et al, 2014; Thulien et al, 2019). By employing the methodology of critical ethnography, I was able to examine the broader context of the CTO and the biases and beliefs inherent in its structure and its position within the larger mental health system.

4.2 Setting, Sample & Recruitment

In ethnographic research, the setting of the research can be continually redefined throughout the process of the study, as the researcher learns more about the activities and habits of the culture they are investigating (Creswell & Poth, 2018; Hammersley & Atkinson, 1995). In my study, I began by making contact with a community mental health team, who provides community-based mental health services to people with CTOs. This team became a gateway, a way of gaining access into the culture of CTOs. Through building a trusting relationship with the program manager and case workers, I had the opportunity to meet and interact with patients with CTOs in naturalistic contexts. Through this process, the settings for the research evolved to encompass whatever locations were important or relevant for the participants in this culture. This included patients’ homes, care facilities, community health centres, and other health care organizations. In this way, the iterative approach to ‘setting’ facilitated by ethnographic methods allowed me to access rich data from unpredictable sources. Partway through my study, due to recruitment issues brought on by the COVID-19 pandemic, I added a second research site. Similarly to the first, my relationships with the program manager and the case workers of this second site acted as a ‘gateway’ to the various settings where CTOs were used.

These settings became the location of my fieldwork, an essential component of ethnography (Draper, 2015; Roper & Shapiro, 2000), which allows the researcher to learn about interconnected social contexts, as opposed to gathering information about disconnected individuals (De Melo et al., 2014). The sample emerged over the course of the fieldwork (Hammersley & Atkinson, 1995). Throughout the fieldwork process, I was alert for opportunities to create relationships with key informants: individuals who could help me gain access to other participants or locations (Crang & Cook, 1995). I gradually made my presence and my purpose known to the care team through participation in team meetings and spending time speaking to the case workers at the health care site. These health professionals then invited me to participate in care activities; they made contact with patients and asked if they would be willing to meet with me or have me attend a care activity in which they were involved. Once I met the patient and formalized consent for my presence, I observed care interactions that they had with their health care team, and sometimes other services, such as the police. When these participants were open to a one-on-one interview, I also engaged in research interviews. With participants from the second research site, which I accessed during the pandemic, I did not have opportunities to engage in observing care processes, due to restrictions on in-person contact.

I sought out the perspectives of individuals on CTOs, clinicians who worked with this population, and family members. The criteria for inclusion used in this study varied according to the type of participant being recruited: 1) service user with current or past experience being on a CTO, able to consent, over 18 years of age, fluent in English; 2) family member of a service user with current or past experience being on a CTO, able to consent, over 18 years of age, fluent in English; 3) professional working with someone with a CTO, fluent in English. Exclusion criteria were: not capable to consent to study participation, under 18, no experience with CTOs.

I looked for individuals that represented a variety of views about and experiences of the CTO, being careful that I did not design the research processes or approach the participants in a way that excluded the most dissonant or the most challenging voices. Meeting with the participants in naturalistic settings, and using flexible, informal interview techniques, facilitated the involvement of participants who may not have been able to tolerate formal interviewing. This addressed a potential 'sampling error' in which the most congenial and articulate patients are the ones who can feasibly participate in a study, leading to the under-representation of patients with other types of presentations and dispositions.

I intended to have a final sample of 25-30 participants engaging directly in the interviews. For observations, I did not pre-define the number of people to engage with, as the naturalistic nature of ethnography makes this impossible to determine ahead of time. In addition, I planned to have 6-8 individuals (a mix of family, patients, and clinicians who had also engaged in interviews) engage in a focus group. I used a mix of: 1) criterion sampling, that is, I selected cases that had some predetermined importance (in this case, experience with CTOs); 2) maximum variation sampling, that is, looking for a wide variety of perspectives on and experiences of CTOs; 3) snowball sampling, that is, some participants acted to recruit other participants (e.g., a CTO client suggesting I speak with their family member); and 4) opportunistic or emergent sampling, that is, I took opportunities for data collection as they arose (Creswell & Poth, 2018; Palinkas et al., 2015). In the end, I had 7 patient participants, 5 family member participants, and 10 clinician participants who participated in interviews and observations (see Table 1). Another 10 clinician participants participated only in observations. In response to pandemic protocols, I adjusted my study design by eliminating the focus group, as it was rendered unfeasible.

Some challenges arose during sampling and recruitment. I anticipated that I might come across issues with gaining access to elements of the research site if clinicians interpreted the research as critical of their clinical practices or care techniques. As clinicians acted as 'gatekeepers' to other types of participants, it was necessary to secure their trust and buy-in. In consideration of this, I spent time with the clinicians in their work environment and I sought the buy-in of team leaders. I attended a group meeting where I presented my research study to a large group, after which I attended a number of

Table 1: *Participant demographics*

		HCPs (10 total)	**Family members (5 total)**	**Patients (7 total)**	**TOTAL (23)**
Age	20-30	1			1
	30-40	1		3	4
	40-50	3		1	4
	50-65	5	5	3	13
Gender	M	4	1	7	12
	F	6	4		10
Race -ethnicity	White (incl. European origin)	10	2	4	16
	First Nations		1	1	2
	Black (incl. Caribbean and African origin)		1	1	2
	Asian (incl. West Asian, East Asian, and Southeast Asian origin)			1	1
	Undisclosed		1		1
First language	English	8	5	6	19
	French	2			2
	Somalian			1	1
Profession (HCPs only)	RN	3			3
	SW	2			2
	OT	1			1
	MHW	2			2
	Psych	2			2
Years working with people with CTOs/having a family member with a CTO/having a CTO	0-5 years	1	1	3	5
	6-10 years	1		1	2
	11-15	3	2	2	7
	16-20	5	2	1	9
Level of education	Some high-school			3	3
	Completed high-school			1	1
	Some college		2	1	3
	Completed college	1	2		3
	Bachelors	4	1	1	6
	Post-graduate	5			5
How long has self/ family member had MH Dx	0-10 years			1	1
	11-20 years		2	1	3
	21-30 years			3	3
	31-40 years		3	2	5
	41 +		2		2
Housing (Patient's only)	With family			1	1
	Supported housing			3	3
	Subsidized independent apt			3	3

smaller team meetings. I spent time in the health care environment getting to know the clinicians. I communicated respect for their work and pointed to my own clinical work in a similar context. I found most clinicians were curious about the research and appreciative of an opportunity to share their perspective. I also found that dissonance about the CTO was an accepted part of team culture, and therefore not a barrier to participation.

The biggest barriers to recruitment of patients and families were clinician workload and logistics. Where some clinicians put considerable time into facilitating recruitment, others were wary to take on the added work of contacting patients or families to inquire about their interest in speaking to a researcher, or to seek permission to have a researcher attend a clinical visit. Once they did reach out to patients, they then spent time assisting in organizing a meeting time with the patient where I could observe care and/or engage in an interview. Their involvement was necessary in order to fulfill the ethical obligation of having the patients agree to being contacted by a researcher prior to engaging in the study. Since the clinician's had trusting relationships with the patients, some patient participants preferred initially to meet with me with the clinician present, although some patient participants opted to meet with me outside of a clinical visit, and most agreed to a one-on-one interview once we had met in the context of a clinical visit. Once the pandemic began, it became very difficult to access clinicians at my original site (as I could no longer attend the research site) or to gain their assistance with arranging phone interviews. At that point, I engaged in conversations with a second site who was willing to assist with recruitment and I secured ethics approval to add this site to my study. As an added challenge, ethics approval for this amendment took four months. At this point in the study I only engaged in interviews, not observations, as access to care sites was extremely limited.

I also anticipated a potential challenge in accessing clients deemed to be anti-authoritarian or disorganized. In order to account for this, I allowed multiple ways to participate in the study (i.e., from observation only to multiple interviews), built rapport over time, seized moments to have informal interviews, and was flexible in the format and/or location of interviews. I found that this flexibility allowed me to include patients with a variety of views and experiences in this study, including clients who struggled with authority and disorganization. In order to accommodate participants' preferences, I held interviews with and without clinicians present, in cafés, homes, health care centres, and on street corners.

I anticipated the potential for participants' psychiatric conditions to impact their capacity to provide informed consent and acknowledged that individuals with SPMI would need to have their capacity to consent evaluated in a case-by-case, ongoing way. I used enhanced techniques in order to ensure that patient participants were informed and that they maintained consent, e.g., giving extra time to ask questions about the study and its impact; and, during the interview, showing the tape recorder and what it looked like when it is on or off. As I provided information to patient participants about the study, I also assessed their ability to make an informed consent decision. The literature shows that psychiatrically involved individuals do not overall have reduced capacity to consent to research (Graor & Knapik, 2013).

4.3 Data collection

Ethnography allows for a variety of data collection methods (Roper & Shapiro, 2000). For this study, I originally planned to engage in observations, interviews, document review and a focus group. The planned observations were of clinical and non-clinical life, as well as relevant meetings, such as family meetings and Consent and Capacity Board hearings. The planned interviews included both informal and semi-structured interviews with clinicians, family members and patients, while the document review was of documents relevant to the way that care unfolds in the context of a CTO. The focus group was intended to be a way to bring a subset of participants (a mixed group of clinicians, patients and family members) together, near the end of the study, to review and respond to my initial findings, as well as gather their perspectives on what should be changed and how. As mentioned earlier, I had to eliminate this component in order to conform to COVID-related public health restrictions.

4.3.1 Observation and Interviews

Tied closely to fieldwork, participant observation is a key element of ethnography, and is considered critical to developing intersubjective knowledge of a culture and confronting potentially productive conflicts between emic and etic perspectives (Borneman & Hammoudi, 2009; Crang & Cook, 1995). This was therefore a foundational method of data collection. I wrote field notes as a strategy for both recording information and developing reflexivity (Wolfinger, 2002). As the location of my fieldwork was similar to environments in which I have worked as a clinical nurse, field notes gave me an opportunity to reflect on my insider-outsider status, to consider the ways that shifting my perspective changed the significance of events, interactions and meanings, and to look for ways both to become comfortable with what was new and unexpected about the setting, and to stand back and rethink elements that were familiar parts of nursing routine (De Melo et al., 2014).

I hoped that observation would lead directly to informal interviewing, as I interacted with the people around me, explaining my role and the nature of this study. On one level, this worked well: I spent time observing care planning activities taking place in the healthcare centre where the community health team was located, and this led to some informal and semi-structured interviews with health care providers. However, the nature of community-based health care meant that observations of client care had to be carefully planned in advance. The clinician would contact the client and ask them if they would be willing to have a researcher attend their clinical visit; once there, my first step was to obtain their informed consent (see Appendix A). These steps gave structure to the interactions that made it difficult to remain an inobtrusive observer. Often, I would observe care given by the health care team member, build comfort with the participant, and engage in a semi-structured interview in the same visit. Nonetheless, the observations and informal interactions that I had with participants did help focus further observations, as well as guide the content and approach of the semi-structured interviews (Hammersley & Atkinson, 1996). For example, I observed a participant being brought to a health care centre by police, and was present for part of his interactions with his health care providers, who had made arraignments with police to meet with him at this site. After care was provided, I engaged in a semi-structured interview with the participant. I used an interview guide for the semi-structed interviews (Appendix B), as well as gathering demographic information about all interview participants (Appendix C). Patient participants were given the choice to have an interview privately, or in the presence of a clinician with whom they felt comfortable. Only one chose to have a clinician present through the whole interview.

The relationships I built at the research site were just beginning to yield opportunities to observe more types of interactions (e.g, family meeting, CCB hearings, psychiatric assessments) at the time pandemic protocols began. I therefore conducted fewer observations than initially planned. The observations took place over thirteen months, and added up to 40 hours. Nonetheless, the observations I was able to engage in, in addition to interviews, yielded a large amount of rich data. Interviews with family members were generally arranged ahead of time and semi-structured.

4.3.3 Document Analysis

I also collected documents for review. I looked for documents that had relevance to the way that care unfolded in the context of a CTO, in order to understand how these documents both produced and were products of the culture under study (Crang & Cook, 1995; Creswell & Poth, 2018). These documents provided insight into how laws (e.g., the Mental Health Act) become translated into institutional policies, how oversight was intended to function and whether it was acting as intended, and how policies became translated into particular processes—processes that were then acted out and experienced within the group being studied. From a critical perspective, this part of data collection was key to turning knowledge (e.g., how the CTO is experienced) into action (how changes to policy or procedure could alter this experience). I asked research participants to provide me with documents that they used during the course of care for people with CTOs, and I also accessed publicly available documents related to the care of people with CTOs. Several documents were reviewed: the 2012 legislated review of CTOs; an evidence brief, summarizing the current research on the CTO, published by the Evidence Exchange Network and the Centre for Addiction and Mental Health (CAMH); the Ministry of Health and Long Term Care Information Record; The Ministry of Health and Long Term Care Reporting Log; Form 1 (application by a physician for a person to undergo a psychiatric assessment); Form 33 (notice to patient of findings of incapacity); Form 45 (community treatment order); Form 47 (Order for examination); Form 49 (notice of intention to issue or renew a community treatment order); a document called “CTO myths” put out by CAMH; a training presentation for psychiatric residents; and the 2019 legislated review of CTOs. Eight documents received in-depth analysis (see Table 2).

Table 2*: Documents used in Document Review*

Document identifier	Document	Description
D1	The Legislated Review of Community Treatment Orders	The second legislated review of CTOs in Ontario, completed in 2012. The review was legislated by the MHA, commissioned by the MoHLTC, and completed by the market research company R.A. Malatest & Associates Ltd.
D2	Evidence brief: The Positive Effect of Community Treatment Orders on the Mental Health System	An evidence brief put out by the Evidence Exchange Network and the CAMH Provincial System Support Program, summarizing evidence regarding CTOs published between 2012 and 2018.
D3	MoHLTC CTO Information Record	An information record intended to be sent to the MoHLTC every time a physician issues or renews a CTO. Includes information about housing, legal involvement, and service use.
D4	Form 33: Notice to Patient-Incapacity	Ontario MHA form that is given to patients every time a physician deems them incapable to consent to treatment, to manage their own property, an/or manage their health information
D5	Community Treatment Orders Myths	A handout developed by the Evidence Exchange Network and the CAMH Provincial System Support Program, directed at healthcare providers. It cites common myths about CTOs in Ontario, and then provides clarification.
D6	Presentation for Residents	Powerpoint presentation used to train residents about CTOs at one of the research sites
D7	Form 1: Application by Physician for Psychiatric Assessment	Ontario MHA form which is used by a physician to have an individual forcibly brought to hospital for psychiatric assessment.
D8	The Third Review of Community Treatment Orders	The third legislated review of CTOs in Ontario, completed in 2019. The review was legislated by the MHA, commissioned by the MoHLTC, and completed by the market research company R. A. Malatest & Associates Ltd.

4.3.4 Focus Group

Finally, I planned to use a focus group, towards the end of data collection and analysis, which had the dual purpose of engaging in knowledge translation and providing an opportunity to collect data about how participants interact in a setting with a somewhat flattened hierarchy (Agar & MacDonald, 1995; Crang & Cook, 1995). However, the pandemic made this part of the study unfeasible for two reasons. First, it was no longer possible to gather in groups; second, the other data collection processes were significantly prolonged due to the pandemic, making it unrealistic to redesign the focus group into a virtual format. However, the data collected using the other three methods was sufficiently rich to answer my research questions.

4.4 Data Analysis

Many different types of analytic techniques have been used by ethnographers and critical ethnographers. Borrowing from other traditions, they have used interpretive phenomenological analysis (Walby, 2013), thematic analysis (Sharp et al., 2018), narrative analysis (Jobling, 2014) and Leininger's method for qualitative data analysis (Salman et al., 2018). Other ethnographers refer to "ethnographic analysis", a free form, inductive approach that requires the ethnographer to immerse themselves in the data, get to know and understand it, then develop coding schemes that move from descriptive to more analytic (Kueny et al., 2011).

I used critical discourse analysis (CDA) to analyse the data gathered in this study. CDA allows for an examination of the way that ideologies become operationalized as "identities that contribute to the establishing or sustaining [of] unequal relations of power" (Fairclough, 2013, p.8). Using CDA allowed me to retain a critical perspective throughout the analysis phase of the study. CDA is a way of examining discourse, in texts or in speech, that reveals the presence of power structures (Mancini, 2011). It is not only descriptive, but normative; it provides a way of examining the data to generate not just explanatory or causal knowledge but also future-oriented, potential solutions to problems (Fairclough, 2010). This method allowed my data analysis to capitalize on the critical nature of my methodology (Thomas, 1993).

Further, in addition to examining the effect of current CTO processes on identity, CDA also allowed me to fulfill the research aim of using the research process to create space to consider alternative ways to approach SPMI.

Discourse is a rich area for examination because textual artifacts of discourse provide evidence of social cognition. Foucault identified discourse as an area in which we can observe the ways power and knowledge operate, where competing values and complex *savoirs* play out in everyday interactions (Jacobs, 2006). A study of discourses provides evidence of the way that power structures have infiltrated and informed individual, organizational and institutional relations; conversely, discourses can also be a site for the resistance of power, a site of struggle (Wodak, 2011). While different authors have suggested particular approaches to CDA, I relied on Norman Fairclough's approach. Fairclough created methods for operationalizing the analysis of discourse; he has written extensively on practices that can be used to examine the ways in which discourse can reveal information about voices present in a text, about the social practice taking place that has a discursive element, about the role/position of the text in relation to other texts, and about the larger context of both the text and the practice (Fairclough 1992; 2000; 2010; 2013; Fairclough & Fairclough, 2018).

Fairclough (2013), states that textual analysis, "must seek to elucidate the complex interpenetrations of material and semiotic (discoursal) moments, and resist treating text and texturing as having an existence independently of these dialectical relations" (p.10). Fairclough calls for textual analysis to happen on several levels. Texts can be analyzed linguistically, that is, their phonology, grammar, vocabulary and semiotics can be examined to show how they draw on linguistic systems, how they are linguistically homogenous or heterogenous, and how the use of grammatical clauses and certain vocabulary reveals the position of the speaker/author, or the relationship between several speakers (Fairclough, 1992; 2013). However, texts, as artifacts of social practice that exist in the material world, and have relationships with other social practices, also need to be examined on the intertextual level. Intertextual analysis looks at not only how a text is expressed and organized, but how it draws on "orders of discourse" (Fairclough, 1992, p.194). This allows an examination of how the text draws on or accentuates certain historical narratives or value sets, and how a text can incorporate several discourses in order to create a new discourse, or in order to validate certain assumptions and logical structures (Fairclough, 1992, 2003). Intertextual analysis allows the social practice represented in the text to be examined within its broader social context, that is, the context from which it draws its many discursive elements.

Critical discourse analysis, therefore, examines data on three levels: the level of semiotic modes present in the text, the level of the social practice being examined, and the level of the social context (Fairclough, 1992; 2010; 2013). These three levels have an iterative element, in that they inform each other; looking at the context of the text aids in focusing and explicating a linguistic analysis, and "the intertextual properties of a text are revealed in its linguistic features" (Fairclough, 1992, p.195). Looking at the semiotic modes present in the text includes an examination of relationships between sentences and clauses, the semantic relationships over larger stretches of texts, and the ways in which semantics set up relationships between speakers in the text. It also includes an examination of what types of exchanges are happening in the text, what types of statements are in the text (e.g., statements of fact, predictions, evaluations) and the relationships between these statements (e.g. demands as statements, evaluations which are made as statements of fact), what styles are used, the openness or resistance to difference that is present in the text, and how the author/speaker or speakers commit themselves to truths and values (Fairclough, 2003). Looking at the text in terms of the social practice being examined includes understanding the way that the text represents a social event or several social events, how it refers to the processes and actors of these social events, how it locates the social events in time and space, and whether it refers to the social events concretely or abstractly. Looking at the text in terms of the social context includes understanding how the text represents genre and how it may be part of a genre chain, how it expresses ideologies that are rooted in or also present in other texts or other elements of the social world, what discourses are drawn upon in the text, and how these are brought together (Fairclough, 2003; 2013).

In the case of this research study, the texts being examined were interview transcripts, field notes, and documents. The first step in data analysis consisted of an initial review of these documents. I began this review while still in the process of data collection, which is consistent with the iterative nature of ethnography. I read through the data, keeping the aims and principles of critical discourse analysis in mind in a broad way, looking at the semiotic aspects of the text, as well as how particular discoursal trends emerged and re-emerged in several texts, how discursive elements interacted with each other, and what this revealed both about the social events represented in the texts and the broader social context of these events. In view of my research question, I paid special attention to the ways in which identities were constructed and evidenced through the use of language, as well as the particular roles that these identities took in relation to each other and in relation to the social events. I looked for ways in which the text and the social events represented in the texts emerged from and represented the values and ideologies of a larger social context. I watched for interactions between discourses and identity, that is, the way that certain discourses acted as a frame for certain identities, or attributed values or made assumptions about certain identities; I also watched for interactions between identity and the semiotic aspects of the texts, that is, how identities were expressed through speech functions and grammatical structures.

Second, I took the notes I wrote during the first phase and pooled them. Looking at them together, I organized them into three categories, namely ‘social context’, ‘social practice’ and ‘identity’. The first category contained discursive elements that related to the larger social context of CTOs. For example, the discourse of risk is central to CTOs, and it has evolved over time through routinized use by the larger mental health, legal and enforcement systems. The second category contained discursive elements that referred to the CTO practices themselves (e.g., the initiation of the CTO, the CCB hearings), revealing through language several features, dynamics and assumptions inherent in these practices. The third category contained discursive elements that were relevant to a consideration of how an individual’s identity was constructed and mobilized in professional and legal discourse, and semiotic features that revealed something about how such an identity was experienced.

Third, I returned to the texts and reanalyzed them, looking more specifically for the discursive elements outlined above. During this step, I focused in on key passages, examining what social and discursive events were taking place, what values and ideologies were being expressed, how this related to other texts and to the social context, what the semiotic aspects of the text expressed about roles taken on by the speaker, and the degree to which the speaker accepted or rejected ideological assumptions made in the texts, or the identities suggested by these assumptions (Fairclough, 2003).

4.5 Rigor/Trustworthiness

Ethnography is subject to the same debates about rigour as other qualitative methods, such as whether qualitative researchers should use the same criteria as quantitative research (i.e. validity, reliability, generalizability) (Morse et al., 2002), use parallel criteria (i.e., credibility, dependability and transferability), or use criteria that are unique to each study’s purpose (McGloin, 2008; Tobin & Belgey, 2004). In my study, I used the trustworthiness criteria of credibility, reflexivity, reciprocity, voice and praxis proposed by Baumbusch (2011) in her critical ethnography of a residential care facility. These criteria are relevant to the issues that arise in researching vulnerable populations: ‘credibility’ speaks to the need to offer a credible reflection of vulnerable participants; ‘reflexivity’, a central tenet of ethnography, requires the researcher to think about their own power; ‘reciprocity’ involves ensuring that the research process benefits the research site; ‘voice’ involves the ability of the research to be true to the voices of silenced populations; and ‘praxis’ refers to the orientation of the study towards political and clinical change. The methods I used for this are reflective field notes, time in the field, multiple sources of data (as detailed above), thick description and an audit trail (Creswell & Poth, 2018; Roper & Shapiro, 2000). In addition, I was sensitive to issues of power throughout the research process, creating contexts to ensure that the participants felt safe in sharing their stories. I strived throughout the analysis to be true to the voices of participants, even when these revealed deep tensions; I have striven to voice the most troubling and concerning elements of the CTO as they emerged through participants' voices, while also being true to the integrity and sensitivity that care providers put into their practices, and the voices (often of families) that saw the CTO as essential to their loved one's well-being. I engaged with the research sites in a respectful and open manner that facilitated discussion and reflection about CTOs, the ways CTOs are used, and the degree to which CTOs enable the larger project of ensuring that people with mental illness have the opportunity to live safe and fulfilling lives in community environments.

4.6 Ethics

I obtained ethics approval from the ethics board of the institution that oversaw both of my research sites, and approval from the University of Ottawa Research Ethics Board (Appendix D). Informed consent was received from all participants before data collection; during this process the study was described, all questions were answered, and participants signed an informed consent document (Appendix A). All participant information was kept confidential, and all data stored in a secure location. All interviews were audio-recorded, except for three, in which case I took detailed notes. All audio recorded interviews were transcribed. Participants were informed that they could choose not to participate in the study without consequence, and that they could withdraw from the study at any time. No participants withdrew from the study.

4.7 Knowledge Translation

I have shared the results of this study in a way that allows for knowledge translation in a variety of ways. Over the course of the study, the introduction of the research to the research site facilitated reflection and discussion on the part of practitioners; I also plan to present the results of the completed study to the research sites. As part of the research process, I asked participants about potential alternative or changes to the CTO; study findings also revealed some means that participants used to mitigate the negative aspects of the CTO. Presenting these may have a positive effect on practice, as well as facilitate reflective practice. I have disseminated my findings, which include recommendations for practice, research, policy and education, at national and international conferences, and plan to also disseminate them through publication in peer reviewed journals. Research which is rooted in the materiality of a health care setting, as is this project, has been shown to have broad applicability to policy and practice (Jobling, 2014; Liberati et al., 2015; Parissopoulos, 2014). Finally, I plan to continue to address the issues presented in this study through future clinical, teaching and research work.

4.8 Strengths and Limitations

Critical ethnography has flexibility and adaptability, as well as actionable ends; this made it well suited to the aims of this study. This study explored how identity, within the context of CTOs, was politically and socially constructed, and has political and social consequences: this was done through unpacking the meanings embedded in discourses and the use of discourses in the CTO context. Ethnography, which studies culture as a “foundation for communicating meanings” (Thomas, 1993, p.12), provided a route to the creation of this type of knowledge. Critical ethnography, in particular, is well suited to a study of mental health care, as people with SPMI experience stigma and a loss of power within cultural discourses (Burstow & LeFrançois, 2014). Critical ethnography purposefully unpacks this type of asymmetrical power relationship.

Practically speaking, ethnography, by using in-the-field recruitment strategies, helped me manage the critical sampling bias which is likely present in many qualitative studies. It also demands and acknowledges researcher reflexivity: this helped to push me, as a novice researcher, to move past my initial, reactive feelings and interpretations, and to examine and make use of my reactions to gain deeper insight into the culture under study (Streubert, 2011). Using CDA for the data analysis further supported this.

There are also some limitations to this method. Ethnography is time-consuming, requiring extensive hours in the field, and then extensive time to sort through and analyze copious amounts of data from a variety of sources. However, the time commitment was not inappropriate for a PhD study, and therefore in this case, was not a significant drawback. Ethnography, as it develops iteratively over the course of fieldwork, can defy early definition, which can be intimidating for the novice researcher. I managed the potential lack of early definition by carefully planning the study and by relying on experienced mentorship. In addition, my clinical experience in similar environments helped me to anticipate the nature of and settings for the fieldwork.

As ethnography explores a particular cultural manifestation in-depth, in a particular setting, there may be limits to the transferability of the knowledge produced. In this case, the issue of transferability can be considered in two ways. First, one of the aims of the study was to impart local knowledge about local issues; for this aspect of the study, transferability is not an issue. Second, in health care ethnographies, the fact that ethnographic knowledge is nuanced and gained in a real life practice settings has, at times, increased transferability (Sharp et al., 2018). In this study, by delving deep into the particularities of CTO experiences, I was able to move away from broad, dichotomous discussions about whether the CTO ‘worked’ or ‘didn’t work’, and instead consider the intended and unintended effects that specific processes had on the various individuals involved. In this way, the specificity and materiality of this examination has the potential to increase its applicability to actual moments of care, and particular policy and process issues in other contexts that use CTOs.

Overall, critical ethnography was well suited to achieve my research aims. This methodology’s flexibility, focus on naturalistic settings, emphasis on time in the field, and mindfulness of issues of power allowed rich data as well as deep and reflective consideration of the political and social context and ramifications of the CTO. This allowed this study “to not only take us deeply into the lives of individuals, families, and communities but constantly lead us outward, toward broader forms of social rupture” (Biehl et al., 2007).

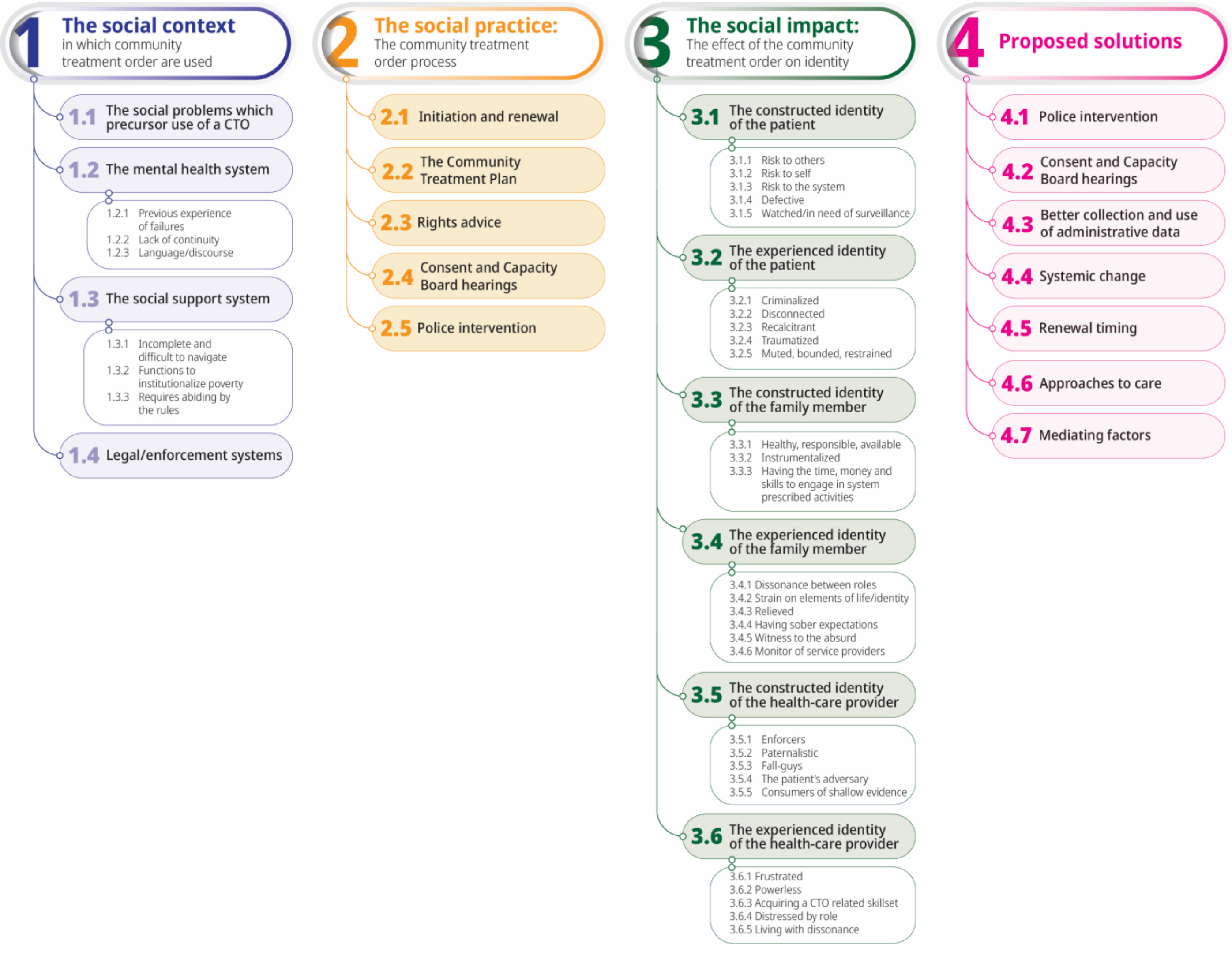
Chapter 5

Results

Community treatment orders constitute a social practice that exists within a particular social context and that has an impact on the identity of the participants, including the patients, the family members and the health care providers (HCPs) involved. Understanding this social practice involves an understanding of the culture, beliefs, discourses and practices of the participants, and how these manifest in the roles played by participants and the actions and decisions they make, as well as the structural factors that make these culture, beliefs, discourses and practices possible. Looking at CTOs in this way—as a cluster of practices that are a manifestation of the culture in which they exist, and which can offer insight into the culture in which they exist—broadens our perspective on CTOs and their role in mental health care. This has the potential to break us out of vague generalizations and dead-end dichotomous thinking (do CTOs work or not work?) and move us toward reflection on the ways that CTOs do and do not enact our stated values and goals (social, clinical and legal). Through critical discourse analysis of interviews and documents, as well as field notes, I examine first, the elements that make up the *social context* in which CTOs are used, and second the elements that make up the *social practice* of CTOs. Third, I examine how this practice constructs an identity for patients, family members and HCPs, as well as how this constructed identity is experienced by each group. Finally, I examine changes proposed by study participants to both CTO processes and to the role of the CTO in mental health care. The structure of this section is reflected in Figure 1.

This research took place with two community health care teams located in an urban centre in Ontario. Because the communities of people who work directly with people with CTOs are small, to further preserve the confidentiality of the participants, I do not identify the role of HCPs within the healthcare team, unless they self-identify within the interview.

Figure 1*: Structure of Results*



5.1 The social context in which CTOs are used

CTOs in Ontario operate within legal, medical, and social contexts. Their legal and therapeutic form, the processes used to initiate and enforce them, and the ways in which they are employed in clinical settings are all shaped by the nature, capabilities and discourses of the pre-existing mental health system, legal system, enforcement systems and social support systems, as well as by specific social problems they are deployed in response to. In the data, certain features of these pre-existing systems emerged, and these are examined here with a view to their relevance to understanding the way that the CTO process interacts with, draws from, and reflects complex norms, values, discourses, and expectations.

5.1.1 The social problems which precursor use of a CTO

CTOs are used within the contexts of personal and family histories, which, although varied, often had in common complex psychological, social, and physical needs. By the time the participants in this study had a CTO, they had many years of mental health treatment, and many years of being involved in the social services system. One participant described their family members life before the CTO:

> Well, uh, my sister at that time was, living in a shelter downtown. She was in a psychotic state a lot of the time. Was extremely fearful and refused to see me...thought I was menacing to her. I had relatively little contact. I was living in [city in Ontario] at the time. I would drive up to see her and she would refuse to see me. And then she would accept to see me but then very quickly want me to leave. And, ah, quite frankly I wanted to leave, because the things she was saying and doing made it very upsetting to try to communicate with her, and she had reached the point where she was refusing to leave her room, was urinating in a coffee pot or something like that. Apparently, she told me she was sure the person, one of the other residents was wanting to kill her. And so, she was basically lying on her bed all day. I think a lot of her physical problems also started then because she was completely indolent, and she was doing nothing. So it was a terrible life that she was leading. (P17)

This participant describes a very difficult, tragic situation, a situation which illustrates a complex social problem. At the time in her life described in the quote above, this woman, the speaker’s sister, needed some sort of intervention. She had previously spent long periods of time in an institutionalized environment, where, while taking medication and receiving therapeutic services, she had been stable. At the time described in this quote, she was receiving intensive, outpatient voluntary mental health services. However, the symptoms of her mental illness limited her ability to utilize these services in a way that would be impactful. This story and others like it are critical to understanding or even critiquing the CTO, as they provide an understanding of the social purpose of the CTO, and insight into the individual tragedies and the social dilemmas which lead to use of CTOs.

Many participants in this study described complex family histories. One participant stated:

> Because see now, family, in our culture we're supposed to go for the other, you know, anybody in the family. My mom and dad separated, and my mom was in an asylum for almost 20 years...The violence occurred in [name of country] with my dad, and in Canada it started with the children. (P3)

In this quote, we see a history that includes mental illness, divorce, immigration, and violence. This participant succinctly tells a story that alludes to a complex history rife with tragedy. Other participants described family struggles with addiction. One stated,

> Both my parents were alcoholics, so it [referring to brother's diagnosis of schizophrenia] came from, you know, not a great background, sort of thing. (P4)

With this statement, this family member acknowledged that her brother's mental illness had a complex etiology that went beyond biological factors. Another participant described a memory of his parents, recorded here in field notes:

> He recalled a memory where his dad came home drunk, he let him in, then this led to a huge fight between his mother and his father, with his sister saying—she was hiding in the basement with her hands over her face—saying, make them stop, make them stop. (FN15)

For this individual, as for many participants, life disruptions, substance use, violence and instability intersected to form a harmful background to their stories. In this way, the CTO is set up as a 'solution' to an extremely complex set of political, social, and personal tragedies.

Sometimes, patients experienced progression in their illness in a way that led to the use of a CTO. An HCP participant described the illness history of a patient who ended up being on a CTO:

> Many episodes of being unwell and ending up in hospital and being discharged and lots of challenges...and as she aged, she had the challenge of physically needing help as well as the mental health needs. (P6)

This participant describes a person whose overall mental and physical condition deteriorated with age, until the available voluntary services no longer met her needs. This is an interesting scenario which provides evidence that the CTO is used as a tool that has different roles with different types of patients; HCPs use it as a tool in the management of complex social and psychological issues, and as a tool to manage the limitations of the systems serving patient's needs. In this case, a community care model became untenable for this woman as she aged. In the absence of other types of support services, she ended up under a CTO.

Another feature of participant's personal experiences that is relevant for this study was the lack of identity producing activities, events, and relationships outside of their contact with the psychiatric or social-service systems. People on CTOs in general reported a paucity of positive life events. They were frequently unemployed, single, and without children. They often had low levels of education, and infrequent contact with people outside of their care team or care environment. One patient, now a young adult, lived in his family home his whole life:

> F: How is it living with your mom and your brother? Have you, has that been for a long time, or, did you move out and move back in?
> 11: Ah, it's been a long time that way, since I was young. Since I was born, I always lived with them. (P11)

This young adult had lived his whole life in his family home, and he had no plans to live independently. Moreover, he did not imagine a future life independent from or launched from this system.

Another patient participant described living in various group homes since late adolescence, grouping residential treatment, supported housing, and hospitalization all together:

> F: And did you go back to living with your family after you left the hospital?
> 12: Ah, I went to a group home after that. I went to (name, program) and then I went into the (name, hospital) ah, (pause)(sigh)and (sigh). I've been hospitalized for 23 years now. (P12)

This patient's early adulthood and middle age reflected a mix of treatment facilities and group homes, with no defining events or living arrangements outside of these treatment experiences. Another participant described how little contact her family member had with the outside world since he was first institutionalized at the age of 17:

> He was diagnosed at the age of 14, with schizophrenia, and probably at the age of about 17, he landed in [forensic institution]. My dad was always there for him, and supported him, but the drive to [institution] from [city] is a hell of a long drive, so we got up there usually a couple of times a year, which was very bad for him [her brother] as well, because he was never really anchored. Um, so there was no anchoring for him, neither, right, because he didn't have family contact. (P4)

This participant speaks of being ‘anchored’, suggesting that individuals’ connections with people, with places and with roles provide them with an anchor that allows them to feel like they are part of a group, to know themselves, and to make decisions about how to act. When psychiatric and social services are provided in a way that completely strip a human being of all their anchors (as was the case in the quote above) then that individual will not be able to grow and develop in a healthy way. This provides another example of how life events intersected to form a scenario where the mental health system itself took on an outsize part of an individual’s life story replacing other events and milestones that are generally part of normal development.

These quotes reveal a complex array of personal and family experiences that provide a backdrop for mental health care in general the use of CTOs in particular. Patients and families enter the mental health system with multiple overlapping psycho-social, emotional, and practical issues, complex histories of trauma, a paucity of positive identity forming experiences, and at times, many years of attempting to navigate a complex health and social services system. The CTO becomes a tool of last-resort to manage a very complex and intertwined tangle of issues, often at a point in the patient’s history in which these are manifesting as a psychiatric crisis.

5.1.2 The mental health system

The CTO has a complex relationship with existing mental health structures. On the one hand, CTOs are intended to reduce the burden on psychiatric acute care and emergency rooms, by reducing the number of ‘revolving door’ patients. On the other hand, they are intended to increase engagement with services for patients who may otherwise have no contact with the system. CTOs are intended for a subset of patients, those with severe and persistent mental illness, that the mental health system has historically found very difficult to manage effectively, and whom have been (and in some cases, continue to be) the object of abuses within the mental health system. Over the past 40 years, deinstitutionalization has left many patients with SPMI in need of a new model of care, and CTOs emerged as one of the tools used, in Ontario and in many other jurisdictions around the globe, to treat and manage this subset of patients. In the analysis of the study data, several aspects of this system became apparent.

5.1.2.1 Previous experience of failures

The mental health system has radically failed some patients, both historically and in the present. One participant discussed the history of her brother, a man in his 50's who was on a CTO at the time of data collection, but who was previously institutionalized, first at a forensic institution and then a non-forensic institution. She recounted a memory she had of what life was like for him:

> He called me from the hospital in [forensic institution] and, begging me to untie him, he said, 'I'll be good, I'll be good, can you have them untie me.' Um. Sort of thing. Because they had tied him to a bed, and whatever, had security on him and stuff. And couldn't do a thing. Sort of thing, so he didn't understand why he was there, what he had done. He said, 'If I was bad, if I was bad, I'll be good I'll be good.' You know. Sort of thing. So, he didn't get it. He was, you know, anyways, all that kind of stuff. Ah. I lost my train of thought. All that stuff that happens. (P4)

This family member struggled to recount this memory, pausing, using filler words, and finally losing her train of thought as she was overwhelmed by the emotional impact of this recollection, where her family member was restrained after experiencing water intoxication. In this quote, a patient who is self-blaming and who is perceiving themselves as judged ('if I've been bad, I'll be good'), seems to have been left restrained for an extended period of time without any understanding of why. This quote refers to practices which have historically been taken for granted within forensic psychiatry (e.g., practices of mandated institutionalization and the use of mechanical restraints). In the quote, the subjects of these actions are "they"; the people who engaged in these activities have an anonymity given to them by their role. Twice the speaker used causal relations between clauses ("So he didn't understand why he was there" and "so he didn't get it"), both times to refer to her brother's ignorance. By doing so, she highlights that there are two concurrent events happening: the event constructed and understood by "them", in which the subject acted in a bizarre or uncontrolled way, was perceived as dangerous, and then had his dangerousness controlled through restraints and the use of guards. The speaker, however, is aware of another event, one that is being constructed (in a fractured way) by the patient, who is ignorant of the first construction. In this second version of the events, the patient perceives himself as experiencing a moral judgment (if I've been bad, I'll be good) by the anonymous force (they), for an unknown reason. He is appealing to a known ally (the speaker) to step in and save him (begging me to untie him). This text however also reveals a third event, the event experienced by the speaker. The speaker had to stand at the crossroads of these two interpretations; this quote accentuates the struggle she experienced in knowing and understanding the difference between the two perceived events. This crossroads represents an impossible dilemma; if she aligns with her brother's interpretation, she loses her status as ally of the system, a status that allows her to enter into dialectical relationship with the system. However, to align herself fully with the system interpretation is to fail in a moral obligation to remain a support to her brother. The quote starts with a very specific event and ends with a vague abstraction (all that kind of stuff...all that stuff that happens). This abstraction may indicate a diminished connection to agency which was affected by standing at an impossible crossroads between these two concurrent events.

This participant also recounted being allowed to look at her brother's chart, at which point she discovered some distressing information:

> He was drinking out of a toilet—and I said to her [a social worker], can you explain this to me? And she said, oh, well, because they were all drinking too much water, I guess he had the seizure, I guess maybe other people did too, that, they, turned the water off to the rooms. So, they were thirsty. Because psych meds, right, they all, they all make you thirsty and dry. So, they [patients] were drinking out of the toilet. And they said, and [patient's name] was one of the ones who took a long time to go back to normal. Like, for the 'why' part. I thought like holy shit, like, come on, you know, they turned the water back on, but he just kept drinking from the toilet. (P4)

There are several discoursal events and social events woven together in this quote. There is the textual document (the client chart), the reading of the chart by a family member, the discussion of the chart between the speaker and 'she' (an HCP), and there are the events referred to in the chart (they turned off the water to the rooms; they were drinking out of the toilet). That the speaker was allowed to read the patient's chart and then ask questions about it implies an alliance between this member of the healthcare team and the speaker. The HCP (‘she’) answers the speaker’s questions using the phrase ‘I guess’; this construction implies a tentative alignment with her own words, a way of creating space or distance between herself and her interpretation of the textual document and the events contained in it, as well as reducing her agency in these events. The speaker echoes this by again using ‘they’ to refer to the actions taken (they turned off the water; they said), protecting her alliance with this HCP by not pinning the blame for these actions on her in a direct or specific way. In speaking of her brother, however, the subject and the action are clear and specific (he was drinking out of a toilet). The clarity and specificity of this information are glaring. This event was reproduced and therefore recontextualized in the patient’s chart, where it was reduced to a clinical event; later it was recontextualized in the conversation between the speaker and the HCP, where it was somewhat explained (they were thirsty) and abstracted (they were drinking out the toilet); it was explained as part of a series of events, and contextualized as having occurred to a group. However, this is not sufficient to reduce the dehumanizing and degrading nature of the image on the speaker. The quote ends with a reemphasis on the event, and a rejection of any attempt to explain this as logical or reasonable, and a reiteration of the clear image (I thought like holy shit, like, come on, you know, they turned the water back on, but he just kept drinking from the toilet). This quote illustrates how the mental health system led to degradation and de-humanization of this participant’s loved one, to the point where drinking out of the toilet was recorded in a routine manner as a delinquent behaviour, rather than as a clinical emergency. Although this took place decades ago, the memory of it is still vivid for this participant, as is its emotional impact.

Another family member recounted the story of a loved one who died as a result of her psychiatric treatment (lithium toxicity): “My one sister, she died in 2017. She was overmedicated with lithium” (P3). In some cases, psychiatric treatment was not just a tool of humiliation and degradation, but a direct cause of death. The speaker in this case was recounting the history of the mental illness of her brother, who was on a CTO; this information about her sister relates a significant family event, but it also refers to an experience with, and therefore a heightened awareness of the potential dangers of psychiatric treatment. Side effects are often a reason that individuals who are prescribed psychiatric medication refuse to take this medication; when CTOs are ordered, these side effects are often argued to be ‘worth it’ compared to the potential for psychiatric symptoms. This can lead to a proneness in providers to improperly account for the impact of side effects on patients’ lives.

The same participant, at another time, felt failed by how difficult it was to get treatment for their family member. She recounted how she tried to get treatment for her brother. Although he was, in her view, psychologically deteriorating, he was quickly discharged every time he went to the hospital.

> And I had to come from [city]. It was outrageous for me. And I told them, ah, ah, I wrote on a note. My brother just assaulted me. Please get him into the hospital. When I got home, the doctor discharged him...I was so angry. (P3)

This quote suggests several discoursal and social events: the note written from the speaker to the mental health-care team of the patient; some communication between the hospital and the speaker, travel between cities by the speaker, and an assault. This family member saw her brother’s ongoing deterioration and the systems failure to react; when he began acting violently while in this altered state, she thought this would finally prompt someone to act. However, although her brother did go to hospital, the doctor there assessed her brother and then dismissed his case as not meeting the threshold for action. The speaker’s attempts to get services, both through travelling to see him from a different city, and by writing a note to his community providers to advocate for hospitalization, failed.

Another participant described the process of attempting to get services for a family member suffering from significant cognitive changes along with emotional distress. In this case, it is a series of failures that led to a tragic outcome:

> From March—March, April, May—I fought to get my daughter treatment, and have her kept in the hospital until they diagnosed her properly and treated her properly, which nobody would do. And which was ultimately the end to her life, because when I finally got a JP [Justice of the Peace] to order her back to the hospital because she was in psychosis all the time, they made so many errors at the hospital, she overdosed. They gave her a lethal combination of drugs. (P21)

In this tragic recounting, a mother tells the story of trying again and again to get mental health services for her daughter, only to have her daughter assessed and sent home, un-treated and undiagnosed. When she finally received treatment, it led to her death. In this and the above quotes, we see psychiatric care and treatment waffling between impotent and lethal.

Participants had many experiences of the fallibility of mental health care providers, as well. For instance, a patient participant described an experience, before he was on a CTO, where hospital staff made errors and then blamed him:

> They messed up on me a few times, but I always let it go. Another time my doctor said, there's these three different types of med, and I want you to try one each day and tell me which one you like the most. And he put them on my chart. And the nurse told me, she comes in and says, you have to take all three of them. I said, I don't think I'm supposed to take all three of them. Ah, I said I think he wants me to take one each day. And she wasn't allowing me to go out for a smoke till I took all three of them. But apparently it was too much, and I passed out outside, having a smoke, and I lost my bank card. And they tried to blame me. The doctor said, 'Did you see what you were like yesterday?' And they thought I had done drugs. (P18)

This patient recounted that in the end, his understanding was confirmed; he was supposed to take one medication each day. While recounting these events, the participant did not express animosity or anger. Despite various experiences of mistreatment, he described them in a way that suggested that he was accustomed to it, or that he did not have a sense of their significance. Here too, several disturbing social events are recounted: the nurse failing to listen to the patient; the doctor failing to leave a clear order; the nurse failing to reconcile the order; using a smoke break as incentive for the patient to take a medication that they might otherwise refuse; and incorrectly accusing the patient of becoming intoxicated. This highlights a mental health system that as a whole makes sloppy care acceptable by assuming that patients are unreliable and intoxicated, both capitalizing on and furthering the precarious position of the patient in this system.

This participant recalled another hospitalization where the staff characterized him as aggressive, although, in his recollection, it was the treatment he received that made him 'lose it':

> I ended up losing it because Dr. [name] kept injecting me with all this stuff, kept code whiting me, strapping me to the bed, saying I was getting aggressive. (P18)

In the interview, this participant described ‘code whiting’ as the practice of forcibly administering sedating medication. This participant experienced a series of coercive and violent interventions (forced medication, being strapped to a bed, being told he was aggressive) which led to feelings of distress, hopelessness, fear, and anger. This patient’s experience of the mental health system was shaming, blaming, and violent.

An HCP reflected that the public rightly is wary of the possibility of abuses within psychiatric systems of care:

> I don’t blame the public for thinking that CTOs are potentially problematic, because psychiatry doesn’t have a clean slate, in terms of how they treated people in the past, right. (P16)

In this quote, an HCP acknowledged that this context must be taken into account when considering how people may perceive the CTO. However, this HCP characterized the abuses of the mental health system as being ‘in the past’, whereas most of the examples in this section are current.

5.1.2.2 Lack of continuity

One element of the mental health system that emerged from participant’s accounts was the impression that the hospital and community systems were siloed, i.e., there was a lack of communication and understanding between the two systems, which translated into gaps in care for patients. One HCP participant stated:

> Even in terms of communication, I could go on for the rest of the day about that, but in terms of how we communicate to each other, between hospitals, between staff, I mean, oh my god, really? I see that on a daily basis. Of how there’s no, of how the lines of communication and the silos that everything operates in. (P8)

This HCP, part of a community care team, was exasperated by the difficulties with communication that existed between the hospital and community mental healthcare systems. He represented these problems with communication as frequent (daily) but also as insurmountable, as almost a taken-for-granted feature of these monolithic systems. This foreshadows the way HCPs spoke of CTOs (as seen in later sections): with a sense that the forces that make up the mental health system are outside of them and outside of their control.

One family member participant described their impressions of the lack of continuity between providers as follows:

> And every time she'd go to a different hospital, and every time it was different care, different everything. Every time she'd get to the point where she'd have to be admitted—because you'd have to be in pretty bad shape—she'd be worse. And that was explained to me also. Every time [name] has a breakdown and has to be admitted to hospital she's never going to come back to where she was. That was their [the treating psychiatrist's], the opinion at the time, and I'm assuming it's true because I saw it. It was very easy to see. That she'd just get farther and farther away from being able to cope. (P20)

This quote provides a window into a participant's experience: as she watched her daughter's health deteriorate, she looked to the psychiatric system for an answer. However, the psychiatric system was able to give her little other than brief stabilization with no coherent treatment plan in the longer term. This mother did not experience being offered early intensive and coordinated treatment for her daughter struggling with psychosis; instead, she had several entry-points and several care providers. This quote raises the question of whether the phenomena of the 'revolving-door' patient (a term addressed in more depth later in this chapter) is the function of a mental health system that fails to take a coordinated and cohesive approach, rather than some deficit in the patient.

5.1.2.3 Language/discourse

Within the participants' responses, there were references to a variety of different philosophies and approaches to mental health. One of these was the discourse of 'recovery'. The recovery model is an approach to mental health care that grew out of the American civil rights focus of the 1960s and 70s (Brown, 1981). This approach recognizes the need to recover not only from illness symptoms but from the iatrogenic effects of treatment and stigma, as well as secondary effects of illness such as poverty and loss of social status (Anthony, 1993; Corrigan et al, 1999). It involves a flattening of hierarchies that have historically existed between patients and providers (Winship, 2016). As recovery models have been adopted into mainstream care, this approach has been praised for being a hopeful and patient-centred approach (Jacobson et al, 2005), but it has also received criticism for being rooted in the assumptions of rugged American individualism, for making assumptions about the sorts of goals that patients are interested in, and for putting the onus on individual as opposed to health system change (Henwood and Whitley, 2013). The language of 'recovery' was frequently used by health care providers in this study. For example, one HCP, described a client who had come off their CTO in this way:

> So this guy, I believe, being medicated appropriately and consistently, for 2-3 years, he actually gained some insight. He gained some insight; he gained a little bit of motivation as far as recovery goes. He did some peer support stuff while he was well. Ah, he, he engaged more in treatment overall. (P7)

This quote illustrates the types of the patient behaviours the current mental health system routinely uses to define treatment success: 'insight', doing 'some peer support stuff', and 'engaging more in treatment'. Of note, all of these are different ways of stating that a patient has become more agreeable to accepting a psychiatrized view of their experience, endorsing the label of psychiatric patient and engaging in psychiatric services. They are not statements about symptom control, reduced emotional distress, increased cognitive function, or better relationships. The discourse of recovery can mimic or prop up this circular definition of success when recovery becomes defined as participating in goals that are defined as healthy and productive by someone other than the patient, for example, goals defined by the care team.

One word of note in the above quote is 'insight'. The word 'insight', as it is used in clinical settings, refers to a patient's belief that they have or do not have a psychiatric illness. However, the concept of insight lacks clarity (Reddy, 2016), and can be used in a circular manner. Since 'insight' refers to an understanding that one has a psychiatric disorder, clinician's may judge a patient's insight by their ability to use and 'buy-in' to a psychologized, pathologized understanding of themselves and their experiences. When someone's wellness is assessed by their ability to accept their illness, this creates a double bind (Manghi, 2006).

Another HCP spoke of recovery as an intrinsic goal for patients:

> As, yeah, the carrot and the stick. It's too easy to use the CTO as a stick, whereas the carrot, is maybe being their recovery or maybe showing the value of how much recovery ah, how, encouraging insight between, hey, this is what you're like when you're on meds, this is what you're like when you are off meds. (P8)

In this quote, the HCP spoke of recovery as being something that may prompt a patient to engage in psychiatric treatment. In contrast to the previous quote, this HCP defined recovery as the patient's understanding of their own experience of being on medication, with the presumption that the patient, with 'proper' support and guidance, has a more positive experience of themselves and their world when medicated than when not-medicated. The 'carrot and the stick' metaphor derives from a way of motivating a donkey to move forward: a carrot is dangled in front of the donkey to entice it to move forward, and it is a beaten with a stick if it refuses. In this way, recovery is reduced to a management tool; a way of enticing a patient to engage in desirable behaviours. Using this metaphor also alludes to an idea of the patient as an unruly beast; the job of a kind or compassionate practitioner, therefore, is to entice them into 'good' behaviour, as opposed to understand their holistic human experience.

While P8 discussed CTOs and recovery as divergent notions, another HCP spoke of how CTOs and a recovery philosophy could be complementary:

> I do a lot of advocacy...in regards to trying not to polarize CTOs vs recovery based mental health care, because they're not opposite things. You can do a lot of recovery-based things while a person is on a CTO. (P16)

In this quote P16 touts 'recovery' as the positive goal of mental health care, one that patients and families and care providers can agree upon, even when they disagree on the means. One is however left wondering about what is meant by 'recovery-based things', and whether this refers to engaging in psychiatric treatment activities, or engaging in activities that are chosen by the patient and give meaning and satisfaction to their life. Further, there is some question of the subject of the clause 'do a lot of recovery-based things'; in this statement, it seems to be the care providers, (you can do a lot of recovery-based things when a patient is on a CTO). Again, this may evidence a skewed understanding of recovery that entrenches patients more deeply into a psychiatrization of all parts of life: i.e., a philosophy by which one is treated by the psychiatric system with the goal of participating more meaningfully and fully in psychiatric treatment activities, as opposed to receiving treatment so that one can participate more fully in life.

Another discourse that entered participants' language was the discourse of 'resources.' During interviews, participants often engaged in cost-benefit assessments of care interventions. For example, one HCP referred to the resources used to recall someone for assessment who is on a CTO:

> And the health care system, it costs, right, in order to have, just think of the money. You have to be picked up, there's police officers involved, then, they're triaged, and then, they're seen, so just that alone, is about a thousand dollars, or more. Just to bring someone in. (P9)

While care providers are expected to base decisions on clinical and therapeutic decisions, this quote evidences that HCP's also consider the resources and costs involved when they are making decisions about engaging the hospital and police systems. This is part of a larger neo-liberal discourse in which we apply financial reasoning to healthcare choices (Carney, 2008). Similarly, another HCP mentioned the resources involved in the Consent and Capacity Board (CCB) hearings:

> Yet the system is still expecting the hearing to go on, so I still have to prepare a report and I still have to show up at the hearing and then sometimes the hearing doesn't happen and then that's more of a waste of my time etcetera, etcetera, so it's costing the system a lot more money in work and resources and my time than it would necessarily. (P13)

This HCP expressed their awareness of how many resources were being shuttled into the CTO process, and the degree to which they found this use of resources appropriate, frivolous, or wasteful. This framing of a problem in terms of resources may be a learned behaviour resulting from being part of a system that rewards and responds to fiscal wellbeing over and above other success indicators, such as patient wellbeing.

Interestingly, this language of resource use entered clients' understanding of themselves and their relationship to the health care system and society as a whole. One HCP shared how a client would refer to herself as such:

> I'm a waste of taxpayers' money. She would always tell us that. I'm a waste of taxpayers' money. (P5)

In this case, the language of resources was used to express negative self-worth. This patient tied her self-worth to an anonymous, faceless collective ('taxpayers'), as if the deservedness that taxpayers had to wealth could be measured against the deservedness that she had to care. She implied that taxpayers were somehow other than her, and more inherently deserving. Further, this suggested that she was in need of ongoing care—but that she conceived of her ongoing needs as an internalized failure rather than as the responsibility of the services she was receiving or of her healthcare providers. In this way she endorsed the discourse of fiscal responsibility, to her detriment.

Risk constituted another pervasive discourse in participant accounts. This word 'risk' is enshrined in the Mental Health Act, however some, such as Robert Castel, have noted that the management of risk can be used as an apparatus to "identify, monitor and discipline" (Paradis-Gagné & Pariseau-Legault, 2019, p.4) populations deemed at risk. Documents reviewed for this study show that use of the mental health act necessitates an assessment of risk on the part of the HCP. For example, the Ontario Mental Health Act Form 1 uses the words:

> I have reasonable cause to believe that the person, if untreated...is likely to cause serious bodily harm to himself or herself, or, cause serious bodily harm to another person, or suffer substantial mental or physical deterioration, or suffer serious physical impairment. (D7)

Although later in this chapter I will examine the concept of risk in the context of CTO specifically, as well as its effect on identity, what I wish to highlight here is the pervasiveness of the concept of risk in the mental health care more generally. For example, a participant described their family member in terms of their riskiness:

> He's not a risk to the community unless he's off his meds. And then he'll get confused and make stupid decisions. He makes stupid decisions on his meds, but, uh, it's more of a high risk. (P4)

Here, risk is linked directly to medication compliance; medication lowers risk to others and failing to take meds increases risk.

Although risk was a vague and indeterminate concept, it was considered something substantial enough to be weighed against someone human's rights. One HCP stated:

> But I think that level of risk needs to be assessed against the level of impingement of the person's rights, the impingement of the person's ability to have insight into their own recovery. (P8)

In this quote, if risk was perceived to tip over some invisible balance, it justified taking someone's rights away. The idea that risk can be accurately assessed however, is questionable considering the ambiguous and open-ended way it is applied to SPMI. Further to this, it is not entirely clear what risk is being assessed against; here, the participant stated that it needed to be weighed against 'the impingement of the person's ability to have insight into their own recovery', a statement rooted in the established psychiatric discourses ('insight' and 'recovery', both discussed earlier in this section). The participant framed removal of rights as being damaging to an individual's ability to engage in and take responsibility for their own health status.

One patient participant remembered being told that he posed a risk, and wondering how and why this prediction was made. He had stopped taking his medication because of the sedating side effects, however, in his account, his behaviour had not changed. When the police picked him up, he was at home playing video games, and had not engaged in any violent or aggressive behaviours. He was (at the time of the interview) still baffled as to how the medical and legal systems arrived at the conclusion that his was risky.

> It [psychiatric medication] just made me really tired. And I didn't see that I was a threat, anyways, cause I didn't have a criminal record. And I...I wasn't doing anything violent, they [police] just came and picked me up. And they kept saying I was going to do something bad. (P18)

This statement provides a poignant example of how the concept of riskiness can become attached to a person, not an action or a context. The participant grappled with the perception that others (the police) had that he was ‘going to do something bad’. Because the bad action had not yet occurred, the ‘bad’ did not reside in an action, but in some potential that resided within the participant himself. Riskiness in a psychiatric context, due to its ambiguity and its focus on future actions, is devoid of context and devoid of particularity. Therefore, attention is removed from contextual or particular elements that may contribute to risk; the only element of risk that can be defined and managed is the person who is defined as risky.

Alternatively, one family member described how the language of risk was used to dismiss the seriousness of her daughter’s condition:

> And I asked the doctor, I said, please don’t release her, I’m telling you...His response to me was, ‘Well, we can see she’s very sick, but there’s nothing we can do for her, because she’s not homicidal, she’s not suicidal, so we have no basis to keep her.’ So they released her and you know, she kept going downhill, of course. Eleven times in the two months I called the police for help. Three, four times I called the mobile crisis unit for help. Each time they would go to her and see she wasn’t well, but nobody would help her, nobody. (P21)

In this case, risk (or the lack thereof) was used as a rationale for inaction on the part of the health care providers. However, the lack of coherent intervention resulted in a downward trajectory for this participant’s daughter. Together, these examples show risk to be a concept so vague and ambiguous that it can be used to explain or justify a wide range of actions.

Another discourse that had relevance for CTOs was the discourse of evidence-based care. During this research, I observed a family meeting between a psychiatrist, a family member, and a patient. When the family member expressed concerns about her brother’s prognosis, asking about his quality of life for the future, the psychiatrist responded by saying that, in a case like this, the CTO was the ‘gold standard’ for treatment (FN4). This term implies that there is research that shows that the CTO is the most effective when compared with other treatment options. In fact, the scientific evidence in support of CTOs is weak; moreover, this statement, applied to a patient who had already been on a CTO for several years, failed to address the family member’s deeper and more pressing questions regarding her ongoing concerns about her brother’s quality of life, which were rooted in context, availability of resources, and availability of structured activity. This is an example of how HCPs use a discourse of ‘evidence-based care’ to sidestep more difficult questions. On one hand, this can be a reasonable way to focus a meeting intended to resolve one clinical decision point (since not every clinical meeting can address every concern of every patient); on the other hand, this can be seen as an analogy for how the system uses both the CTO and a discourse of evidence-based care to skirt thorny issues such as the emotional and spiritual consequences of spending a lifetime in an overstretched psychiatric system.

5.1.3 The social support system

Patients with CTOs have typically been in relationship with the social services system for many years and have care plans in which there is a co-mingling of pharmacological, therapeutic and social interventions. For example, the care planning document mandated for use in all community mental health agencies in Ontario includes sections on housing, addiction, medication, employment, food, and housekeeping (Ontario Common Assessment of Need, 2017). The social support system includes housing providers, emergency food services, disability pensions, shelters, community groups, childcare and employment supports. The organizations that provide these services have a wide variety of funders including government (provincial and municipal) and non-government sources. Although a full description of the current social service system is beyond the scope of this study, it is essential to acknowledge the relevance of this system as part of the context in which CTOs are used. This is especially significant in that province wide de-institutionalization in the 1980’s resulted in the need for new ways to provide housing for people with SPMI. These services therefore share with CTOs that they emerged in response to a need to house and treat people with SPMI that was no longer being met. Several features of this system emerged from the data.

5.1.3.1 Incomplete and difficult to navigate

A participant described the social services system as divergent, spread out, and difficult to navigate.

> This, uh, yeah, higgly-piggly, hodge-podge duct taped together thing that we call a system, but that really isn't. (P8)

He went on to describe the frustration of people trying to help patients navigate this system, saying,

> The services just aren't there... We just don't have the services. And now trying to piece together things like housing and... services... and things for clients... it's become more evident, the need for services. (P8)

This quote demonstrates the amount of time and effort that mental health service providers spend navigating the social service system on behalf of their patients. When providing direct patient care, it becomes clear that psychiatric interventions will not be effective unless patients have a way of meeting their basic needs for food, housing and shelter. And yet the system intended to meet these needs is so de-centralized and insufficient, that in an absurd doubling-up of system inefficiency, service providers spend a large amount of their time negotiating and fenagling with other service providers.

5.1.3.2 Functions to institutionalize poverty

People with SPMI are eligible for an Ontario Disability Support Pension (ODSP). Since most cities do not have publicly funded housing for people with mental illness, individuals with SPMI need private services for housing. For someone living in a domiciliary hostel, for example (a place that provides room and board), most of their ODSP cheque (plus a subsidy from the city) goes directly to the hostel. They are left with a little over $100/month for all other expenses, including transportation, clothing, birthday gifts for their loved ones, personal items, hobbies, savings, and social, outing, or holiday expenses. These residences are often bare bones operations, with up to three people sharing a single room. On family member described a typical room:

> Because when you think of the residences that they live in, he's in a room with three other people, in a space, from here to that window...not much bigger than this. You put three beds in there, put a couple of dressers in, and you put three grown men together, and let me tell you, not good stuff happens, right. (P4)

The participant provided a description of a typical setup at a domiciliary hostel, as well as an implicit reflection on the de-humanizing potential of such a set up. One patient participant spoke of his living situation this way:

> P12: I had friends in the psychiatric system, who were hurting me all the time.
> F: Oh, okay, so you met people, like while you were hospital, and those people were not good relationships for you.
> P12: The one's I lived with. (P12)

Although this participant chose not to expand on what he meant by 'hurting me all the time', nevertheless, this quote provides evidence that grouping people with mental illness together in underfunded and crowded living quarters can lead to negative outcomes. The behaviour of this participant's 'friends' was reported in a matter-of-fact way, suggesting that he had accepted this as a part of life. By calling them 'friends in the psychiatric system' he implied that these people and this type of behaviour became part of his regular experience, something he had come to expect from that system, and by hiding this violence ('who were hurting me all the time') in an embedded clause, he minimizes its importance.

Such social housing environments, which house primarily people with mental illness, are privately owned, underregulated, and often staffed by minimally trained staff. One patient participant described his experience in such a housing environment this way:

> My big fear was always that something bad was going to happen while I was sleeping, like in these houses where there's loud noises, people fighting, no lock on your door—all that...Like all my houses, I had people break in while I'm sleeping, doing drugs in my apartment, stuff like that, like at [dom hostel name], I had a roommate, and there'd be like four people in a circle smoking crack when I wake up, and they'd tell me, 'Go to sleep!' And—it wasn't good like that. (P18)

This participant refers to a problematic social context; he describes an environment where people are fighting all the time, there are a lot of loud noises, and where, in addition to this, he was not afforded basic privacy. In addition to having roommates, the doors did not lock, and there were times he would wake up to people doing drugs in his room. One of the symptoms of this patient's illness was paranoia; this quote exemplifies the absurdity of providing pharmaceutical and medical treatment for paranoia, while placing people in a house without locks, where noise, violence, and crime, are all common. Another participant also reported regular drug use at their family member's residence:

> So, he was in a residence there with about ten other men. And my son is very quiet, and he ended up being, uh, kind of...people were taking advantage of him. Kind of the place got really bad, and people were there abusing drugs, and so...it got bad. (P21)

For these patients, basic living situations were not only inadequate but led to abuse and victimization, further threatening their psychological (and possibly physical) wellbeing. This type of housing environment can undermine the overarching goal of the CTO, which is for individual's to be able to live in the community safely and with adequate supports.

In addition to concerns about housing, many participants mentioned that finances were a primary concern. One, who felt he had, overall, moved into a better part of his life, stated,

> There's nothing I really want to change now. Maybe to get more money but I don't really see that happening. (P18)

In this statement, he expresses a sense of fatalism around his financial situation. Another, sharing a similar sentiment, stated,

> The only problem I have is the PG&T [a Public Guardian and Trust manages the finances of people who have been declared incapable for finances and who do not have a family member to act in this role] ...I'm tired of chasing money around. (P19)

Another participant also expressed concern about finances:

> He said, 'What I really want to know about is my money, why am I only getting $100 month?' and the nurse explained that that actually probably makes sense, with his income where it is at and the fact that his rent is paid off—he has a PG&T. (FN14)

Each of these three quotes evidence that the social supports available to people living with mental illness function to create a sentence of life-long poverty. Although de-institutionalization has allowed them to live (independently or in supported housing) in the community, it has not provided them the means to integrate into community life in a way that allows them equitable opportunities for employment, housing, meaningful activities, other necessities, or financial security. Instead, the social service system has created a new context for people with mental illness, one in which they live in community environments, but remain excluded from the potential benefits of these communities by systemic poverty. This is not only incongruent with the goals of the CTO but has the potential to counter the goal of the CTO, that is, for patients with SPMI to live meaningful lives in the community.

5.1.3.3 Requires abiding by the rules

One family member described how her daughter had found a housing environment that at first seemed a perfect fit for her needs. She had her own room with a kitchenette, access to a shared cafeteria, and 24 hour support staff.

> But, ah, she couldn’t handle the rules. But they were really good to her there. They were lovely, lovely people who ran it. Even the people that ran, like, the canteen/cafeteria, they knew [daughter’s name], they were super nice to her, they were always nice to me when I came to visit. You know, they were just lovely. But she couldn’t handle the lack of freedom. You know, you can’t have anyone overnight, you can only have one person at a time in your room, you have to be in at x, and, you know. Meals are at x. She chafed against that kind of thing. Always, since she was little, she was an iconoclast, she was born that way. (P20)

This quote reveals a deep struggle in meeting the needs of people with SPMI while they continue to live in the community, which is one of the major tasks facing both the mental health system and the social service system currently. Through a mix of private and public funding, good, well-funded and appropriate housing does exist, although the type of housing described here very rarely becomes available. However, because it rarely becomes available, a disorganized ‘iconoclast’, as described above, has very little chance of having the logistical skill or the foresight to get on a long waiting list to get a room, or to manage the rules of the setting once there. Even when public and private funding combine to create a best-case scenario for housing, living in supportive housing still requires that the individual identify themselves as in need of help, and subordinate themselves to a structure of rules and regulations that limit their personal freedom. Because this is so difficult for the people who most need these programs, this type of room often ends up going to people with middle-of-the-road needs, who have just enough organizational skill and patience to get on and stay on a waiting list, and submit to the rules that govern the facility when they do access a room.

The social support system is the replacement for the institutions that once housed, fed, clothed, and treated people with SMPI. Like the CTO, it is intended to facilitate independent life integrated into community. However, like the CTO, although it functions to meet some needs some of the time, it also creates and maintains systemic barriers to community integration.

5.1.4 Legal/enforcement systems

The CTO is an outgrowth of an existing mental health act and relies on the pre-existing structure of the Consent and Capacity Board (CCB), Psychiatric Patients Advocacy Office (PPAO), legal aid, and police systems. These systems have their own value sets and predetermined discourses that colour and influence the way that they approach CTOs and interact with CTO processes. They also interact with each other in complex ways: The MHA grants the police the authority to apprehend someone and to bring them for assessment if they believe they are a risk to themselves or others; in addition, a Form 1 employs the police as agents to bring people in for assessment when a psychiatrist deems it is necessary. The law also mandates rights advice, and a hearing when requested. The presence and power of legal and enforcement bodies are enmeshed into the psychiatric system and effect the way healthcare professionals and patients perceive the purpose of care, and the way that care is provided.

For example, professionals include legal and enforcement means into their assessment of how to manage clinical scenarios:

> I can really see that there is a huge population of people that fly under the radar of any sort of healthcare, because they’re not unwell enough to be in hospital. So there is definitely that problem that I saw a lot in the shelter, and I don’t see, I don’t really know how that’s going to change, but I would hope that, I hope that some things can change in the future. Not necessarily a CTO, but I don’t know, even like, getting to be on a form, or having to be hospitalized in the first place, because I think there is a certain amount of wellness that somebody needs in order to have insight, right. (P15)

HCPs, who often do not have first-hand experiences of poverty, disenfranchisement and stigma, are enculturated into a view of mental illness that sees it as a problem experienced by and contained in individuals, and that is (therefore) solvable through hospitalization and medical treatment, and that it is reasonable to achieve this forcibly (using a form) if need. The MHA enforces and entrenches this view, leading to a situation where HCPs, when faced with problems such as chronic poverty and disenfranchisement (as evidenced by this quote), envision strategies that involve coercion of individuals. Removing someone's rights is perceived as ethical and as expedient because the person does not have the insight to make decisions in their best interest. It is worth noting that the expedience and ethics of this type of mandated intervention is dependent on the assumption that the care will go well, achieve the desired ends, and that the patient's encounters (with police and with healthcare professionals) will not be traumatic. In addition, a clinical determination of a lack of insight (as discussed in section 5.1.2.2) often refers to a patient's inability to understand their symptoms through a psychiatric lens; the ethics and expediency of the type of mandated care referred to in this quote, therefore, is dependent on an outcome where care results in the patient gaining alignment with treatment goals. The solution to these complex problems (living in the shelter, flying under the radar, not having insight) is characterized as existing in the patient, without acknowledging larger contextual issues which likely need attention.

For their part, people on CTOs often have past experiences of interactions with the police, and/or legal services in some way. Many patients with CTOs have been 'formed', e.g., picked up by the police and brought to the hospital for involuntary assessment. Being on a Form 1 or 2 involved interacting with the police; if the patient was then put on a Form 3, they would have received rights advice from the PPAO; if they contested a form, they may have had some previous interactions with the CCB. One HCP recalled the experience of one client:

> I know he, ah, he's kind of recounted stories where he's been tased by police and stuff like that and I think that's probably related to having forms done on him in the past. So, it's obviously a very traumatic experience for him, and something that he's never really forgotten, and something that's going to stay with him forever, so that's unfortunate to hear. (P15)

This quote refers to a scenario where a patient was brought into hospital by the police, and, at least one of these times, was ‘tased’ in the process. For many persons’ with SPMI, this is their first step into the realm of forced hospitalization and treatments, and it leaves an indelible mark on their understanding of the mental health system as (un)safe and (un)therapeutic, as exemplified above, even when the use of force is ‘short-lived’.

Police contacts, which often occurred in the context of a psychiatric event, were generally negative. An HCP stated:

> In general, yeah, yeah, their experience with the police they find that very traumatizing to be, you know, on a Form 1 or on anything, the fact that the police knocks on your door, cuffs you, and puts you in the car, it’s like, it’s very difficult for anybody. (P5)

In this quote, the participant described some of the actions of police that patients find traumatizing. Police show up at the individuals’ house, they put them in handcuffs and put them in a police cruiser. These are routine actions taken by police when answering a call, and as such, their significance can sometimes be dismissed by HCPs. This participant emphasized that these actions would be ‘very difficult for anybody’. This discursive shift is necessary because of a long history of dehumanizing psychiatric patients. Because of a tendency to dismiss the significance of trauma that occurs in the context of police interactions, this practitioner reminds themselves and the listener that the patient is ‘anybody’.

Another HCP reported the type of a ‘support’ a family member had received from police over the course of her son’s battle with mental illness:

> I had a woman the other day say to me, after this guy had a long admission and was put on a CTO: ‘I’ve finally feel like I’ve got some support, all that happened before was like a knee in my son’s neck by the police.’ (P16)

This participant spoke with the researcher during the time that Black Lives Matters protests were occurring around the globe; here she recalls a family member evoking a powerful image of police brutality that echoes the police brutality involved in George Floyd’s death. This image is symbolic of a police presence that is indifferent, powerful, brutal and that cannot be trusted. And yet, police action is a very common element of people's experience of psychiatry. In this quote, the HCP is making the point that hospitalization and the CTO provided relief from this type of police intervention. However, the continued presence of police intervention is a defined part of a CTO; this suggests that both the HCP and the mother believe that the CTO will be able to deploy and manage that police presence in way that makes it less brutal and more trustworthy. This belief—that the CTO can manage the potential for brutality in police interactions successfully—allows HCPs and family members to see the CTO in an unproblematized way, as a cogent part of a social justice discourse.

For one patient, the police were involved in his life throughout several decades of psychiatric care, beginning with the first time he disclosed his symptoms:

> F: Can you tell me a little bit about the first time you went to the hospital when you were 20?
> P12: Ah, I went to a church, talked to a priest, I was getting mentally ill, then.
> F: How did you know you were getting mentally ill, what was going on?
> P12: I was just paranoid. I had thoughts about, ah, bad things. And ah, the priest called the police, and they took me to [name of hospital]. From there I've been in the psychiatric system trying for years. (P12)

This account provides an example of a longstanding propensity among community members to call the police when witnessing psychiatric illness and provides further evidence of the commonality of enmeshed experiences of the police and of psychiatric care.

Family members reported calling the police when they felt there was no other way to access services for their family member:

> Um, well, this was at the time when I was trying to get him diagnosed. I knew what was wrong with him because I'd been researching at home, like, the way he was behaving, all these behaviours. And I was finding it, googling it up, and it was like, okay, is there something else it can be. And then, uh, he was able to contain it somewhat around other people, enough that they wouldn't really know. But so I was trying to get him some kind of treatment, and the first time I took him to the hospital, they were just like—there's nothing wrong with him, he's just like, a bad kid. And I said, no, it's not just a bad kid, I'm telling you, there's something seriously wrong with his head, right. And, um, so, what happened was that, when the police were involved, he was actually kind of threatening towards me. He wanted something, I said no to him, and he kind of threw something at me and kind of cut my foot or whatever. I kind of um, I did call the police, but they ended up making a deal with him. I said, you know, the police are here, you're gonna get arrested and

> charged with this, or you can go to the hospital and be evaluated, willingly. Because up until then it was a hard thing to get him to go there. (P21)

This participant raised several potentially problematic systemic issues within the mental health system. She had trouble being heard and believed by practitioners. When practitioner assessments did not lead to a clear diagnosis, they reinforced the socially dominant idea that the problem was the individual, that he was 'a bad kid'. When this adolescent engaged in violence, the system finally became involved. The mother (the speaker), who sought mental health care for her son several times, accessed the system by reporting this violence to the police. She was dismissive in the way that she reported the violence, (he kind of threw something at me, and it kind of cut my foot, or whatever), suggesting that she did not want to label her son as violent. There was also tentative-ness in the way that she reported calling the police (I kind of, um, did call the police). This suggests an understanding of how negatively a label of violence can affect an individual, as well as how difficult police intervention can be. Nonetheless, as she expressed in this story, she had no choice but to engage in this counter-intuitive, last resort measure. The lack of timely intervention and the difficultly she had with being heard and believed by providers led to a situation in which her only option was police involvement.

Another participant recalled calling the police when her brother became violent while in a psychotic state. Although it was the only available resource that she felt she could reach out to in a psychiatric emergency, she was unhappy with their approach once they were on the scene.

> I called the police, right, to get him into the hospital, right. I didn't want to charge him, because he's my brother right. And–it's hard. Do you know what I mean?... For him to go to jail and that, I mean, I didn't want that. So, anyways, so, the police came, and the ambulance came, and I had a bruised eye, and my glasses were broken. One of my arms [of my glasses] came off in his apartment. And I said to one of the police, 'Can I go back into the apartment to look for the piece of my glasses?' And he said, 'No'. Then I see him [referring to brother] coming out with a police in handcuffs, right, and a police says, 'Your brother says that you assaulted him. So, what do you want me to do? I'm going to arrest both of you and put you in jail for the night and let the judge decide.' (P3)

In this case, calling the police backfired for the participant, adding to the angst of attempting to manage her violent brother. The police comments ('so what do you want me to do') suggest that the police are not equipped to handle this situation and are not equipped to find an appropriate solution to its root causes. The mixed match of needs to services is striking, and the forcefulness and punitive nature of police action (‘handcuffs’, ‘arrest you both’, ‘jail for the night’) creates further trauma for both parties without addressing the issue at hand. In this case, the participant, not wanting to go to jail, signed a paper saying she wasn’t charging her brother. He was brought to hospital but discharged the next morning. As in the previous story, the participant turned to the police because she felt she was out of options, but this, while it may have managed the immediate risk of violence, did not result, as the participant hoped, in an entry point to services. Instead, the police intervention led to an interaction that was traumatic for both parties, and further, the police officers’ approach may have acted to stigmatize both her and her brother, minimizing their issues and making entry into services more difficult.

However, not all interactions with police were negative. One family member participant reported:

> You know when she had her suicide attempt and they brought her to the [hospital]. And, I spoke to one of them and they were like, super nice. Really really caring, really awesome. But I’m sure they’re not all like that. But every encounter I’ve had has been sort of positive, but I haven’t had that many. (P20)

This story hints at a different element of police presence; police become involved at distressing and potent moment in individuals’ lives, and some police officers, despite the authority and forcefulness often required by their role, have the skills to be present at these moments in a way that manifests kindness. In the accounts collected during this study, such behaviours were the exception, rather than the norm. Police interventions mostly evoked force and expressions of power to control situations perceived to be dangerous in some way. The niceness of individual officers cannot undo the hazardous mismatch that is the deeply entrenched relationship between mental health care and policing. In this case, although this incident did lead to a hospital admission, this mother still felt that she had to continue to fight to convince her daughter’s care team that the situation (her daughter’s illness and distress) was profound and urgent.

In these accounts, police were normalised as an entry point to mental health system, often in cases where other entry points were closed off to participants or failed to get them the service that they or their family member needed. These accounts show what kind of circumstances lead to the use of police presence; they also illustrate how tying police involvement to mental health service use results in negative experiences for patients and families, is often antithetical to care and support, harms identity and relationships, and emphasises force and coercion.

5.2 Social Practice: The Community Treatment Order Process

A community treatment order is not a single, consistent entity but is made up of several elements which involve many steps and many actors. Breaking the CTO down into its constituent parts, provides a clearer picture of which parts effect identity in which ways. This may help bring into focus which parts of the CTO are beneficial to patients, and which parts are less beneficial; this could allow for targeted policy and practice adjustments to increase the efficacy and decrease the negative effects of the CTO.

The elements of the CTO are dictated by the MHA. These include the list of forms that need to be completed and distributed at the initiation of the CTO and at each renewal, the requirement for rights advice, the timing of the renewals, mandatory Consent and Capacity Board (CCB) review hearings, and provisions for a recall process that involves police (Form 47’s). In addition, the CTO, in accordance with the Health Care Consent and Capacity Act, must be consented to; if the treating psychiatrist deems the patient to be incapable of consenting to treatment (the most common scenario), a substitute decision maker (SDM) must consent to the CTO. This is done in accordance with the Substitute Decision Maker Act. In the data for this study, features of each of these elements emerged.

5.2.1 Initiation and renewal of the CTO

To initiate or renew a CTO, there are a number of forms that must be completed and provided to the patient, at specific times. This is regulated by law and is intended to be protective of the patient's rights. The legislated review of CTOs that was done in 2012 attempts to summarize this process:

> Before a CTO may be issued, the physician must develop a community treatment plan that includes all services and the terms of the CTO.... Within 72 hours prior to the treatment plan being entered into, the physician must examine the individual to establish the need for care and the likelihood of adherence; that the services prescribed are available; that the person meets the criteria for a Form 1... Before a CTO may be issued, the physician must complete Form 49 (Notice of Intention to Issue or Renew Community Treatment Order) and provide a copy, including the community treatment plan, to the consumer and his or her SDM, if any. The physician must also notify the rights adviser, of his or her intention to issue a CTO. Rights advice is provided to the consumer and the SDM and Form 50 (Confirmation of Rights Advice) is completed.... The physician subsequently issues Form 45 (Community Treatment Order) with the community treatment plan. These are provided to the consumer and SDM as well as to all other persons named in the community treatment plan. A Form 46 (Notice to Person of Issuance or Renewal of Community Treatment Order) must also be provided to advise the consumer of his or her right to a hearing before the CCB.... A consumer may apply to the CCB, by completing Part 1 of Form 48. (D1)

This excerpt, intended to summarize the CTO process, highlights the administrative features of CTO initiation, around which an intricate bureaucracy takes shape. The proliferation of forms necessary to initiate or renew a CTO creates a bureaucratic flurry for the psychiatrist, patient and SDM (often a member of the patient's family). There are precise timings for these forms, so that once the process has begun, everyone is kept to a tight schedule.

One HCP reported:

> I think most people find the process not great, because it's a process with a lot of hoops...it's confusing for families; it's extremely confusing for physicians. (P16)

The participant underscored the effects of such paperwork for patients, even ones that had been on a CTO for several years:

> It's generally a period of um unrest, to be honest. The process. Because you're bringing things up, your asking people to do things. The patient's reminded that they have to take their meds again. It's generally a difficult time for people, I think. So they want it to be over. (P16)

The legal justification for such intricate paperwork is that it acts to protect the patient. This quote, however, reveals that the process of renewal generally has a negative effect on patients. This was furthered by a participant who spoke of the effect of the renewal process on their own family member's wellbeing:

> She goes through the stress of wanting to fight this, becoming aware of it because she is alerted to the process by her rights advisor if nobody else, and ah, when she's particularly well, in terms of her ability to process and organize herself, she'll rally to try to fight this... So it does add a lot of stress, unnecessarily, for her, this review process. She pleads with me to help her with it. She tries to organize getting a lawyer, tries to, you know, take action, and is very disappointed when she again doesn't succeed. (P17)

The quote refers to several of the steps involved in a CTO renewal (rights advice, the hearing), including managing significant paperwork. It also draws attention to the fact that this process must happen every six months. For patients that have been on a CTO for a long time (the patient referred to above had been on one for almost twenty years), the frequency of this heavily bureaucratic process becomes like the re-opening of a just-healed wound. Beyond this, the structure intended to protect the patient is organized within a frame of literacy, comprehension, capacity, and organization that is not reflective of CTO subjects; it is a massive structure with its own jargon that few patients were able to manage.

A patient participant also reflected on how the renewal process seemed too frequent, and redundant:

> I mean, I'm taking my meds, but why do I have to sit there and answer these personal questions, that I would only want to do once, and I already said I'm going to take it. So why are you going to ask me these personal questions every six months and they always sort of make me feel bad and down that day. And you keep doing it every six months and it's going to be till when, till I'm 90 years old? (P18)

This patient, far from perceiving this process as protective, experiences it as nagging and intrusive. He also alludes to the effect that this has on him: 'makes me feel bad and down that day'. This participant was on an involuntary CTO, and yet, there was a level on which he accepted this as a part of his life, and with which he complied. Cognitively, this required a balancing act, a balancing act that the every-six month renewal served to disrupt. The process felt like an interrogation of his attitude or behaviour, which he did not appreciate. ‘All of these questions’ may probe whether he intends to remain compliant, and make him feel like he needs to re-prove his willingness to cooperate: ‘I already said I’m going to take it’.

This bureaucratic workload may serve to distract practitioners and patients from deeper thinking about the CTO process. While it created an illusion of order and safety, it was questionable whether it served its purpose. For example, one of the rationales for the legal parameters of the CTO are to serve as a check on physician power. One family member recalled:

> So, he [the physician] said that, um, he thinks that my brother would do well on a CTO order. And he thinks it will be beneficial to him. But he says that he needs my signature. But then he says, or I don’t really need your signature, I can sign it by myself, right. So, I signed it, right, for him to be monitored in the community. Well, that didn’t happen. (P3)

This participant described a process where there appeared to be inconsistencies in the CTO paperwork, which served to undermine the purpose of this paperwork. The physician in this quote was required by law to speak with an SDM about treatment decisions, and to have an SDM sign the paperwork for the CTO. However, he alludes to having found some way around these steps (perhaps he was alluding to having a Public Guardian & Trust act as the SDM, but it is unclear in this quote). If so, this demonstrates the degree to which doctors assume PG&Ts will consent to any interventions based on the recommendation of the prescriber, therefore being an ineffective safeguard. When bureaucracy is too complex, the focus on its purpose becomes overshadowed by a focus on the fulfillment of its functional steps, it also incites creativity around ways to avoid or circumvent prescribed processes.

The forms themselves can be intimidating, and they use legal language in a way that leaves little room for nuance, reflection, or difference. In this, they encourage dichotomous thinking in both patients and clinicians: Mental distress defines one as having a mental illness or it doesn’t; one fights one’s diagnosis at a trial, or one accepts treatment recommendations; one accepts medication, or the police will come. The world called into being by mental health forms, a world intended to protect the rights of patients, is a world of black and white that does not reflect the grey zones of mental illness. A Form 33, for example, is given to a patient before the notice that the CTO will be renewed, to declare that they meet the criteria for a Form 1. Form 33 contains a Ministry of Health crest in the left-hand corner, and on the right-hand side reads "Notice to the patient under subsection 59(1) of the Act and under Clause 15(1)(a) and 15.1 (a) of Regulation 741". The form reads:

> This is to inform you that on [date], I, [name of psychiatrist], have made a determination that you
>
> - ☐ Are not mentally capable to consent to the collection use of discloser of personal health information within the meaning of eh Personal Health Information Protection Act, 2004
> - ☐ Ae not mentally capable to manage your property
> - ☐ Are not mentally capable to consent to treatment of a mental disorder ("treatment" within the meaning of the Health Care Consent Act). (D4)

The purpose of this form is to inform the patient of a psychiatric decision in clear language, so that they can contest the decision if they wish—it also contains the names of the five other forms that the patient or their lawyer could use should they wish to contest this determination. The formality and technicality of it is intimidating. The government symbols and arcane language assert the power that exists behind the decision. As a result, far from achieving their purpose, they may effectively deter patients from fighting the CTO.

5.2.2 The Community Treatment Plan (CTP)

Before a CTO can be initiated or renewed, the psychiatrist must create a Community Treatment Plan. It is part of the legally required paperwork, and it is enforceable by law. The 2012 review summarizes the CTP as follows:

> Before a CTO may be issued, the physician must develop a community treatment plan that includes all services and the terms of the CTO. This treatment plan must name all participant's treatment partners and be consented to by the consumer, or if incapable, by their SDM. If the consumer is unable to consent to the community treatment plan, the plan will be provided to both the consumer and their SDM. (D1)

In this quote, it appears that the CTP is intended to include a comprehensive service plan, one that includes community and social services and clinical visits—in other words, one that provides for the holistic needs of the patient. The requirement of a CTP, therefore, makes the CTO appear to be a comprehensive and holistic intervention. However, the legal mechanisms of the CTO make this holistic approach wholly impractical. Anything in the CTP is enforceable by use of the MHA; however, the only means of enforcement is to bring people into the hospital for assessment. Participants found that this was not a reasonable mechanism of enforcement for any element of care other than medication, thereby limiting the usefulness of including holistic interventions in the CTP. One HCP participant, who worked in the mental health system since CTOs came into being in Ontario in 2001, reflected on the evolution of the CTO:

> P1: Although the beginning of CTOs was trying to be holistic, CTOs were actually trying to say, we are going to work with you under the CTO for housing, for employment, blah, blah, blah, then they cleaned that up and you know, it was a nice intention but it was a bad idea ultimately.
> F: And why was it a bad idea?
> P1: Uh, because how can you believe, how can you under the rule of law say I'm going to help you get housing, I'm going to help you with your worries under the community treatment order, it just doesn't...it's ridiculous. (P1)

In this quote an HCP reflects on the impossibility of including a holistic care plan in the CTO. From his perspective, this is obvious ('it's ridiculous'). He still believes providers should participate in all of these activities with patients, but finds that trying to include them in a CTO is not functionally helpful or effective. As a result, for this participant, stressing the holistic nature of the CTO seems dishonest.

Another HCP also reflected on the results of making the CTP holistic:

> There's nothing in the mental health act which reads exactly what you can and can't put in plans, but we all kind of have plans and processes that work for our particular region and our particular consent and capacity boards' tendencies or picks. So, if, you might find in a smaller community, um, that they add things that I wouldn't consider adding. Like I never touch housing in CTOs because there is really no way to enforce it. (P16)

This HCP also reflects that making the CTP truly holistic is not realistic given the mechanisms for enforcement. For example, it would be bizarre to bring someone to the hospital for assessment because they missed their community cooking class. The result of this is that the main element of the CTP is the medication orders. Participants confirmed that in practice, the main purpose of the CTO was medication compliance. One HCP, when asked what she saw as the number one purpose of CTOs as they'd been used with her clients, stated: "Well, med compliance" (P5). Another HCP indicated this thinking clearing:

> You can't put them on a CTO, there's no point, if there's no long-acting injection.
> (P10)

These quotes, taken together, reveal that HCPs perceive the purpose of a CTO to be the enforcement of medication. Exposing the CTOs implicit goal of medication compliance can help us to better consider and critique the role of the CTO in community mental health care.

5.2.3 Rights Advice

One of the legally mandated steps in the CTO process is the provision of rights advice to both the patient and the SDM. This is provided by a publicly funded arm's length organization created in 1983 (prior to the existence of the CTO) called the Psychiatric Patient's Advocates Office (PPAO). The mission of the PPAO is to

> provide rights advice, education and advocacy services to persons in designated mental health care facilities in Ontario. We ensure the voice of the patient is promoted and their rights are protected. (PPAO, 2018)

This office must, legally, provide rights advice to patients regarding all aspects of the Mental Health Act, excepting Form 1 and 2s (Assessment). Rights advice provides patients and their SDMs with information about their rights to dispute decisions made on their behalf under the auspices of the Mental Health ACT, and information about the processes for dispute. For example, a patient on a CTO could be provided with information about how to request a Consent and Capacity Board (CCB) hearing, in which they can contest the CTO, should they want to do so. According to their website, they gave rights regarding 12, 867 CTOs in 2018. This number has been growing steadily since 2003, when they gave advice regarding 817 CTOs. In fact, they report a steady increase in instances of the provision of rights advice for all reasons: 12 thousand in 2003, 25 thousand in 2008, 37 thousand in 2015, and 44 thousand in 2018. These numbers suggest an overall increase in use of the MHA in Ontario, including the use of CTOs.

However, despite this, some participants felt that the relevance of the PPAO as an advocacy organization had diminished over time, as their work became more focused on the provision of rights advice, and less focused on education, policy statements, and patient advocacy:

> Well...Psychiatric Patients Advocates office doesn't have a statement. I know it's declined in relevance over the years. I know it's declined in relevance over the years, over the decades, I think it really has declined, because, who knows what they're doing. I mean, they used to have these beautiful briefing summaries, it's hard to know if they're really up to date anymore. (P1)

This HCP, who had been working with people with SPMI for more than a decade, viewed the current role of the PPAO as insignificant compared to their previous work. This provides evidence for a way in which rigid CTO processes have usurped the purpose of an oversight body and turned it functionally into a passive entity peddling information and advice on demand, rather than and advocacy organization actively engaged in shaping the legal landscape impacting a highly vulnerable population.

The process of providing rights advice for CTOs takes place over the phone. An advocate from the PPAO calls the patient and SDM to provide the advice. There is a time frame in which this must happen, and without it, the CTO cannot move forward. This means there is pressure on the rights advisors to provide this phone advice in a timely manner. This process has many logistical hurdles. An educational document called "Common CTO myths", put out by the Centre for Addiction and Mental Health (CAMH) identifies the following as a myth:

> The PPAO must give rights advice within 48 hrs of giving them the CTP and the Form 49. (D5)

It then corrects such myth with the following 'accurate' information:

> The PPAO endeavors to start rights advice within 48 hours, but they are not expected to have completed the process within this time. It's often difficult for right advisers to get in touch with clients as phone numbers change and clients move around. Physicians and CTO coordinators can help make the connection easier by providing clear contact information, and looking for opportunities to connect the client and the rights adviser. (D5)

This document stresses the function of rights advice as a mandated step in the CTO process, but it does not explain the concrete benefits of the rights advice (I was not provided with any documents arguing that rights advice was a vital and useful part of advocacy). The document delineates what is ‘true’ and what is ‘false’ in relation to the CTO related duties of the PPAO, but ignores situational nuances. It also positions the HCPs somewhat ambiguously, in relation to CTOs and CTO clients, in that it highlights that the HCP is expected to act as a collaborator in the rights advice process. It is worth noting the potential confusion this may cause, as it is the HCPs' actions and decisions that may be the focus of the advice being provided to a patient. One HCP reflected on how this created some tension for HCPs:

> P7: I mean, it’s up to us to continue having the conversations with them [patients], that it’s important that you receive this [rights advice], they might give you information that you’re not aware of, but, I don’t know how many clients really take it in.
> F: And I guess they have you, too, to explain it, if necessary,
> P7: Yeah
> F: Someone who sort of understands...can almost translate the information
> P7: Yeah. Except we’re not involved in the actual call. I mean, I know what rights advice is, informally, right, and what, how it can protect you, but we’re not actually involved in the call because we’re...
> F: Because of your bias
> P7: Bias. right
> F: That’s a tough one, where you’re almost the one who can get through to the client, but your bias keeps you from the being able to give the advice.
> P7: Yeah, so instead, it’s someone on the phone who they don’t know, who’s in Sudbury. Right? (laughs) (P7)

This HCP struggled with his role in the rights advice process. On the one hand, he saw that patients were not really benefiting from rights advice in its current form, and that they had trouble connecting with or understanding the rights advisors. Patients with SPMI often struggle with managing logistical and practical tasks, in particular tasks that involve speaking with unknown persons on the phone. This is therefore one area in which the treatment team provides support; mental health workers often use the trust and rapport that they have built with patients to assist them with managing bureaucratic and logistical tasks that they find intimidating or confusing. Therefore, on one level it is natural for the treatment team to help patients manage the provision of rights advice, a logistical task that they find confusing and stressful. However, the HCP indicates that he did not feel that he could get involved in the process, due to his role as an ‘adversary’ in the CTO process. Since rights advice consists of advice about how to contest a provider's treatment decisions, having the provider involved in the process felt absurd. This reflects the larger conflicts that HCPS struggled to manage during the process of mandated care, where care providers were at once attempting to build rapport and trust with patients while at the same time being legally defined as the patient's adversary.

If patients do not want rights advice, the Rights Advisor must document their refusal in order for the CTO process to move forward; however, they will only accept a direct refusal from the patient. In practice, this creates new levels of absurdity, which one HCP described this way:

> So if you have somebody come in for an appointment [with their mental health care provider], and you're trying to get them rights advice, because they don't have a phone at home, which is super common, or they've been avoiding the phone, and the patient refuses to speak and is standing across from you and the worker says "he's refusing": they [the rights advisors] have refused to take that as a refusal before. So, I've had to educate workers or nurses to say like, explain your advocacy to try to get them to understand, like I'm holding the phone out, he [the patient] is shaking his head and refusing to take it. Hopefully get the client to actually say 'no', or you know 'fuck you' or something that tells the rights advisor that the person is saying no. (P16)

This quote describes what it is like for HCPs who are attempting to facilitate the process of rights advice, despite the conflict in roles that this creates. In addition to the fact that many patients do not have a phone, many patients, for a variety of reasons (symptoms, lack social skills, discomfort with strangers, suspicion or misunderstanding of their role, or simple disinterest) recoil at the thought of speaking to a stranger on the phone. In these cases, mental health workers, during home visits, to fulfill this bureaucratic necessity, hold up their phone in the vicinity of the patient, and hope they will yell out some sort of slur as evidence of their presence.

This is in fact such a common practice, that one HCP stated, in passing: "He's had rights advice and everything, well—we've held up the phone" (P15). This participant equated a tacit refusal of rights advice (i.e., the patient's refusal to talk to a rights advisor even when she put them on speaker phone in his vicinity) with receiving rights advice. This is evidence of how mismatched the rights advice process is with patient preferences and abilities; it also speaks to the way that HCPs have been recruited to participate in this charade, and the degree to which this may deteriorate their ability to discern the difference between patient advocacy and bureaucratic need.

The rights advice process is entrenched in law and is logistically time consuming. It was not generally appreciated by patients or family members, and rather, was seen as a chore:

> Um, SDM's—I have not had any feedback from them generally that its helpful. Unhelpful if anything, because they have to get the full deal every time, and I think some rights advisors are better than others at cutting it short for the family member if they can. (P16)

This quote provides a sense of how the process unfolds: rights advisors call SDMs every six months, and family members express exasperation or annoyance at having to hear the same spiel over again. It is worth remembering that the advice is related to an issue which can be emotionally agitating; it may reopen a wound regarding a decision they have laboured over. Some rights advisors cut the process short, while others stuck to the letter of the law and went through the whole process, regardless of the family member's engagement. One family member, when asked if this process was helpful, replied:

> Well, no, really, because, it's a situation that is so repetitive, for me it's like a broken record, so, no. But again I get it, for some individuals, presumably, this is new information, or this information is useful in terms of them determining whether they should or shouldn't be supportive of a renewal. For me it's not. I understand that I have the right to not support the renewal and have understood that for many years, so its gets repeated out of bureaucratic necessity, I guess. But, so in my particular place, for sure not. (P17)

This family member demonstrates willingness to engage in, and the expectation that they will need to submit to some bureaucratic processes; they also recognize that these may in fact be useful for some people. However, it is very clear that for them, this rests mostly on 'bureaucratic necessity', rather than the desire to provide tailored, relevant advice.

Rights advice was repetitive without providing an opportunity for authentic discussion and did not appear to engage patients in a meaningful way. One patient participant who stated he wanted to contest his CTO, which had been ongoing for over a decade, said this regarding speaking with the rights advisors:

> P2: I say go ahead yes, yes, good.
> F: You say go ahead, yes.
> P2: Yes. good. I understand, I'll be on the pills.
> F: Is that what you say every time, or do you have questions sometimes?
> P2: I say that every time. (P2)

When the researcher asked how he felt about these phone calls, he stated:

> P2: Its sort of bugs me
> F: Okay, why's that.
> P2: Wondering what they really want. (P2)

This quote reveals how the calls do not make sense for a patient who neither knows nor trusts the caller, and who therefore responds to the caller in a way that hides his true sentiment. While the rights advisor may believe that the patient understands his rights and will comply with the CTO (making further discussion unnecessary), the patient feels exactly the opposite, thus making the advice process moot.

Another patient participant had this to say about rights advice:

> But the fact that, I already said I'll take it [the injection], right. So, sometimes it sort of irritates me a little bit that every six months I've gotta call these people and they ask me the same questions, and I'm not really a phone person, and I've got to talk on the phone for ten minutes, six months, every time for the rest of my life. It's almost like...you know what I mean...I don't know who this person is who I have to say 'No, I don't want to fight it, I already said I'm going to take it.' (P18)

This quote further illustrated the incoherence of ritualistic and generic rights advice, a process that forces the patient into an unwanted interaction, and gives the patient a feeling of dread regarding the future (I've got to talk on the phone for ten minutes...every time for the rest of my life). It is notable that it is not the mandated medication that this patient is concerned about taking for the rest of his life, but being subjected to bureaucratic processes that are not relevant to him and that do not take into account the constrain for him to discuss with strangers personal matters that have already been settled. .

5.2.4 Consent and Capacity Board Hearings

Another mandated part of the CTO process is Consent and Capacity Board (CCB) hearings. A mandatory hearing is held at every other renewal of a CTO (once yearly), and another one is held at the six-month mark, if requested by the patient. At the hearings, the CCB is represented by a psychiatrist member, a lawyer member, and a community member. The psychiatrist who has issued the CTO must be present, and may or may not have legal counsel. The patient is invited to be present and may or may not have legal counsel or other support people. The intention of the hearing is to review the CTO and decide, based on the law and legal precedent, whether it should be upheld. CTOs can be contested by the patient or by the patient's legal counsel on several different grounds, including the capacity of the patient, the wording of the CTP (e.g., requirements are worded too broadly) or a failure to meet the standard for a CTO in another way. The CCB, like the PPAO, is an arm's length organization funded by the Ministry of Health, a "quasi-judicial tribunal which makes decisions under six Acts including the *Health Care Consent Act, The Mental Health Act, The Substitute Decision Maker Act*" (CCB, 2021).

When they decide to attend, the hearings are major events for patients. At the hearing, they present arguments about their capacity and their ability to manage their own health care decisions in front of a panel of authoritative people. Earlier, this chapter looked at the paucity of identity forming activities for clients with CTOs (section 5.1.1); in view of this paucity, the hearings take on an even greater significance. Of particular concern is that participants did not report positive experiences of their hearings. One stated:

> I don't go to hearings...they say I can argue it, but if I argue it they're going to tear me apart in there. (P19)

Such a statement reveals that some patients do not find the hearings to be a realistic means or forum for them to express their dissent. This patient expressed his sense that the board and psychiatrist together represent a group of powerful people with a shared agenda against which the patient can do very little. Another participant echoed this sentiment, stating,

> Well, I went to one of them once and they all ganged up on me. So, I never went to one again. (P18)

In both of these cases, the carefully constructed format of the hearings (e.g., having a board that is made of different perspectives) is not perceived as fair or safe by these patients, who rather see a group of intimidating men in suits examining them, questioning them, and judging them.

Both patients and families who had attended the CCB hearings reported not being able to distinguish between the lawyer, community member and psychiatrist who made up the board, and they were not always able to distinguish the board members from their own healthcare providers. As such, the hearing had the result of magnifying a medical perspective as opposed to limiting it or mediating between the two (patient and provider) legal perspectives. One patient participant recalled one CCB hearing as

> ...a bunch of doctors, there was about six of them. And, ah, there was, ah, a radio thing with some psychiatrist on the radio, and all they were doing was saying all this stuff that I did, but I didn't see that I had done it, they were trying to say I didn't know that I did it. (P18)

Sometimes, as in this account, a medical or legal professional will attend the hearing through a secured tele-network; this statement shows how this can lead to further confusion for the patient about exactly who is talking about him or her. This patient did not perceive the CCB hearing as an instance meant to protect him and his rights. Instead, he saw 'a bunch of doctors', with others yet at a distance, commenting on his case. He perceived these 'doctors' as all 'saying stuff that I did' in a way that contradicted his own perspective on these matters. They were all in agreement, and none of them believed him, or understood his perspective.

A family member also saw the board as being made up of 'mostly older doctors'. She stated:

> Virtually everyone at the table looked bored, except for [patient], [patient's] lawyer, and me. Because I imagine they do it all the time. And they kind of know how it's going to roll out. They've kind of been there, they've done that. They were all mostly older doctors, men, and they, you know, it wasn't their first rodeo, whatsoever....Going through the motions, I guess is what you'd call it, mostly. No one seemed to really care. (P20)

The fact that participants were not able to pick out the members of the CCB hearings and define them as a separate entity from the medical team is extremely concerning. It defeats the purpose of the hearings, which is to provide a method by which to check and contain physician's clinical and discretionary power with regards to the maintenance of a CTO. In addition to this, this participant identified a sense of general disinterest and boredom towards what was, in her mind, a life-or-death matter for her daughter, further emphasizing the impersonal and disconnected nature of this experience. This disinterest also speaks to how scripted and predictable the outcome of the hearings may be.

In addition to this, some HCPs identified that patients struggled to navigate the dynamic of the hearings, giving the clinical perspective an unfair advantage:

> And the information that's provided even at the hearings, is one sided, often...I've attended the hearings, and its often very—it's our perception—and our clients do have a voice, and they can, you know, say what they think but often I think that our, our perception is heard a little clearer...I just felt like the clients themselves felt like...you could see that they, you know, they were trying to articulate why they felt they didn't need the CTO, and they were trying to give their reasons, but in the face of all of the facts and the documentation provided I think it very much quieted their voice. (P6)

This HCP acknowledged that the formality and the format of the hearings, though unremarkable and familiar to the board and to the medical professionals, was often foreign to the patients, making it more difficult for them to express their point of view. Moreover, another HCP reported that there was almost a trickiness to the hearings, in which the patients were asked questions that elicited the features of their illness that would lead the board to decide in favour of the CTO.

> The psychiatrist asks the right questions to show the incompetence... There's certain questions that the psychiatrist will ask, to show that this person lacks the insight. (P9)

In this account, the hearing functions in a way that does not so much uphold the patients' voice or rights, but rather functions as a carefully choreographed performance that elicits certain aspects of the patients' discourses or behaviours in a way that entraps them in the system.

Considering participant accounts, the hearings can be understood as potentially damaging to clients. One HCP stated:

> The other aspect of the other whole hearings, that in terms of, um, the potential, um, I..I'm tyring to find the right wording for this...reverse abuse of the system, if you will. So that, sometimes, I find, that the hearings are, in fact, abusive to the client, because the lawyers aren't trained in mental health care, and they end up letting the client run the show in a way that actually is stigmatizing to the client, and ends up actually causing them a lot of distress. So, I mean, some of the hearings are very respectfully run, but some are not well run, and, sometimes the uh, I've had a few situations where the defence lawyers are actually, ah, not getting it, and are letting the patient almost dig a hole for themselves, and I feel that is reverse, kind of, abuse, of the client, if you will, so I have some problems on that. (P13)

This HCP saw that the hearings themselves enacted a form of subtle violence on the patients, which she terms 'reverse abuse' towards patients. The degree to which she struggled to articulate this phenomenon suggests that this process is subtle and difficult to pinpoint. It also suggests that this is not a common topic of conversation amongst HCPs, never mind between patients and HCPs. As such, the hearings further suffer from a lack of reflective conversation, and patients suffer from a lack of opportunity to have properly trained support with preparation or opportunities to debrief from the hearings. The hearings are adversarial, and the HCP and the patient are set up as adversaries in the process; this foils the HCP's ability to support the patient with this activity, which is extremely demanding, both cognitively and emotionally.

Some HCPs reported what they found to be a disturbing trend, a focus in the hearings on 'technicalities'. One HCP stated:

> I don't like when people, ah, lose their hearing for technicalities. With lawyers and stuff. I think that, if a doctor really feels like he can win a review board, then it's probably because a doctor really believes he needs a CTO, and it can be life threatening, to not have it. (P5)

This HCP uses the term 'lose their hearing' to denote a CTO that is not upheld. The language of winning and losing provides a further example of the discourse of competition and adversity between patients and provider that pervades the hearings. The quote evidences the perception, held by HCPs, that the real work of the CTO is done before the review board hearing ever happens. She uses the phrase 'if a doctor really feels like he can win', revealing a potential mechanism by which the hearings may in fact be useful—their very existence may improve the self-regulation of the involved physicians. Nonetheless, she finds it upsetting that someone who has been deemed to need a CTO for a clinical reason may have their CTO revoked for a purely legal reason. Another HCP expanded on this:

> Often, it's been a paperwork error or something in the process that didn't happen correctly. Which is really disconcerting...So now it's, okay, so they don't, we're not going to do something in their best interest because someone forgot to put a date on a legal form...And there is a whole bunch of other steps along the way that I have seen challenges with. Like if they have a substitute decision maker and we can't reach them in time, and things don't get filed, then their CTO's not in effect for a lag period, so there are a lot of other challenges that really impact the CTO. (P6)

This HCP revealed the sort of process errors that can lead to the revocation of a CTO, as well as her concern that a decision about a patient's wellbeing be made over a legal technicality. While HCP participants generally expressed openness to having the clinical perspective challenged, largely, they felt that the legal perspective formed an inauthentic, unenduring, and potentially disastrous alternative.

5.2.4 Police intervention

If a patient fails to comply with the terms of their Community Treatment Plan, the psychiatrist can file a Form 47. This form is sent to both the police and the hospital emergency room (ER) to which the psychiatrist has requested that the patient be brought. Once the form is submitted, the police pick up the person and bring them to the hospital ER for assessment. This is the only provision for enforcement of a CTO as detailed in the MHA. Once the patient is brought to the hospital ER, the MHA applies the same way it would to any patient, that is, the attending physician decides how to proceed with care based on his or her assessment as well as collaborating information.

Although theoretically a CTO can contain several activities in which a client is required to engage (as seen above in the section on the Community Treatment Plan), in general, the Form 47 appears to be mostly used to enforce compliance with medication orders. The study data revealed that, most often, when a client is brought to hospital on a form 47, they receive their injection and are sent home. This reconfirms that the main purpose of the CTO is medication compliance. It also reinforces the sense that the system is working in concert: that the assessment done in ER is largely reliant on corroborating information provided by the community psychiatrist, and treatment generally follows the existing plan.

Sometimes, when enforcing a form 47, the HCP would meet up with the police and the patient in a community location (e.g., a shelter, or the patient's home), or have the police bring the patient to a community location rather than the emergency department.

> What we've done is they'll bring them to us, at [community healthcare location], and we are still the ones to do the injection, and it's not like they're...I don't know, I just think it's probably less traumatic than going into a regular ER, seeing various physicians, or nurses that you don't know. (P15)

This was done in partnership with the police to reduce the overall negative effects of police intervention on the patient. At times, this seemed to lead to a positive working relationship between the HCP and the police officers, as well as a less disruptive experience for the patient. Although this could be seen as confusing for the client, or as colluding with a police approach, one HCP felt that she was willing to engage in this sort of partnership because it created a better experience for the patient:

> Well, I can't say it was positive for the client, just because they're very unhappy about getting their injection no matter what. So, I think it, it was probably less traumatic for them, I like to think. For us, um, it worked out pretty well, um, just because it was nice to be able to provide, like, I get to close the loop and provide the full circle of care rather than sending them off to a hospital, that's how I looked at it, anyways. So, the officer was really good to work with and the communication was really good so, he would update, like, he was going to look for our client and then updated me that they had found him, and then I asked how long it would be to meet us, um, he was very good with the client, too. I noticed in their interactions he was very respectful, like, um, nothing that I found was concerning. I think the client was respected in the most, in the best way he could have been. Giving him, you know, as much choice as possible, offered him a drive back home after. (P15)

This HCP offers a particular perspective on collaborations with law enforcement, where police officers constitute partners who can facilitate mental health care for a patient population who can be complex and challenging. By working as closely with them as possible, this HCP felt she was able to reduce the trauma that the patient experienced secondary to care, and possibly also act as a check to the police approach. These collaborations can create a blurring of roles for HCPs, where their values, philosophies and goals become mixed with those of law enforcement. The police approach in this quote is much more aligned with a healthcare approach than in previous quotes that in this chapter describing police involvement (section 5.2.5). At the same time, the HCP also describes engaging in police work: that is, aiding the police in finding a person (who does not wish to be found) for the purposes of law enforcement. These collaborations may be unavoidable in a mental health system that relies on police to execute medico-legal treatment orders; nonetheless, they create tension for both HCPs and patients.

Another HCP had a very different experience when she attempted to collaborate with the police:

> P6: That was my worst experience.
> F: Yeah? Can you tell me about that?
> P6: That was absolutely. So, we went in to give a client an injection, and police were present. And, um, the client was refusing it, and it was the first time in my practice where I, I, I , the CTO was really, in that scenario, something that I felt really damaged the therapeutic rapport with my client. Because the police were very much doing what they are comfortable with, which is, um, using some force to get people to comply, which is not the way we do things. And it turned into a bit of a power struggle between myself and the police officer with the client present. Um. Which was just, it was just a bad scenario, um, and I will never do it again. I will never go to see a client with the police. (P6)

In the language used by this HCP, we see that this scenario was not only potentially traumatic for the patient, but also for the HCP herself. She used very strong and categorical language to express that it was her 'worst experience', and that she 'will never do it again'. She referred to an approach that officers are 'comfortable with', implicitly referring to an issue of culture among law enforcement that she found very disturbing and against her principles as a mental health-care provider. However, her decision to "never do it again" is grounded in her own experience rather than the patient's experience. Interestingly, while she clearly stated her intention to never work with the police again in such contexts, she did not advocate for the end of police involvement in community care altogether. This approach may be related to a feeling of powerlessness to change the larger system, something that is discussed in more detail later in this chapter.

A patient participant confirmed that he found police interventions to be aggressive and engendering a sense of disruption, confusion, and stress:

> So if I didn't take my meds for a week, Dr.[name] would call the cops on me and have me brought in. And once they pepper sprayed me. Oh, this was a horrible day. I didn't know what...because I didn't think I was really, like I was fine. I was calm. And ah, I was doing my job. And I bought a twenty sixer of Crown Royal and I was just going to go drink and play video games, and I wasn't...everything was going well with my family, nothing was wrong, and ah, but I was a week late for my meds. And Dr.[name]...my parents...we [the patient and his parents] pulled into the driveway, he [the patient's father] opens all the windows, two cop cars come pull up behind, they come running to the car and they pepper spray me. (P18)

In the incident described in this quote, the participant had not taken his psychiatric medication for a week. He recalled feeling fine and getting along with his family. However, one day when he was in the car with his parents, coming home from a liquor store, the police pulled into the driveway immediately after him and his parents. His father immediately opened all the windows of the car, suggesting that he had been expecting the police and knew what they are about to do. The cops then ran over to the car and pepper sprayed the participant. Later in the interview he spoke of the police again, stating,

> ...it was like they were his [the psychiatrist's] hit men. (P18)

In this scenario, we see the police bringing medical power into the community, while also changing the nature and tools of that medical power, so that it becomes maximally invasive and maximally coercive. Police enforcement changes both the reach and the nature of medical power. The police become a technology of surveillance and enforcement which moves practices, such as coercion—that society may accept in institutionalized environments—into the community and into the private life of the individual. When mental healthcare moves into the community, and then harnesses the powers of the police to enforce its mandate, there are no longer any private spaces.

5.3 The Social Impact: The Effect of the CTO on Identity

As discussed in previous chapters, this study employs a conceptualization of identity as something that is produced within a social and political context and inscribed onto a psychological actuality, effecting the way an individual experiences their subjective self, their role with others, and their agency. The identity that is produced for the individual by their role within a particular social and political context is their constructed identity; this constructed identity, however, is experienced by the subject in a variety of ways. In this section, I examine the effects of the CTO processes, which have been described in detail in the section above, on the identity of patients, family members and HCPs. For each group I simultaneously look at how these processes work to construct an identity and consider how this identity is experienced.

5.3.1 The constructed identity of the patient

CTO processes work to construct an identity for patients which defines them as risky, defective, vulnerable and in need of monitoring. Many of these identities were represented in this single quote from the 2012 legislated review of CTOs in Ontario:

> The legislative changes have helped facilitate care for clients by ensuring that people posing a risk to themselves or others get the care and treatment they need. The legislation allows for a CTO to be issued by a qualified physician to provide a person with community-based treatment or care and supervision that is less restrictive than hospitalization. (D1)

This quote frames several layers of controversial and complex information into a simple, positive, and pseudo-scientific package. It defines the CTO (which, as seen in section 5.2.2, has the main role of ensuring medication compliance) as ‘care and treatment’, and constructs patients on CTOs as ‘people posing a risk.’ However, the risk in this case is undefined, leaving interpretations of this term broad and loose; this lack of boundedness has the potential to create a questionable and precarious situation for the patients defined by this term. It goes on to paint the CTO as ‘less restrictive than hospitalization’ although, as seen in section 5.2.5, for some patients, the CTO brings institutional-style restrictions into their private spaces. It also states authoritatively that the CTO has helped ‘facilitate access to care’, when in fact the research on the efficacy of CTOs remains inconclusive. These concepts will be explored in more detail below.

5.3.1.1 Risk to others

The language of risk, and the discourses surrounding risk which have become pervasive in both the legal and clinical elements of mental health care (as explored in section 5.1.2), construct an identity for the patient: the patient is constructed as both risky and at risk. The concept of risk is integral to understanding the function of the CTO. One HCP explained the purpose of the CTO this way:

> So the court is going to order this medication be provided, um, and the idea is, I think the idea behind that is to mitigate risk. Mitigate risk to the community, mitigate risk to the person, as well as the person's immediate—to the group home—immediate to the client. (P8)

This participant confirms that the concept of risk is integral to understanding the function of the CTO, as well as being integral to justifying taking away someone's autonomy to make treatment decisions. However, this quote also demonstrates how broad and indeterminate the concept of risk is in relation to CTO. In the criminal justice system, the concept of someone's riskiness to others is based in the actual harm they caused through committing a crime. In mental health care, risk to others is more subjective, speculative, less tangible, and is defined for the most part by clinical judgments, and, in some cases, through risk assessment scores. The definition of someone's riskiness is therefore influenced by and filtered through the lens of an HCP, and can be affected by their fear of liability, potential stigma, their past practice experience, and their overall risk tolerance.

In the part of the medical system that treats physical health concerns, risk to the patient is also a critical concept, but it refers to the potential risk of harm that may be done by a treatment intervention, in contrast to the benefits of that intervention for the patient. In mandated mental health care, the concept of risk is manipulated to have a different focus. In considering a CTO, 'risk to the patient' does not refer to the riskiness of the CTO to the patient, but to the risk of the patient to the patient. In this way, the way the word 'risk' as it is used in reference to the CTO reinforces a discourse in mental health that puts the responsibility for mental illness (and the proposed solution to mental illness) squarely on the patient—their behaviours, their neurobiology, and their psychology.

Another HCP explained the origin of a particular client's CTO, and how the CTO mediated perceived risk when managing this risk was no longer justified under the auspices of the criminal justice system:

> There is an element of that in his actual history, where he was criminally involved and dangerous to people, and then I think he was NCR, and then the NCR stopped...the theory I guess was that if he got off his meds he might be at risk of raping someone. (P1)

In this situation, the patient was incarcerated in a forensic psychiatric facility for several years after committing an assault (the details of the assault are unknown, but it was sexual in nature). At the time of this assault, he was a teenager, he had no formal diagnoses (although he was thought to be on the fetal alcohol syndrome spectrum), and he was experiencing the onset of psychotic symptoms. When he was released from the forensic institution, he was discharged to a non-forensic institution. When that site closed down (after more than two decades of being in institutional environments), he was moved to the community, and at some point after that the CTO was started. His story provides an example of how being deemed NCR (not criminally responsible), which is sometimes perceived by society as less punitive than a conviction, can result in lengthy and significant restrictions that go beyond what the individual would experience if they had been in the mainstream correctional system. Moreover, this patient's story demonstrates how the concept of risk in the context of a CTO has more reach and persistence than when it is used within the context of the forensic system. Although at some point this patient had received an absolute discharge from his NCR (meaning that in the eyes of the Ontario Review Board he no longer constituted a risk to society), he still constituted *enough of a risk*, in the clinical judgment of his psychiatrist and care team, to warrant the continued use a CTO. The HCP's language ('I guess', 'the theory') suggests hesitation about this interpretation of the patient. During the interview, the HCP seemed to express some regret for the way the label of 'risky' had not only caused this patient to lose years of their life and the opportunity to experience adult life stages, but that even now, this amorphous, blanketing concept of risk was continuing to follow him and shape his existence.

For one patient participant, the sense of himself as 'risky' pervaded his relationships, and explained the 'caution' of the people around him:

> P2: It's like the animal...say you're walking down the street near a fence or something, and a dog bites you, and you go home and you're like yeah, I got bit by

> a dog, then you wake up another time and there's a dog there again...(...).So you look both ways, there or there, when you're there...
> F: So you're cautious after you've been bitten.
> P2: Yeah...the dog don't know better.
> F: So the people who care about you, are they like the dog?
> P2: No, they're people who once seen in me something. (P2)

In this quote, the participant uses a discursive register focused on animals—dogs—in framing how his identity is perceived by others. Historically, the comparison of mentally ill persons to animals was a common discourse, one that served to dehumanize. The 'animal' identity constructed for those with mental illness caused fear in others by eliciting a sense of irrationality, dangerousness, impulsivity, and unpredictability. This discourse was one that justified the use of chains, beatings, abandonment and killing. This register is present in this quote: 'the dog don't know better'. Because he, like the dog, once hurt someone ('bit someone once'), the sense of riskiness has become the most prominent feature of his identity. In the interview, this sense of himself was internalized and accepted; even in this quote, he takes on the view of the person bit by the dog and shows empathy and understanding for their fearfulness (say you're walking down the street...and a dog bites you...you look both ways).

Another patient participant spoke of his experience of being labelled as risky by his psychiatrist:

> I didn't see that I was actually causing problems. And I didn't have a criminal record at this point. Like I got a criminal record after I was on medication. And he [the police officer] kept saying I was a threat to society. (P18)

In the scenario described by this participant, he was being picked up forcefully by the police, who wished to transport him from his own home to the hospital in the execution of a Form 47. The words used by the officers, as remembered by the participant ('threat to society') are vague and blanketing; the patient himself is still (years after the event) attempting to understand what they meant. The participant was frustrated by the use of abstract language, and by a conceptualization of himself as a threat that relied on a subjective judgment of his potential dangerousness, and was therefore impossible to argue against. In this quote he continued to question and refute this construction of himself, evidencing that he retained agency in his self-perception despite the heavy-handed actions of the psychiatric system and their enforcement through the security apparatus of the police.

5.3.1.2 Risk to self

Patients on CTOs were also constructed as a risk to themselves. However, risk to self was also an ambiguous concept that relied on the subjective judgment of the provider or the patient's loved ones. Previous clinical experiences could act to impact a provider's perception of the riskiness of their patients. One HCP shared how her previous experience impacted her desire to mediate risk for patients with SPMI through use of the CTO:

> Because I saw some pretty horrible things as far as people ending up being sexually assaulted, because they were ill, or no, because someone sexually assaulted them; it's not their fault, but them being ill contributed to circumstances under which they were more likely to become victimized. I saw family members hurt, property destroyed, patients with severe injuries to themselves. A lot of loneliness and just malaise, so I had hoped that CTOs would be a way to mitigate some of that effect. (P16)

This HCP had clinical experience in which she had observed negative effects of mental illness including vulnerability to assault, and risk of violence. After first ascribing sexual assault to the individual's vulnerability, she makes a discursive shift, recognizing sexual assault as an unacceptable action by another party. However, by conceiving of the CTO as a way to mitigate these risks, she strengthens the idea that the solution to the harms caused to people with SPMI, and harms fostered by SPMI both lie within the biology of the individual with SPMI. She also expands the concept of risk to include 'loneliness and malaise', in a sort of "concept creep" (Haslam, 2016, p.1). This expansion of negative psychological concepts to encompass more individuals and more experiences not only expands the reach of psychology, but is also "identity-conferring" (Furedi, 2016, p.34); that is, it creates the conditions for individuals to be defined by their relationship to an event that has now been defined as psychologically distressing. By expanding risk to include risk of 'loneliness and malaise', she confers an identity: patients are no longer experiencing loneliness or malaise, they are embodying loneliness and malaise due to their defective psychology. This method of defining risk thus creates a rationale for the CTO, which acts on the patient, not their environment.

One commonly perceived risk to self was the risk of untreated psychosis. Many HCPs saw one of the roles of the CTO as to reduce the risk of untreated psychosis leading to permanent deterioration in the patient's cognitive ability:

> P5. There are a couple of our clients that I can say, that were decompensating, and the doctor was like, I, I can't do anything, they have the right to consent to their own treatment, and they don't have a CTO, so, all you have to do is watch them really drown themselves.
> F: Until the point where you can do the Form 1.
> P5: Yeah, until they're really really really sick and have to go to hospital and then yeah, you get that whole ball rolling again. So it's very hard to see, it's hard because you might not get them back to their original baseline. (P5)

Here, risk refers to the risk of the illness, if untreated, to the patient. Because the patient is the impediment to treatment (because they are refusing treatment), the patient is constructed as a risk to themselves. The participant is expressing a genuine and pressing concern for the patient's long-term welfare and cognitive functioning, however, there is little recognition here of the possibility that patients are making informed value judgments, or that they may be choosing to experience the symptoms of mental illness over and above medication side effects; there is also little acknowledgment of factors other than medication compliance that may have led to a decompensation of the patient's wellness. This is another means of affirming SPMI as inherently a problem of defective individuals, that can only be managed through alterations of an individual's biochemistry. This construction leads the provider to weigh one type of mandated intervention (the CTO) against another (a Form 1); in this equation there is no room to consider, for example, means to alter the risk to someone that arises due to inadequate housing, poverty, or stigma, or to consider other means of developing the patient's interest in treatment, such as sophisticated relational skills that can lead to greater collaboration between patients and providers.

One HCP, in explaining the purpose of the CTO for an aging client, explained how this client had become “a risk to herself in terms of going places, you know, wandering” (P6). Again in this instance, ‘risk to self’ takes on broad connotations, where neurochemical solutions become the answer to a host of issues that can be perceived as risky. Another participant talked about the risk of sexual exploitation to which her family member was exposed when untreated:

> Yeah, he’s an easy target, right, for all the stuff that goes on...and, caught in the bushes with another guy, and all that kind of stuff. And I think to him, he’s such a, such a weak... how to put it.... if you offered him money, or cigarettes for what you wanted, he’d probably do it for you. And I think that’s how a lot of the stuff he got involved with would happen. For the benefits. Not that he’s attracted to the males. Because he’ll complain about it, every now and again. And that happens in the homes as well, so it’s not, it’s not, I know it’s everywhere, and and...I believe, I believe he’s a real easy target, for sure. (P4)

In the situation described, the CTO is framed as the solution to a general sense of the vulnerability and fragility of the ill individual. Indeed, a CTO can reduce an individual’s vulnerability to abuse; a Cochrane review of CTO outcome research found that the one advantage of CTOs was that patients on a CTO were less likely to be victims of crime (Kisely et al., 2017). However, suggesting or mandating a biochemical change to the individual to prevent crimes against them that may be perpetuated by others is akin to telling women not to wear short skirts or go out at night in order to avoid being raped. These may be effective and even life-saving strategies in the short term, but they are ultimately an inadequate and unjust solution to a larger, more complex problem. Further, when the CTO is packaged as reducing the risk to a vulnerable person, it has the effect of making it feel more acceptable, even merciful, while at the same forcing the burden of systemic injustice to be carried by the ill individual.

5.3.1.3 Risk to the system

Patients were constructed as posing a risk to the system, in that, without mandated care, they may consume a limitless number of resources through an on-again off-again pattern of treatment. Part of this construction occurred through the use of the term ‘revolving-door’ patient (Barron, 2016). This language is found in the 2012 legislated review, as cited earlier: “Mandatory or compulsory treatment in the community aims to prevent so-called ‘revolving door’ mental health consumers” (D1). There is a stark contrast here between the term ‘revolving door’ and the term ‘consumers’. Using the term ‘consumers’ for people who access mental health services originated with the psychiatric survivor movement and was intended to empower individuals to see themselves as people who accessed mental health services on their own terms. The term ‘revolving door’, in contrast, infers someone who is accessing services in an uncontrolled and wasteful way.

The term ‘revolving door’ was integrated into the language used by HCP participants; one talked about her experience with patients experiencing homelessness, and their frequent movements between the hospital and shelter systems:

> We see people in shelters, it was just a—revolving door of Form 1’s, Form 2’s where, you know, they turn around pretty quickly on meds, like in three days sort of thing, and they’re not certifiable anymore, but then it’s like they don’t have any sort of quality of life because their life is just constantly like...they just don’t have that stability of the CTO. (P15)

In this quote, the term ‘revolving door’ is applied to MHA mechanisms (Form 1’s and Form 2’s) that allow an individual to be forcibly brought to hospital for an assessment and detained for 72 hours. This participant problematizes these mechanisms as ineffective in the pursuit of long-term stability. In this way, she suggests that the reason these ill individuals ‘don’t have any sort of quality of life’ is their inability or unwillingness to engage in psychiatric treatment. In this characterization of the patient, the patient poses a risk to the system, in that, due to their lack of continued engagement, they may consume limitless resources without making any progress. The CTO, thus, constitutes a logical solution: reduce financial and logistical risk to the mental health system created by patients who fail to engage consistently with their treatment plan. This focus on resources is motivated by economic concerns consistently evoked in government and media discourses around the cost effectiveness of the healthcare system. This characterization of the problem (and the solution) does not consider the many failures, limits and inadequacies of the mental health and social support system, even when patients are seeking care (as discussed in section 5.1.2 and 5.1.3). It also serves to distract from the complex and multi-faceted problem of primary prevention.

Another participant also used the term 'revolving door':

> So I felt kind of justified, that CTOs in general could be used to stop the revolving door, and ultimately keep people out of the hospital if they don't want to be here. (P16)

In this quote, the rationale for stopping the 'revolving door' was to keep individuals out of hospital, when this was appropriate and according to their wishes. The use of the phrase 'I felt kind of justified', suggests that HCPs, on an individual level, look for concepts that help them to rationalize the use of force mandated by the CTO. In doing so, however, they create a characterization of the patient as both self-defeating and resource-depleting. The phrase 'if they don't want to be here' implies that the CTO is providing the patient with more choices and meeting their preferences. This may serve to conceal the fact that the CTO is also motivated by the fact that the 'system' doesn't want the patient to be in the hospital, because this is an extremely costly intervention.

The construction of a revolving-door patient, who constitutes a drain on resources, has also been integrated into considerations of evidence regarding CTO outcomes. An evidence-brief, targeted at HCPs, made a financial argument for the increased use of CTOs, stating,

> The mental health system will benefit from greater use of CTOs. A reduction in hospital re-admissions and stays reduces the number of hospital dollars being spent to treat an individual. (D2)

In this quote, the 'benefit' to the mental health system is identified as cost savings or reducing the spending of 'hospital dollars'. This evidence-brief ignores the fact that the evidence that CTOs are beneficial to patients remains inconclusive at best, focusing instead on their effect on the system. Cost savings are assumed to be an accepted measure of success, one that supersedes patient wellbeing.

5.3.1.4 Defective

As argued previously, the CTO constructs an identity for the patient as an individual whose current, unacceptable state (that of being risky) is due to a defect that resides within their own biology, such as their neurochemical make up, abnormal brain anatomy or faulty genes. This concept, that mental illness is an issue that resides within individuals and can be solved by treating individuals, underlies many parts of psychiatric treatment. The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines and labels human experiences in a way that allows them to be classified and treated (Jacob et al., 2014). Since the 1950's, the development of the DSM and the creation of formal psychiatric diagnoses has opened the door to the development and marketing of pharmaceutical treatments for mental disorders, leading to enormous advances in this area (Kawa & Giordono, 2012). Pharmaceutical technology has been of significant benefit to many individuals with SPMI; however, this technology has also served to crystallize the idea that mental illness is primarily a problem of/within individuals. The CTO is an outgrowth of this conceptualization of mental illness, and further entrenches this conceptualization.

As discussed in an earlier part of this chapter (section 5.2.2) the 'community-based treatment' (D1) that is enforceable under a CTO is mostly the pharmaceutical portion of treatment. In fact, HCPs reported that other aspects of community based mental health care (e.g., such as forming a therapeutic relationship, or aiding someone with rehabilitative tasks) can become harder to achieve with the presence of a CTO, because these are reliant on the presence of a therapeutic relationship between the client and the provider:

> I do think, in most of the scenarios where we're involved with CTOs...we don't have great therapeutic relationships, because ultimately there's always that time where we're saying, you have to take your medication and if you don't, we have to form you, so, there always is that sort of legal form behind us that puts us in a different relationship. (P6)

This participant describes how the presence of the CTO can act to disrupt the relationship between an HCP and a patient. The focus of the relationship becomes pharmacological technology, and the enforcement of its administration. This detracts from the HCP's ability to form a therapeutic alliance with the patient.

The construction of the patient as ‘defective’ is also reflected in the Ministry of Health and Long Term Care’s (MOHTLC) CTO Information Record (D3). This form asks for information about the patient’s legal involvement, diagnosis, involvement with services, and household composition. Notably, it is does not ask about the systemic failures in mental health or social care that have led to a place where the CTO emerges as the only viable option, or what community services may help to avoid the use of a CTO. This entrenches an individualistic approach to solving systemic problems.

The construction of the patient with SPMI as ‘defective’ is widespread and is also evident in the assumptions made by social service providers. This characterization makes it permissible for non-clinical providers to scrutinize and judge individual patients’ relationship to their medication. One HCP shared this story:

> We’ve had one incident that at a dom [domicillary] hostel, she [the housing manger] was like, if you contest your CTO you won’t be able to live here anymore. Yeah, it was quite interesting, because like if you don’t take your meds you can’t live here, and really intimidating them to do something that is part of their rights, right, so, ah, yeah, that was very touchy, to try to deal with that. (P5)

In this account, a community provider with no healthcare background felt it was appropriate to use an ultimatum with the patient that forced a psychiatric course of treatment. The presence of the CTO led the housing provider to issue a directive grounded in assumptions about the defective neurobiology of the individual; in addition, her directives did not consider the patient’s right to contest their CTO, a right explicitly protected by law. Her position of power as the patient’s housing provider created further inducement to comply. This account suggests that the presence of the CTO has the potential to create a context for individuals with SPMI where their community labels them as defective both in neurobiology and in judgment. Although the HCP identifies the inappropriateness of the housing manager’s behaviour, her language (characterizing the situation as “touchy” and “interesting”) may indicate a reluctance to take a strong stance.

5.3.1.5 Watched/In need of surveillance

The CTO is considered ‘least restrictive’, when compared with in-patient care (D1). However, as seen earlier, although the CTO reduces the overall amount of time an individual spends in an institution, it also legitimizes intrusion into an individual’s private residence, bringing the power, the perspective and the surveillance of government bodies into people’s most intimate spaces, in the form of ‘care and supervision’ (D1).

One patient participant saw the police come into his house every two weeks to enforce the terms of the CTO. He refused every injection, and so a routine had formed around this: every two weeks, his treatment team filed a Form 47, whereby the police went to his home to pick him up and brought him to meet a nurse from his mental health treatment team at a clinical location where he could both receive his injection and also be assessed by his community psychiatrist. This patient often went willingly with the police and accepted the injection once he arrived at the clinical location. I observed this client being transported for his injection and noted that the police were congenial and the patient was cooperative (FN11). This was so routine that it was easy to minimize the impact of this process on the client, or to assume that he did not mind being picked up. However, when I asked the patient about this, it was clear that this ‘routine’ remained intrusive:

> F: Every two weeks it’s the police that come to your house?
> P11: Yes.
> F: And how do you find that. How do you find, when the police come to your house, what do you think about that?
> P11: It’s not pleasant...Wakes me out of my bed, early, usually I’m in a deep sleep. And uh, so I don’t enjoy it. (P11)

This participant refers to being woken up out of his bed, in his home, while in a deep sleep. In this case, the CTO allows the reach of the mental health system into his most intimate and private spaces, with the forcefulness of police presence. For this client, the CTO, intended to provide ‘least restrictive care’, meant that the police became the arms of the institution, able to enforce medical orders beyond the walls of the hospital, bringing this power into his bedroom. His CTO, which led to a construction of him as in need of ongoing surveillance, opened his private life to regular and intrusive monitoring, to the point where it became routine.

Sometimes, as mentioned in section 5.2.5, clinicians met police at a patient's home. The purpose of this arrangement was that the HCP could provide the injection on the spot if the patient agreed to accept the injection, or be immediately forcibly brought to hospital if the patient continued to refuse the injection. The intent of this, again, was to be 'least restrictive'; that is, to give the patient an opportunity to avoid going to the hospital. An HCP participant reflected on being present when the police moved from knocking on a patient's door, to entering his home, to entering his bedroom:

> The client refused to come downstairs so they felt, they just went upstairs anyways. ...Into their personal space. Into their bedroom. Which I found really intrusive. And he was accepting for me to go up, but he was saying no, I don't want the police to come up. But they came up anyways. And right there, at that, I knew it wasn't going to go well. (P6)

The police then moved into the bedroom and approached the client in bed:

> P6: He [the officer] had tried to take the blanket off the client...it was just not a good scenario
> F: The policeman was like physically removing—
> P6: Yeah. And trying to convince him that he was going to get his injection and I had to say: I'm not going to give it. Even if he, if you take down his pants right now, I'm not going to give it while he's saying no. (P6)

The HCP then described what she saw as the difference between this experience, versus mandated treatment in hospital settings:

> I think for me, because I've been an inpatient nurse, who's given injections to people who are refusing injections in code situation, so I'm not, I understand how bad it feels. I feel like going into someone's home and doing that is a completely different feeling that was just...it was just not therapeutic at all. Um, for one. And for two, not ethical. It was his personal space. That's a lot different than bringing someone into a hospital, I think. They can refuse an injection but we're taking all of their power away if we walk into their personal space and force it. That's how I felt, anyways. (P6)

Contrary to the idea that providing the injection in the patient's home allowed 'least restrictive care', this nurse found that going into someone's home and someone's 'personal space' was just 'not therapeutic at all'. In practice, this intrusion made mandated care feel more disempowering than when it was provided within the walls on an institution. Implied here is an argument that coercive behaviours are justified in a hospital setting, even though the same behaviours, in a patient's home, are not. This may speak to the potential for health care providers who have been desensitized to the use of force within institutional settings, to see the use of force in a different light when it is used in a community context. In the account, the police showed up at the individual's house: this in and of itself was an intrusion that could have lasting effects for a patient. The forceful removal of the blanket from the patient's body also carried a symbolic meaning, removing the patient's last line of defense. The nurse expressed a feeling of dismay concerning the intimacy of this intrusion. This attempt at 'least restrictive care' in fact rendered the patient as someone without any private spaces. In this way, the concept of least restrictive care backfired to construct an identity for the patient as someone who was not deserving of or in need of privacy, or sanctuary; someone for whom surveillance could invade their most private spaces.

A patient participant talked about a long history of being constructed as someone in need of monitoring:

> P22: In the eighth grade, this is kind of like my life story here. But in the eighth grade and the seventh grade, they, ah, introduced this new system that they put all these kids on. And we had to bring this stupid fucking book to every one of our teachers because we 'weren't doing our homework' or some shit. You know, it was a behavioural tracking program thing. So we had to sign it every day, they'd put a note in, and then my dad would read it, sign it, say, 'oh that's cool' and then give it back and shit, so, on top of that, he would call the school every day and talk to the principal—how's he doing today, is everything okay? So I had like, no life,...[My dad] monitored everything. [He] didn't really give a shit about it, but [he] monitored it the entire time. Ah, what I was getting at is, he kind of has, he enforced the same kind of shit when I went back to his house, where now he has another like, carrot on the stick type of thing, with these guys [community mental health team], and he calls them. And it's 'oh, I was just looking out for his wellbeing' but really—
> F: Oh, so now the [community mental health] team kind of becomes the principal of the school. It's the same.
> P22: Yeah, if you don't do what I'm saying, I'll tell the fuckin' principal on you. Like what are you, fuckin' my age, you know? (P22)

In his interview, the patient described how his father needed to control the world around him, and how this control extended to his children. In the case of this patient, a tool used by the school to track homework played into this need, and became a tool for excessive monitoring of P22, leading him to feel stifled and oppressed. When P22 was put a CTO, he drew parallels between his childhood experience and his interactions with the CTO team, which allowed the replaying of this old pattern. Once again, this participant was trapped in a web of surveillance, with his dad being formally enabled to re-enter the role of monitor. This provides an example of how the person with the CTO becomes targeted for monitoring that goes above and beyond medication compliance, where their (the patient's) day-to-day behaviour is scrutinized in a way that does not extend to the rest of the population. For this participant, being constructed as in need of monitoring became another example of being blamed and vilified for (in this case) an unhealthy familial patten; the CTO was seen as reinforcing this damaging dynamic.

5.3.2 The Experienced Identity of the Patient

The CTO constructs an identity for individuals by using a broad and ambiguous conceptualization of risk; by focusing on the consumption of resources, by conceiving of the problem of mental illness as a problem of defective individuals, and by extending the reach of psychiatric power into personal spaces both through the mandated presence of psychiatric workers and through police presence. Patients' experiences of this constructed identity differed. However, some commonalities emerged: for the patient, this constructed identity was experienced as being an outsider to their communities, care teams and families; as a loss of privacy; and as a sense that they were enrolled in a 'game' in which the rules were stacked against them.

5.3.2.1 Criminalized

One striking way that patients experienced feeling segregated from their community was a feeling of being criminal, as several participants perceived the CTO as a punishment, or equivalent to 'doing time'. One participant explained her brother's experience this way:

> He felt like he was still doing time. And to this day, he still says, do I have to, am I still doing time? So he feels like he's doing time still. And I'm sure that's a common thing. Because they're watching him, right. (P4)

In this quote we see how being constructed as in need of surveillance can be experienced as a judgment and as a punishment. This participant explains that the experience of being watched through the continuing, mandated presence of the psychiatric system, became equated, by her brother, with an extended jail sentence. The participant notes that her brother uses the expression 'doing time', a slang term that refers to the way a jail sentence demands a certain number of months or years as a defined cost for a crime. However, with a CTO, this 'time' is open ended and undefined.

An HCP participant reflected on one of her patient's understanding of his CTO:

> He talks a lot about, um, being in prison or being imprisoned, or serving a sentence, that's what he calls it. (P15)

Again in this instance, the CTO is equated with punishment. Like a prisoner, this patient perceives himself as somehow in breach of the social contract, and therefore an outsider to mainstream society. Like 'doing time', above, 'serving a sentence' refers to the determined price of committing a criminal offence. Perceived in this way, the CTO can be experienced as open-ended punishment for an ambiguous crime.

An HCP reflected on how such a perception was pervasive among her patients: "I can't think of any clients who don't perceive it as a punishment" (P6). Yet another HCP reflected on how the CTO reinforced the idea of the patient as a regulated person who was cut off from mainstream society: "I think for sure it perpetuates the psychiatric inmate thing. I'm an inmate" (P1). An inmate is someone who is kept out of society through force, to live a regulated and institutionalized life under the control of the state. This representation clashes with the neutral wording of official documents which describe the CTO as 'least restrictive care'. The concept of least-restrictive care, as seen in the previous section, is intended to reduce the amount of time patients spend in institutions. The participants above, however, report how patients on a CTO experience themselves as segregated and regulated, institutionalized in the community.

In some cases, there was a direct lineage between a conviction and mandated treatment in the patient's history, where they moved directly from incarceration through the criminal justice system to a treatment facility, after which they were put under a CTO, as exemplified by the following field note about a patient's recollection:

> He started to talk about the CTO as related to a criminal offence from 25 years ago. I got some details later. It was an offence where he, he had, there had been two assaults, just sort of fights on the ground where he pushed somebody, and he ended up at [jail], and from [jail] went to [treatment centre]. (FN14)

In this instance, a patient connected his CTO to a specific incident in the past. On one hand, this history reveals a humane progression: the patient was in a fight and was arrested, he was jailed for a short period of time where he was recognized as having a mental health condition, and he was released to a treatment centre. However, this progression indicated to the patient that there was a direct relationship between his behaviour (being in a fight), and his CTO. He experienced the police, jail, hospital and CTO as part of the same apparatus, an apparatus that acts to contain and manage people like him, so that other people can be protected from the risk that he poses.

Another participant described living in the community with a conditional discharge, after being found not criminally responsible for an offence by the criminal justice system, and after having spent some time as an inpatient at a forensic treatment facility. A conditional discharge means that the patient can live outside of the forensic institution, but that they must abide by certain restrictions—including medication compliance—or they can be recalled through the forensic system. When this patient received an absolute discharge, he was immediately placed under a CTO. He asked, "Can you even have a CTO after an absolute discharge?" (P19). Since for him, the CTO led to restrictions to his freedom that were similar to those mandated by the conditional discharge, he experienced it as a continuation of his forensic treatment. Since he had received an absolute discharge, he was confused about the legality of this.

Another participant experienced the CTO as connected to an understanding held by others of himself as criminal, even though he retained a sense of this being false or unjust:

> One thing I don't understand was...I kept...I never broke the law, I don't steal, I stay to myself and I don't really like going out. So why do you think I'm going to do something bad...It's not like I'm doing this [getting angry] every day, it's because you're telling me I'm going to do something bad, and you're forcing me to the bed, chaining me up, so that's what I never got. I kept saying I don't have a criminal record. (P18)

This participant retained a sense that his CTO was unjust because it imbued him with a criminal identity, and this did not match his knowledge of himself as someone who never broke the law and did not have a criminal record. He resisted the identity that was constructed for him by the CTO—that of someone who was a threat, who was risky. This patient mentioned specific behaviours of healthcare providers that led him to feel criminalized: 'telling me I'm going to do something bad', 'forcing me to the bed', 'chaining me up'. These actions sent a message that resisting a criminal identity would lead to increasingly grim consequences.

5.3.2.2 Disconnected

Other patients expressed experiences of disconnection related to their CTO. One HCP spoke of a patient who had become more disconnected from the team since the advent of her CTO:

> Our relationship with her is obviously impacted quite a bit by the CTO, in terms of, she doesn't appreciate any contact with us. Where initially...prior to the CTO, she would tolerate her visits a little more with us because they could be ones where she could sort of talk about her thoughts and her feelings but now, I think that, we're more seen, well she calls us the enforcers, so, we, you know, we are more on the side of the law and enforcing the injection. (P6)

In this case of a patient with whom HCPs had some relationship, the CTO created an additional barrier to therapeutic relating that had a counter-productive effect on the work that the patient and the health-care team had been doing to build trust. This patient had been opening up and sharing her personal thoughts and feelings with her treatment team, an inclination that ended with the advent of mandated treatment, suggesting that the CTO was construed as a form of betrayal. Since this patient had shared their interiority, this betrayal likely felt deeply personal; a judgement of their inmost spaces. By calling the HCPs ‘enforcers’, the patient alluded to a feeling that some vaguely defined state power had entered her life; the CTO, in this case, created a circumstance where people (her care team) came into her life under the guise of one approach (relationship building, trust building), but switched approaches to become agents of enforcement.

Another HCP spoke specifically about the damaging effect of the Consent and Capacity Board hearings on the therapeutic relationship:

> Because it can be quite traumatizing to the clients to go through that process, and then still have the CTO upheld and then, who supports them after. Because then your rapport with the client is now damaged, right. (P13)

This participant refers to the experience that patients have of the CCB hearing, where they are positioned as the legal adversary of their HCP. The patient or the patient’s lawyer present the reasons that the patient should not be on a CTO; they then listen to the psychiatrist present a case that the CTO should be upheld. The psychiatrist’s case often involves a presentation of the qualities of the patient’s illness that are most likely to be perceived as problematic, risky, or threatening, and a description of events that paint the patient in a poor light. The psychiatrist, for the purpose of making a strong argument, may use language that is harsher and more direct than the language they would use with a patient in a therapeutic context. When the patient does not win the hearing (by far the most common outcome), they need to go back to working with the very health care provider who aired embarrassing, shameful, or difficult life events to a room full of powerful strangers. This may involve feelings of both resentment and humiliation; this humiliation is then reinforced by the mandatory nature of the ongoing interaction with this HCP.

Another HCP participant spoke about the toll that CTOs could have on relationships with family members who act as SDMs:

> So then you have substitute decision makers who are parents who are making that decision that they need to be on a CTO, and the person is saying I don't need a CTO, and so, that relationship that you [the patient] have with the doctor, that you know, didn't work out. Well, it can be with your parents. So that can be very difficult. (P5)

A family member echoed this. When asked how being SDM affected her relationship with her family member, she stated,

> It made it even worse. Um, because they, ah, he thought I was going behind his back. Which I was. (P3)

This participant used the term 'going behind his back' to highlight one of the features of the CTO that make it damaging to relationships. From the patient's perspective, the CTO may entail a trickiness, a lack of forthrightness. This builds on P6's quote, earlier, where the HCPs involved in the CTO were perceived as engaging in an act of betrayal. Because consent laws (as discussed in section 5.2.2). require that the CTO be consented to by an SDM, this feeling of betrayal extends to family, further damaging the patient's sense of community, support, belonging, and trust in others.

A patient participant spoke of the toll on their family relationships in the context of a CCB hearing:

> What it's like is they get your family to say all sorts of stuff, but I wasn't doing well with my family at the time, so it was just their point of view of what was going on. But I wasn't even living with them. I didn't see my family for a couple of months before this happened. So they didn't really know where I was at that time. Because I hadn't seen them in six months. And then they all ganged up on me. So I didn't know what they were talking about. (P18)

Although at the time of sharing this account, the patient had re-established a warm and close relationship with his family members, it is clear from this quote that he continued to feel betrayed by their role in this hearing. He used language that reduced his family's agency in the process ('they get your family to say all sorts of stuff'), suggesting that directing his anger towards the process is one technique that he has used to preserve family relationships. He perceived that his doctors, the board, and his family members colluded to construct an identity for him, a characterization of him as threatening, defective and risky. He experienced this as being ‘ganged up on’. This was destructive of his feelings of trust and belonging and constituted (as also noted in section 5.2.4) a traumatic event in itself.

One HCP reflected on how the experience of the CTO, in the form of treatment visits or police interactions, took a toll on the patient’s ability to engage in social relationships:

> I think one of the most obvious tolls to our team is the disintegration of relationships between the individual and the team, but also that I’ve heard clients complain about, that, it effects, that having too much interaction with the team, you know, having daily visits, or whatever it is, impinges upon their relationships with others. (P8)

The term ‘disintegration’ is a vivid descriptor of the effect of the CTO on the relationship between care providers and patients. However, this statement draws attention to the fact that the CTOs impact can reach the patient’s social relationships as well. The participant refers to ‘daily visits,’ suggesting a level of imposed interaction. The need for surveillance that is implied in the imposition of daily visits interferes with the patient’s ability to maintain social relationships, further limiting the patient’s access to natural community supports. One patient participant confirmed that the CTO was something that limited his ability to have other relationships:

> Because I have a... friend that comes over every now and then, and you know, it’s embarrassing to tell her that like, I’m stuck going back and forth to the doctors and taking needles and shit every four weeks, and I’m just embarrassed about it entirely, so I don’t tell her about it... I feel embarrassed. I feel like she’d leave and never come back. (P22)

This participant felt that his mandated psychiatric care put other life developments at serious risk. The identity crafted for him by the CTO, that of someone who was risky, defective and in need of monitoring, was something that he was ‘embarrassed about entirely’. He therefore felt he needed to hide it from someone with whom he wanted to have an ongoing relationship. As such, he felt the CTO foiled his ability to grow into a confident, adaptive, and connected young adult; in undermined his ability to have an integrated and confident identity, and it impeded his ability to be honest and forthright in his relationship.

5.3.2.3 Recalcitrant

Some patients became increasingly defiant and uncooperative with their treatment plan in reaction to the limitations set by the CTO, or the way it was enforced (e.g., threat of police intervention). One HCP described this type of patient response:

> Pulling back or, what do you call that, the, ah, resistance that comes from, something being forced upon them.... just because of the sheer act of it being forced upon you, you resist. (P8)

This participant shifted from using the object ‘them’ to using the object ‘you’. This discursive move, employed by several HCPs, may help convey the impact of patient experiences in a powerful way, by reformulating them as happening to ‘you’, or to someone without a psychiatric condition. Thus, this discursive move implies a context where stigma against people with mental health remains prevalent. Whereas resistance is generally denoted as a negative quality in psychiatric patients, this discursive shift allows resistance to be conceptualized as the normal or expected response of someone who has a strong sense of their own boundaries and agency.

One patient participant (referred to in the previous section) would not voluntarily come in for his biweekly injection, which resulted in a Form 47 being filed, and police picking him up twice a month. This had been going on for approximately a year. He explained this choice:

> I make that decision based on the fact that, ah, it’s just not helping me. It’s the only thing that if I um, if I accept the treatment, if I say okay, I’ll come, you can come and I’ll accept the injection, then I’m accepting the fact that you’re, you’re, ah, you’re, ah, whatever you’re doing to me. So I need to protest. So it’s a way for me to protest. (P11)

This patient framed the CTO, and the resultant psychiatric intervention, as something being done to him by the care team (‘whatever you’re doing to me’), highlighting the lack of agency that he felt regarding his treatment. Engaging the enforcement mechanisms of the CTO, therefore, became a way to make a statement and express his agency. The same participant also attended every CCB hearing, with a similar rationale:

> I’m going to take every chance I get to, ah, to ah, go, because if I don’t go, then I’m consenting. (P11)

This provides an example of what happens when the legal mechanisms of the CTO and the legal protections offered to patient's are taken to their logical end. This patient expressed his agency through the tools provided by the medico-legal world; his commitment to consistently make this statement ('to protest') usurped any concerns about the discomfort or inconvenience this may cause him. Through his approach, he demonstrated how the rigidness and inflexibility of the CTO can motivate a rigid and inflexible response. Expressing agency within the context of a CTO activated an escalating show of force involving enforcement and legal systems. This show of force entrenched the patient's commitment to non-compliance as his only method of communicating dissent.

Another patient participant explained how the CTO itself had made him feel aggressive:

> So why do you think I'm going to do something bad? And that's what they wrote on the CTO, and that's when I started getting aggressive, but that's the most aggressive, like, with Dr.[name], when he told me all this stuff about me, that's the most aggressive I've ever been in my life. (P18)

For this participant, being characterized as risky was a self-fulfilling prophecy. The CTO itself was received as a powerful act of aggression in an escalating conflict with his psychiatrist. In this therapeutic relationship, the doctor asserted his perspective and encoded it as 'truth' in a legally binding document. The CTO invalidated the participant's point of view and gave the doctor's truth legal and social value. Perceiving this as an act of aggression, P18 responded with aggression, which reinforced the doctor's perspective. In this way, the CTO created a context where the patient's expressions of agency were self-defeating. Notably, this patient continued to resist this construction of themselves as risky.

Another patient participant also described the negative effects of pushing back against restraints to his freedom:

> So I had like, no life, so I just quit school pretty much five different times, and just went and did drugs, because I didn't give a fuck...There was just no freedom for me to do anything, so, you kind of, then you look for it in different places, right. And I don't mean to go too far with that. But there was no freedom to do anything I wanted to, so I went looking for it in, somewhere else. (P22)

This participant responded to being controlled and monitored by his school and his father by finding alternative ways to express his agency, through disengagement from expected social norms and behaviours. This disengagement took the form of quitting school and doing drugs with no care for potential consequences ('I didn't give a fuck'). However, adopting these socially deviant behaviours typically led to further control and monitoring, as well as further disconnectedness from potential relationships.

5.3.2.5 Traumatized

Patients experienced several elements of the CTO process as traumatic. One HCP described the effect of the CCB hearings on some patients:

> It can be quite traumatizing to the clients to go through that process, and then still have the CTO upheld and then, who supports them after? Because then your rapport with the client is now damaged, right, so, I've heard that over and over from client's, that when they go through CCB hearings...that's how they feel afterwards, they feel traumatized... They come out with a bit of trauma, PTSD almost. (P13)

This participant turns the language of the psychiatric system back on itself, making a claim that the very system intended to treat distress and trauma becomes a cause of trauma itself. Several other HCP participants built on this theme.

One participant discussed the difference between meeting with the police and the patient in a community location during the process of a Form 47 (e.g., to administer the injection), versus having the patient brought to the ER by the police during the processing of a Form 47. In this discussion she commented on how being brought to the ER could be traumatic:

> I've seen extremely serious things happen when people are picked up [by the police, during the processing of a Form 47], so, I'm cautious, and I'm cautious about the potential for things to go sideways if you're not sort of maximizing the reach, and by that I mean going to emerg [the emergency department]. I recognize that that can be traumatic for some people [patients]. (P16)

In this account, the participant characterized trauma as a necessary side effect of managing a volatile situation that may involve risk to healthcare providers or the health care system. In this way, the trauma a patient may experience during mandated treatment becomes directly linked to the general unpredictableness or the riskiness of the patient themselves. Thus, the patient is identified as the cause of the trauma. In contrast to P5's quote in section 5.1.4, where she identified that some elements of the CTO would be traumatizing 'for anybody', this participant states that these interventions could be traumatic for 'some people'. This phrasing denotes that the trauma is due to some characteristic in the ill person, and is in contrast to the idea that being picked up by police and brought to the ED could be defined as universally traumatic. This participant does not draw attention to elements of the situation itself that are constructed in a way that is traumatizing.

Another HCP also commented on the potential for trauma when there is police involvement. She reflected on how, in scenarios involving police, there was

> that power and control over the client that is always very difficult for families and for the client, themselves, so although there's great things about CTOs, I can see how that can be very traumatizing for some clients. (P5)

This participant identifies one of the features of police interactions that could lead to trauma: demonstrations of power and control by enforcement personnel. By labelling the loss of agency that patients experienced in situations involving police as 'traumatizing', the participant suggests that such interactions resulted not only in momentary distress and discomfort, but had an effect that persisted beyond the event. In this quote, P5 also used the term 'some clients'; again implying that there was a feature in some people that made this loss of agency traumatizing, as opposed to it being inherent to the process. She used a disclaimer in the middle of this sentence about trauma ('although there's great things about CTOs'). Similar disclaimers were frequently used by HCPs to downplay or temper their critique of CTOs. Myself, as a researcher and as a clinical nurse, have often acknowledged the positives of the CTOs to frame or introduce a critique, as a way of cueing that I am not discrediting or attacking the work done by clinicians in this area. This hesitancy around critique could be a strategy HCPs use to protect their own identity as both caring professionals and functional, competent members of the mental-health care system. However, it is important to note that this type of disclaimer could act as an impediment to reflective practice, and be something that keeps us from fully appreciating the traumatizing nature of the CTO. In this quote, P5 points out the potential for police involvement to be traumatizing, but leaves out the possibility that the actions of healthcare professionals, as enforcers of CTOs, may also be traumatizing to patients.

5.3.2.6 Muted, bounded, restrained

Some patients internalized the presence of the CTO in their life as a general feeling of restraint. One participant explained his sister's perception of the CTO as "this authoritarian shadow" (P17). This alluded to the ever-present nature of the CTO; for the patient, the CTO did not exist only as a sum of its parts (e.g., paperwork, hearings, medication administration, etc.), but as a constant, overbearing, muting presence. Another participant associated the CTO with suspicious people and unpleasant past events; for him, the presence of the CTO in his life was much broader than that dictated by its legal structure: it caused a general feeling of unease, and in his mind it was associated with "persons that want to lock me up" (P2).

An HCP participant spoke of this effect, that is, the way patients experienced their CTO as a generalized feeling of being monitored and suppressed by an ambiguous and indeterminate force.

> It's a conglomerate of things, and that's true for any of us. If you think about it, it's not: under this statute I'm okay and under this I'm not, it's the force and the power of the institutional power. So in the end you're being brought back...the hospital is going to discharge you right back to where you came from, and that's going to be another reinforcer of, this must be all one big bundle together, and that's where you can't really pick and choose. (P1)

This HCP reflected on the universal nature of the experience of power-over: he used the term 'true for any of us' as a reminder of the humanity of the psychiatric patient, as a member of an empathetic collective. The psychiatric system, social services systems and legal system were experienced as a single powerful and connected apparatus that affected the patient's sense of freedom in a general and comprehensive way. P1 gave a specific example of how the sense of ambiguous and indeterminate force was supported by the actions of the agencies involved in the CTO, describing how patients felt stuck in a cycle where the police brought them to the hospital which discharged them back to an institutional housing provider. The seeming collusion between these monolithic agencies left patients with a sense that this must be 'all one big bundle together'.

One HCP participant commented on the ability of the CTO to induce general compliance, even when a Form 47 was never used:

> I think the whole legalese aspect of it kind of makes them pay a little bit more attention. (P13)

This participant used a diminishing term ('legalese') to refer to the power of the CTO. Legalese is a word to describe the type of jargon or language that a lawyer may use; in some instances, this type of formal language may be intimidating or appear authoritative. The use of this term in this quote implies that it is the formality of the CTO that is intimidating to clients or that gets their 'attention'; this minimizes the fact that it is not only a process that uses legal language, but a process that indeed is backed by the full force of legal and enforcement systems, and that has the legal power to significantly restrict a patient's autonomy. This may, again, be indicative of a tendency in HCPs to diminish the negative effects of CTOs. However, the idea that the CTO has an effect on patients that goes beyond its actual legal powers is significant. It suggests that the CTO creates an experience for the client of being continually monitored, whether or not that monitoring is taking place.

5.3.2.7 Gaslit

Gaslighting is a form of abuse in which some person or group causes another person to doubt their judgment and the clarity of their own thought processes. In some cases, the logic used to enforce the CTO created a context where everything that a patient said in order to explain the underlying environmental and emotional disturbances that led to their distress or their psychiatric crisis was construed by clinicians as confirming their diagnosis. This further amplified their sense of being stigmatized and misunderstood. One participant shared this experience:

> That was with [previous psychiatrist] saying all kinds of stuff. I didn't know what he was talking about. He said I was talking to demons, that I'm connecting all kinds of

> stuff. The thing with [current psychiatrist] was, [previous psychiatrist] wrote on my file that I connect stuff and assume all this stuff is happening when it's not and I'm connecting all kinds of stuff, so when I tried to say that [previous psychiatrist] was wrong, they all thought I was connecting this stuff, you know what I mean? (P18)

This patient described a scenario in which his doctor constructed him as delusional and irrational ('connecting all kinds of stuff'). When P18 attempted to rectify this description of himself, this was further interpreted as delusional and irrational, therefore confirming the original assessment. The patient experienced this circular logic as a double-bind, and worried that it would work against him in the context of the research interview:

> And he would say 'I knew you would say that.' I think he's [past psychiatrist] the crazy one, if anything. I was actually getting nervous that you would ask me about...because if I ever did say this to anyone, they'll say I'm connecting all kinds of stuff.

This statement demonstrates that this client resisted the definition of himself constructed by his physician, retaining a sense of himself and his ability to know himself despite this experience. He pushed back the definition of self with which he has been constructed: 'I think he's the crazy one'. Instead of internalizing this definition, P18 engaged in extensive self-censorship, for example, by monitoring his speech so that he would not say things that could be interpreted as 'connecting all kinds of stuff'. His repetition of this phrase may also indicate a cautiousness in self-expression; he had found one set of words to describe this experience that felt 'safe' and did not deviate from it. Specifically, he believed that, if he expressed this critique of his past psychiatrist, it would be interpreted as proof that he was irrational and delusional. He went on to say:

> I sometimes get anxious when I'm talking to [current psychiatrist] because I don't know what to tell her, because I already know what [previous psychiatrist] wrote on my file, and even if I say that, she'll assume I'm connecting stuff, and I get uncomfortable. (P18)

Although at the time of this interview, it had been several years since he had had a relationship with his previous psychiatrist, and he described a positive relationship with his current psychiatrist, he remained affected by the construction of himself as someone who 'connects all kinds of stuff', and who is therefore risky and in need of surveillance. He still worried, about what the doctor ‘wrote on my file’. This highlights the effects of the damning, lasting narratives (in this case, in the form of clinical documentation) that follow patients as they navigate the mental health-care system, which make possible the re-enactment of perceptions, attitudes, descriptors and dynamics that negatively impact patients’ sense of self.

One participant described a family context in which his father’s inability to tolerate difference, free-thinking, dissonance, and pain led to a situation where his father projected his own anxiety, fear and discomfort onto him. This participant explained how, during moments of his father’s heightened anxiety, he would be sent to the hospital by his father on various grounds:

> You know, you got a skinned knee, go to the mental hospital; you got a fucking, you know, you got a problem, go to the mental hospital; you think that playing music all day you’re going to be famous, go to the mental hospital; you think that, you know, it’s a viable excuse to be a free-thinking, free-spirited person, go to the hospital. You know, it’s like, you know, you want to take a shit in the bathroom and make it smell, go to the hospital. (P22)

This instance is considered a form of gaslighting because it reflects a family situation where a person with more power (the parent) convinced another with less power (the child) that all of their relational, shared problems resulted from a psychological deficit in the child. Although this patient, now a young adult, resisted this definition of himself, he still experienced himself as being caught in a system eager to manage contextual and relational problems by labelling and managing *him*. He went on to say:

> It’s cheaper to throw them in the mental hospital than it is to sit down and talk with them, and go and pay ten thousand dollars, you know, and hours, whatever it may be. An exponential amount of money, for a family therapist. (P22)

From this patient’s current vantage point (now living independently) he could see how his family would have benefited from a different approach, e.g., family therapy. The system’s failure to view this situation from a psychologically sophisticated standpoint led to a superficial treatment of the situation, as it was defined by one member of the family, which led to the system’s endorsement of the father’s views. P22 experienced his CTO as an ongoing endorsement of this view.

5.3.3 The constructed identity of family members

Family members play an important role in CTOs. Consent legislation in Ontario requires that all healthcare treatment be consented to. In cases when a patient is deemed incapable to consent (the most common scenario in the case of CTOs), the Health Care Consent Act deems that the next eligible person to consent take over this role and become the substitute decision maker (SDM). This eligibility is defined in the law through a specific hierarchy, with a legally appointed SDM being at the top (e.g., a court appointed guardian or attorney for personal care); then spouse or partner; parent or children; sibling; and any other relative. At the bottom of this list is the public guardian and trustee, who is considered an SDM of last resort. Expectations of family members not acting as SDMs may also act to construct their identity to have certain features; for those who act as SDMs, the expectations inherent in this role may have particular effects.

5.3.3.1 Healthy, responsible, available

The CTO process contains the assumption that family members will act as mentally, socially and financially fit, responsible advocates for the patient. Family members are expected to take responsibility for sharing information with health-care providers, to mediate the relationship between HCPs and the patient, and to take on the burden of helping the patient through a complex system, often one that they themselves do not understand.

One family member recounted an event where the police insisted that she come to the emergency room (ER) of the hospital with her brother, so that she would be present to provide any necessary information to the ER doctor.

> There was another time where the police said, [name of speaker], you have to come with us to the hospital so that the doctor can talk to you, right. This was at nighttime, and I said, you know what, sir, I have to go home, I have to work tomorrow. He said, it won't take long... Well, I, I was up all night waiting in a coffee shop for the buses to start running the next day. Because I missed the last bus and train. (P3)

This family member was expected to act in a way that served the needs of the system, regardless of their own needs in the moment. The police officer used an imperative sentence structure (‘you have to’), that did not leave room for negotiation. In this way, the police, in the moment being recounted, constructed the family member as an essential accessory to their process. When she attempted to reject this construction, citing her other identities (someone who needed to get sleep, and perform in her job), these were dismissed and diminished (‘it won’t take long’). The needs of the system became prioritized over the needs of the family member.

Another family member spoke of becoming the point-of-contact for the doctors involved in her family member’s care. She stated,

> Anyways, so I got saddled with the responsibility of talking to doctors, and driving up there and stuff, and other family members would go up now and then. (P4)

Here the participant relates the expectations that she would act in a particular role in her brother’s care; it also reveals the dissonance she felt between her constructed identity as a family member of a patient, and her own needs. She used the word ‘saddled’, implying carrying a burden. By stating ‘I got saddled’, she also suggests a lack of agency in this: these responsibilities were put on her by the mental health system. She was expected to be available to the system as needed, and to act responsibly as her brother’s representative; in other words, to conform to the needs of the system, regardless of her own needs, preferences, or what this experience was like for her.

Sometimes, the system required contact between family members that had been estranged or out of touch for a long time, or it brought together people who did not have a positive history or working relationship:

> P3: And then, uh, I got more involved with his case because the doctor called me for a family meeting, and you know, all four of us were there.
> F: Okay, your two sisters, your brother and yourself.
> P3: Yeah. And then, his girlfriend. And I was kind of, um, upset because his girlfriend was there, like I wanted to know why is she in the meeting, right, and she also called my cousins at nine o’clock in the morning, to come down to the meeting, and they didn’t like it one bit. My cousin said, who is this woman, why is she controlling everything. (P3)

This participant describes a family with a history of trauma, with some other members experiencing mental illnesses (i.e., other family members were also being treated), some of whom had been estranged from each other. This family was required by the physician to meet and work together to make cogent decisions on their brother's behalf; this reveals an assumption made by the physician, and by the nature of the CTO process, about the way families work, or should work. It constructs them as healthy, working groups despite the fact that this may not be the case. In this account, the imposed meeting gave rise to various tensions between some of the family members ('who is this woman'; 'I was upset'; 'they didn't like it one bit'). The meeting then became centred on managing these complex dynamics—as no decision making could take place until these were handled. The CTO process expects a certain type of family participation, and, in fact, a certain type of family to support its end and goals of managing someone in their community.

5.3.3.2 Instrumentalized

The CTO process requires the family member who is acting as SDM to be involved at certain points: namely, they must receive rights advice, and they have to sign the Community Treatment Plan and the Form 45. Insofar as these steps need to be accomplished according to a set timeline in order for the CTO to begin/continue, the process instrumentalizes the family member: that is, it enrolls them in various roles—administrative officer, manager, advocate, signatory, etc. Importantly, this instrumentalization assumes there are no issues impacting the family member's relationship with the patient, or that these issues will be managed privately so as to not derail the CTO process. Family members were also expected to be readily available and responsive to the needs (e.g. bureaucratic, legal) triggered by the CTO process. One HCP commented on how much work it was to get the forms signed at the right time by the family member:

> This is probably one of the biggest issues of the moment, is the signing and the dating of the Form 45's. (P16)

This statement reveals how the demands of the CTO process shift the attention of health care providers onto administrative aspects of the CTO, which become prioritized. Family members experience these ‘routine’ parts of the process as both emotionally and logistically burdensome, yet the process necessitates that HCPs prioritize not meeting these complex emotional and functional needs but the timely signing and dating of forms.

Family members need to receive rights advice before the CTO can be completed. As described in section 5.2.3, they have to listen to the full provision of advice whether it is the first renewal of the CTO or the 15th. The 2012 legislated review of the CTO explains,

> Rights advice is provided to the consumer and the SDM and Form 50 (Confirmation of Rights Advice) is completed. The consumer may refuse rights advice but the SDM cannot. (D1)

The declarative nature of this sentence leaves no room for nuance or difference. The elements of the CTO process are stated as if they are self-evident and immutable, and the family member’s role is non-negotiable. In this way, although the provision of rights advice is intended to protect the rights of the person (just as the signing of Form 45 is intended to ensure adequate communication between the family and the provider), it in fact can harm partnerships with families, by instrumentalizing them and by focusing on their role in a bureaucratic process rather than their actual needs. This is not only a poor substitute for engagement with families, but can actually harm engagement.

Family members expressed that they often did not feel like true treatment partners in the management of the patient’s mental illness. One family member stated:

> I’m sure if you speak with a lot of parents from mentally ill, you’ll find that the doctors do not like to side...not necessarily side, they do not like to listen to parents. They have tunnel vision.... Because they have their own ideas, and they’re so set in their own ideas, that this is what works with them, that even if it doesn’t, they don’t even admit that it doesn’t work. (P21)

If family members are constructed as passive agents who receive advice, attend meetings, acquiesce, and sign forms, then attempts to actively engage in the decision making processes may be perceived as illegitimate and out of place. By instrumentalizing the family member, the CTO can sustain damaging conceptions that reinforce deeply held and stigmatizing beliefs about the role of families in mental health that prevent true partnership and truly collaborative decision making.

5.3.3.3 Having the time, money and skills to engage in system prescribed activities

Some participants suggested that CTO processes did not seem to be designed with an understanding of the complexities of life for most people with SPMI, or their families. One HCP, reflecting on this, stated:

> And I really think there's a bias in mental health law, which is probably, like a, there's a class system, white supremacist thing to a certain point. I think there's a bias to thinking that everybody's families live in the same city, that they have access and time and money to be able to come in for meetings and do everything in a super organized manner—it's way more chaotic than that. Family members live everywhere, I've had people living where there's only radio phones, no internet, it's extremely complicated, the process. (P16)

In this quote, an HCP calls out the mental health law processes for being designed for a stereotypical white, middle class family, and not for the diverse population that the mental health and legal systems serve. The participant suggests that the bureaucratic nature of the CTO reinforces systemic racism and classism, but that this only becomes visible at the level of application, to the people who are involved in trying to match the processes to the people they are intended to serve. By constructing the family around certain racial or class ideals, CTO processes create a situation where families who do not fit into this mold can become defined as deviant or defective in some way.

5.3.4 Family experiences of identity

Family experiences of identity, as with patients, were not uniform. Some fit the expectations constructed by the CTO more easily than others. In various ways, the CTO effected their experience of their role with their family member. This changed role had implications that pervaded other areas of their life as well.

5.3.4.1 Dissonance between roles

Some family members experienced a strain on their relationship with the patient related to being the SDM. One HCP participant stated:

> I have had some family members say it's a very difficult thing for them to have to engage in the CTO process because their relationship will sometimes flare up at the times when renewals happen, because they have to sign and the person doesn't want them to sign. And that's one of the most common reasons people don't agree to CTOs. Is because it's too hard on their relationship. (P16)

This participant recognized the conflict that family members felt around CTOs. Although a family member may have been advocating for treatment for several years, the CTO formalized this role, in that 'they have to sign'. Since family members often had mixed experiences of the psychiatric system, which, as seen in the previous section, had constructed them as less than a true collaborator, they experienced dissonance about entering a formal relationship with this system. P16 stated that relationships 'will sometimes flare up' at the time of renewals, suggesting that even in the case of long-standing CTOs, the process itself, which requires the re-signing of paperwork by the family member, has a direct impact on relationships.

One family member participant decided that although she found the CTO to be in the best interest of her son, she would not act as SDM because of the potential for conflict that this may create:

> No, no, I don't make decisions with regard to any of this. Health, or finances, or whatever. Just because I chose not to be involved. I don't know if you know schizophrenics very well, or anything about schizophrenics; they have the tendency to attack the mother, or the parents, when, you know, basically they blame them when things go wrong in their life, for some reason. So basically, I don't want to be the one that he can say, oh you made this happen, or made this happen, right. (P21)

This parent found a way of managing her role in her son's life through an understanding of the tendencies of what she terms 'schizophrenics'. Currently, in the mental health system, HCPs have adjusted their use of diagnostic labels, using terms such as 'having schizophrenia' or 'living with schizophrenia', as a way of recognizing that the diagnostic label does not equate the identity of the patient. In the mother's use of this label, however, we can see how she had, over many years of illness, been given a way of understanding her son's behaviours and choices by psychiatry, adopting psychiatric language as part of this understanding. Her decision not to take on the role of SDM was a self-preservation strategy which helped to mitigate the ongoing worry she had that her son would 'attack' her and 'blame' her. She understood the role of SDM as something that could potentially cause strain to an already difficult relationship, which could also increase the risk to herself.

One family member reported that the CTO had had a net positive effect on his relationship with his sister; within this context, he discussed the dissonance of being both her greatest advocate and the 'co-conspirator' of her CTO.

> There was obviously the negative that I was supportive of this... so she was resentful and still is to this day, of my involvement with any kind of hospitalization that she has experienced, or any kind of limitation on her independence and autonomy. That said, I would say that it allowed us to have a relationship that became a very close relationship again, as a result of her taking her medication consistently and being able to have a more balanced and realistic view of the world around her, including her relationships, so on balance, for the relationship, in spite of the negative of being the sort of co-conspirator or co-author of her having a community treatment order, it's been a dramatic improvement in our relationship. (P17)

This family member accepted his role as the 'co-author', or 'co-conspirator' of his sister's CTO because he felt this negative effect was outweighed by the positive effects. He speaks of a 'balance', suggesting a mental calculation of 'good' and 'bad' impacts; this speaks to the difficult math that family members engage in when deciding to consent to the initiation or renewal of a CTO. He expressed sensitivity to his sister's perspective, and the way that she sees him, considering his role in the CTO. His empathy for her perspective, while continuing to support the CTO, suggests a sophisticated ability to manage the resulting cognitive and emotional dissonance. Herein is an example of how the role constructed for family members by the CTO creates the need for a balancing act. In this way, the cognitive and emotional labour of managing the negative impacts of the CTO becomes downloaded onto family members.

5.3.4.2 Strain on other elements of life/identity

Families experienced strain based on the expectation brought on by their role in the CTO that they remain available and involved in their family member's life. Some family members went through periods in their life where they wanted to withdraw from the situation with a person who had often brought upheaval and distress into their life. Some wished to distance themselves from the stigma that they felt regarding their family member’s illness.

One family member stated:

> I think it’s really impacted my life, in many bad ways, not good ways. You know, relationships with my husband and stuff like that, um, it was a real challenge. I would get phone calls, and I’d have to do this and do that, all that kind of stuff, sort of thing. So, it was a challenge. (P4)

This family member had been the SDM for her brother for several decades, a role that she endorsed early on as she grew into other parts of her life as a professional, parent and spouse. She came from a large family that had its share of dysfunction, and as she herself entered adulthood, she went through periods where she wished to distance herself from her own past, as well as be relieved from her responsibilities towards her brother. However, she described being unable to achieve this goal, explicitly linking this impossibility to the constraint of her role as her brother’s SDM. The costs to her in terms of time and emotional investment are another example of how the CTO, intended to facilitate life in the community, functions to download responsibility and cost onto family members. At the end of the research interview, as we were exiting the location of the interview, P4 stopped me to add an extra point to the topics we had covered. She spoke of the financial strain that she had experienced due to her brother’s illness over the years, which caused a barrage of extra expenses that would never be covered by his disability cheque, again highlighting the financial costs to family members of a system that keeps patients in the community, but within a social context that doesn’t fully meet their needs.

Another family member spoke of the shame that can come with dealing with the legal or medical system. In describing her experience of being at a CCB hearing, she stated:

> Because there’s a little shame...you know it’s not right, you know, it’s not me that did anything that made this happen. But still I feel that someone might judge me at the same time. So that’s always at the back of your mind. (P20)

This mother maintained a constant awareness of the continued stigma directed towards mental illness and the families (in particular mothers) of those with mental illness. It is within living memory that the medical community endorsed the idea of the schizophrenogenic mother, and elements of this view linger in both the psychiatric community and the general public (Seeman, 2002). The rituals required by the CTO—the meetings, the paperwork, the hearings—bring families face to face with the feelings of shame engendered by this perspective. As addressed in earlier sections, the CTO reinforces a discourse about mental illness that conceives of SPMI as having its origins and its cure within the individual, and discounting environmental factors or political solutions. Although a biological account of SPMI could be seen as taking responsibility for illness away from the family, its failure to account for systemic social contributors to mental illness in fact puts responsibility back onto the shoulders of parents and families.

5.3.4.3 Relieved

Some participants described how the CTO gave some family members a sense of relief that their family member was formally accountable to a system, and that the mental health system was now formally accountable to their family member. One HCP stated:

> It's a sense of relief, that I get from family members, that something is in place, that gives them a break. That's, um, not universal, but I think there's some family members that have definitely been able to take a step back and have a bit more of a positive relationship with their family member because someone else is being the bad cop. (P13)

Inherent in this statement is the feeling that the mental health system was not able to play this role without the CTO in place, and that prior to the CTO, family members did not feel that the system provided their relatives with the care at the level at which it was needed. Although this may be partly due to the patient's resistance to voluntary services, section 5.1.2 showed that family members perceived many ways in which the system could have provided better care throughout their family member's illness. By the time a CTO was proposed, family members were tired from advocating for services for years and the CTO felt like a relief. The metaphor of the 'bad cop', used by P16, suggests that the CTO created a hostile situation where the patient's frustrations became downloaded onto the mental health care system. This stands in contrast to earlier sections, which suggest the CTO could also create feelings of betrayal or hostility between a patient and their family member. This speaks to the complexity of the CTO process and its many competing consequences for relationships.

One family member stated,

> Oh, it's been, its, it's nice because I'm plugged in, at least I know what the plan is. There's a phone number I can call, I can check in and see how [name of daughter] is. It's marvelous from that point of view. (P20)

In this quote, a mother makes a causal link between the CTO and being 'plugged in'. Inferred here is the idea that before the CTO, there was no meaningful contact, or a defined plan of care. Another parent stated,

> I feel relieved actually, finally. It's nice that I can finally breathe now, I feel like, you know, I don't have 100% on me all the time. (P21)

P21 situated the CTO in a context where she described having to fight for every admission, and to have someone recognize her son's illness as opposed to being construed as a 'bad kid' (section 5.1.3.3), hardships that lasted several years and led her to feel she had '100% on her all the time'. The CTO, in this context, was described as an emotional and even physical relief ('I can finally breathe'). Both P20 and P21 say 'it's nice', denoting a bland acceptance and approval of the CTO: taken superficially, this is a surprising way to characterize such a complex and double-edged intervention, where personal freedom and relationships are sacrificed for a baseline level of stability. Taken in context of these parents' previous experiences of mental health care, however, the CTO is a relief.

5.3.4.4 Having sober expectations

Participants shared that they felt the options for their family members' futures were very limited. One parent stated:

> I've pretty much run out of hope, and I know that it is really important to have that. But it's also something that you can't really fake. You can't. I can't anyways. So I'm like 99% this is, nothing good is ever going to happen for [name of daughter]. (P20)

This parent had spent years talking with different doctors, watching her daughter go in and out of hospital, use street drugs, become more and more disorganized, more and more floridly psychotic, move from shady apartments and couch surfing to living in and out of shelters: a life in decline. For her, the CTO was a bare minimum intervention that was keeping her daughter from death, but it was not a treatment that she saw as having a true impact in terms of improving her quality of life. Moreover, her years and years of contact with the mental health system had left her with the understanding that it was unlikely there was any intervention that would be able to significantly improve her daughter's life.

Another, mother, when asked how she envisioned the future for her son, and what his life might look like 10 or 20 years from now, stated:

> Where I would like to see him be is you know, get out, and maybe work and be more functional that way. But I don't see that happening, because I know the sedating effects of all this medication. So I don't know how to answer that. Because I know what I'd like to see and what I'm probably going to see are probably going to be two different things. (P21)

This parent thought it was likely that her son would be on a CTO for the rest of his life; in fact, in her view, this was a best-case scenario: her son was receiving a maximum of services, his money was controlled by a public guardian and trust, he had regular contact with a community-based treatment team, and a mental health rent supplement allowed him to live in his own apartment. He had achieved a level of stability beyond what she had once hoped for him; however, there was a cost in terms of his motivation and energy, and his ability to thrive in other respects.

5.3.4.5 Witness to the absurd

Family members often experienced both the legal and medical systems as contradictory, narrowly focused, and missing the point. For instance, they perceived the legal protection of their loved one's rights to be narrowly focused in a way that missed the larger picture. One family member recounted a conversation with the lawyer who was representing her brother in a CCB hearing:

> P4: I found it, I found the lawyer said to me, it's not right for him to be on this medication and I (laughs)
> F: That was the lawyer who said—?
> P4: Who told me, yeah. Because it was taking away his libido. Well, you know, libido is what got him in trouble in the first place, sort of thing, and if you read his

> history, it's a real issue, you know. So I can understand you, but you don't know him either, sort of thing. (P4)

This quote reveals how, from the perspective of a family member, a vigorous defence of the client—that is, a defence focused on contesting the CTO—seemed short sighted to the point of being absurd. The lawyer's argument, that the antipsychotic medication was taking away his libido, and that this of itself was an excessive infringement on his rights, did not take into account the patient's issues with impulsivity, the risk for mental decompensation, or even the fact he had very few avenues to express a fully functioning libido. The lawyer's arguments failed to address the big picture (i.e., how did the libido fit in with his overall wellbeing) and the subtleties or nuances in treatment that could actually lead to solutions. The participant suggested that the protections built into the CTO for the patient were not grounded in reality.

Another family member recounted a time her brother, who was on a CTO, was scheduled to go to a public meeting to learn more about his legal rights:

> There was this guy at [mental health services organization], he was a teacher, or something like that, and he was teaching some people how to get off their CTO orders, or how to get off their public guardian and trustee and all that. But the guy didn't show up. Thank God (laughs). (P3)

From her perspective, these legal mechanisms (the CTO and the PG&T) provided the bare minimum amount of structure that was needed to hold her brother's life together. During her interview, she reported that without these structures, he spent all of his money impulsively, mentally deteriorated to the point where he became physically unwell, and isolated himself from both care providers and family. To her it seemed bizarre that the same health care system that had implemented these structures would then dedicate resources to informing patients about ways to fight these mechanisms. This seemed to be a way of thinking that missed the big picture, and that went against the logic of these orders in the first place. Despite such a forum being geared towards improving the knowledge of CTO patients regarding their rights and recourses, it created angst for P3, evidence by the relief she felt ('Thank God') when the event did not proceed.

One HCP participant mentioned that it was common for family members see the rights advice process as contrary to the purpose of the CTO, that is, legally enforced treatment. She stated,

> Family members can't believe it, that somebody is incapable and they can contest an involuntary admission or a CTO is a big shock for them and they don't understand. (P16)

HCPs are enculturated into the need to respect legal structures and protect patient rights, but families often do not have the same background. This quote reveals how, without this enculturation, the system seems two-headed, as something divided against itself. The design of the CTO, which sets up the legal system and the medical system as adversaries of each other, does not appear to families to create balance, but to be at odds. In P16s experience, family members struggled to fathom the possibility that a person on a CTO can have such rights; their understanding of the CTO was as something even more all-encompassing and over-bearing than it is. They struggled with the idea that a CTO constructs an identity for their loved one as, on one hand, in need of restraint and control, and on the other hand, as able to contest this construction.

The social service system also had rules that seemed absurd. A family member noted that before the CTO was in place, she struggled to get the staff at her brother's residence to cue him to take the antipsychotic medication that he needed to take daily.

> Their rule was, he was on medication, and they said, he has to come to us and ask for medication. And I go, excuse me? He will always take his medication if you give it to him, but he's not going to come and ask you for it, you need to ask him. (P4)

This was a patient who had been institutionalized for years, and was then transferred to community housing when the psychiatric institution in which he was living ceased to provide residential services. The housing he received in the community however, likely did not staff health care workers, and therefore had specific rules around dispensing medication that involved the residents taking ownership of the process. The health care system underwent a major change, and this change shifted more responsibility to the patients. Because this was not done in a way that accounted for the fact that some patients had been dispossessed of responsibility for decades, this also shifted the roles and the responsibilities of family members. In this case, P4 now had the role of being a voice of reason in an absurd scenario: a person who the system had institutionalized from the age of seventeen was now, in middle age, required to live in the community and required to take ownership of his medication. Since he did not have this skill, the alternative was not cueing him to take the medication, but to put him on a CTO, which legally required him to take his medication, and which allowed for police intervention and assessment in a hospital setting when he did not. The lack of middle ground (someone offering him the medication) was met with incredulity by the participant ('Excuse me?').

Another family member recalled being at a CCB hearing for her daughter and finding that "virtually everyone at the table looked bored" (P20). Things that were of utmost significant to her seemed of little significance to the board members:

> There was one time she was in the hospital because she was picked up by police because she was actually lying on her back in the middle of [name of major urban street], just praying to be run over. And, you know, it seemed to me that should have been enough in and of itself [for involuntary admission and treatment]. But it didn't seem to. People just didn't seem to think it was a big deal. I thought it was a big deal. (P20)

For P20, it was significant that the system in place to protect patients' rights responded to this urgent situation with a sort of disinterested placidity, culminating in a dry meeting in with 'mostly older doctors, men' (P20). In this meeting, P20's direct practical and emotional experience of her daughter's illness clashed with and was subordinated to the fragmented and procedural knowledge of the board members. The meanings that she ascribed to the event (her daughter lying on her back in the middle of a major street), e.g., that her daughter was in extreme distress to the point of making a suicide attempt, abutted with the character, the intent, and the procedural methods of the board, who routinely weighed legal principles in order to come to a decision about whether or not a particular use of the Mental Health Act was warranted. P20's account suggests that this routine was carried out with a lack of acknowledgement of and empathy for the serious and emotionally fraught nature of this meeting from the perspective of the patient and her mother.

Another parent spoke of inconsistencies in the way that medical staff described the legal rights of her adult children, a daughter and a son, who were living with mental illness:

> The mental health system is very messed up. Like it's, you know. I'll just give you an example...They're not homicidal or suicidal, that's what everyone kept on saying to me. And I didn't know what the Canadian Mental Health Act even said at that point, so I just went along, cause I don't know. So I looked it up, and it doesn't actually say that at all. It actually says that, a person could be in danger of something along those lines, to themselves, right, you don't have to be homicidal. You could accidentally harm yourself because you're not thinking clearly, you're forgetting everything, you know what I mean. (P21)

This parent had felt helpless watching her daughter suffering and undergoing major mental changes. At the time, she trusted the doctors and nurses who stated that unless her child was homicidal or suicidal, they could not do anything for her, and therefore discharged her from hospital while she was still, in the mother's opinion, very unwell. When it came to her son's situation, she found the same MHA criteria were applied in an entirely different, and much broader way, such that he was put under a CTO. The unwillingness or inability of HCPs to speak in plain language about the limits of mental health care left this family member feeling confused, and like she needed to constantly be on her guard, and question the information provided to her. Inconsistencies in the application and interpretation of the mental health act left family members with the role of 'looking it up' and trying to reconcile the differences.

5.3.4.6 Monitor of service providers

Participants noted that even with the CTO in place, their family member did not always receive the services they expected, and they still felt like they had to monitor the mental health, social services, and police systems to get them to act functionally for their family member. One family member recounted:

> He wasn't answering the door, and I got worried. So that was one time. And he finally opened up the door to them. His beard, he had a long beard, which was really funny to me—he wasn't taking care of himself. He had no food in his cupboard, no medication. I was so angry at that team. I phoned them up and said: you left him with no food and no medication. And I had to come down, all the way down from [city], and I'm working fulltime, still. Right? And I still, afterwards I was going through a divorce, and going to court and everything, and working, and oh my gosh. (P3)

In this quote, a participant described how the CTO became impotent to ensure her brother's safety in the hands of HCPs who were not assertively monitoring him. This situation highlighted the fact that although in some cases the CTO gave family members a feeling of relief, the CTO did not actually legislate the responsibilities of the care providers. It allowed legal mechanisms to enforce the obligations of the patient, but no legal mechanisms to enforce the obligations of the providers. This was still a de facto role of family members.

One participant's main concern was that her family member wandered, yet she felt this was not taken seriously by any part of the system:

> P4. Come on. Like. I don't get it. So it's frustrating. And I don't feel the police really take...I guess they probably have a lot of calls as well, but ah, for me, it was like two, three days he's missing and (shrugs)
> F: They weren't taking it seriously.
> P4: Well, I don't know. Did they look or not look, I mean, they're going from pictures, I guess. (P4)

When P4's brother wandered away from his residence and disappeared for several days, he stopped taking his medication and was therefore in breach of his CTO. This individual, who P4 described as being impulsive and as having reduced levels of cognitive functioning, was deemed vulnerable; his sister saw the CTO as a safety mechanism that would get the police out looking for him, since, with the CTO, the police were obligated to look for him, although in her opinion, they still did not actively search. Despite the requirements embedded in the CTO, she had to take on the role of hounding services into action.

Commenting on the need to keep track of the various services involved and their responsibility to her child, another family member stated,

> I wish I'd kept better notes. One of my biggest regrets is that I didn't keep, like, a spread sheet. But I just didn't really know, that I would want it. And then it seemed too late. (P20)

Despite being on and off CTOs, this participant's child had received care from so many different hospitals and different providers over the years that looking back, these ran into each other. Retrospectively, this mother was looking for some way to order and understand it all. But it was only now, after years of treatment, that she was taking on that ordering on as part of her role. This speaks to stages that family members go through in their journey with both their loved one and the mental health system, stages in which their role changes many times, from caretaker to distraught and traumatized parent, to advocate, to witness, to monitor, to archivist and historian.

Another parent, glad to have a team involved in her son's care, kept some sense of herself as a 'case manager', but now with the help and assistance of others:

> The only thing , that I've mentioned to his worker, is that I don't think he has a family doctor and that kind of thing. And I asked her if they can put that thing in place. Because the one thing, the downfall of him being on his own is, I was doing his grocery shopping for him since before, and the one downfall I found in it is now he's doing all of his own shopping and his choice of food is not very good. So he's gaining a lot of weight. So I've mentioned that to the [community care team], and I asked if maybe they can put something in place or get him involved with a dietician or something that can help him manage his meals more properly. (P21)

This participant made suggestions to optimize the health of her son, meant to provide continuity for her son while ensuring key aspects of his wellbeing were not neglected. Her request to her son's case worker suggests that she had some confidence that his current care team would listen to and provide support for her suggestions, which would allow her to stay involved in his care and share her experience in order to support decisions. In her interview, she described how she had shifted her approach, moving from a role where she demanded services, utilized the police and the justice of the peace, and sometimes filed complaints or demanded investigation into possible malpractice, into a role where she acted as a collaborator with providers. The recounting of these role related changes in family members' accounts suggest that the system demands this understanding, flexibility, and adaptability of family members: the work of monitoring care, but also the work of reading complex situations, and moving between these demanding roles, all of which construct shifting subject positions for these family members, which in turn shift their relationships and interactions with the health care system.

5.3.5 The Constructed Identity of the Health Care Provider

The CTO process also constructs an identity for the HCPs involved in the care and treatment of patients with CTOs.

5.3.5.1 Enforcers

Participant HCPs described how, in the eyes of CTO patients, they became primarily agents of the administration of a legal imperative. To their patients, they were seen as ‘enforcers’. One HCP stated, “I just end up being the bad cop... I end up being just kind of the enforcer” (P13). P13 used the term ‘bad cop’, jargon borrowed from law enforcement that suggests a cop who is mean, derogatory, and antipathetic, an identity that is antithetical to the way HCPs are usually described. The double use of the word ‘just’ suggests an either/or dichotomy; the HCP is either a caring practitioner or agent of the state and of coercive practices. The use of the word ‘just’ also suggests that P13 saw herself as much more than that, and that she felt this role, (‘the enforcer’) acted antithetically to the potential for a broader role.

Another HCP noted that:

> Well she calls us the enforcers, so, we, you know, we are more on the side of the law and enforcing the injection. (P6)

By being in a position of enforcement of a legal imperative, HCP’s were positioned ‘more on the side of the law’; this implies a neglect of the ‘other side’ of humane care, that is, a care that goes beyond enforcing the injection of medication. This dichotomy also implied that HCPs were less on the side of the patient.

Another HCP expanded on this saying,

> It’s hard to have that trust with someone when they sort of see you as an agent of giving that injection. (P15)

In the phrase ‘agent of giving that injection’, this HCP suggested a very particular identity, an identity embodied by the provider when they meet with the patient and work to provide an intimate and personal level of care. No matter what elements in the HCPs’ worldview or approach may exist in the background to balance this identity, at the moment of giving the injection, they were, in a very concrete, indisputable way, an agent of a state sanctioned act of personal violation. From the patient's perspective, through this action, the HCPs took on a new identity, an identity that compromised their ability to engage in many of the usual care activities—activities that required trust.

An HCP noted that as the number of CTOs in the team's case load increased, the role of the nurses on the team changed. Referring to the act of giving mandated antipsychotic injections, she stated:

> Over the years it's become more and more of our role, I feel...yeah, I feel there's just a lot more CTOs. (P6)

Nurses have always given injections; it is not the act of giving an injection, but the act of giving a *mandated* injection that constituted a change to their role. Given mandated injections required that at the point of care, during face-to-face interactions with the client, the nurse take on the identity of the 'enforcer'. Taking on the identity of the enforcer impinged on the nurse's ability to take on other roles with the patient. Another HCP reported this impingement of the CTO on other potential HCP roles:

> Yeah, in her mind the CTO meant she had to see the [community care team] and she had to go for an injection. So when we saw her, it was never like, oh it's nice to see you, let's go for coffee. It was like, I'm just here because I have to. (P5)

Here, the role of 'enforcer' created a change in the relationship between the HCP and the patient. This change involved a loss of enjoyment in the relationship ('it was never like, oh it's nice to see you'). Many patients, as seen in section 5.1.1, lived socially restricted lives, and their interactions with HCPs were one of the most steady and predictable interactions in their week; the loss of positive associations with this interaction could constitute a significant loss. Interactions with HCPs were no longer motivated by kindship and collaboration, but by coercion and obligation.

5.3.5.2 Paternalistic

Most often, the implementation of a CTO necessitated that a physician recommended to an SDM a course of treatment that restricted a patient's freedom but was seen to be in their best interest. The legal protections for people with CTOs are legal protections from abuse by HCPs; they are mechanisms intended to ensure that HCPs do not provide treatment that is unnecessarily coercive or restrictive, thus providing a check on physician power. In this way, CTO processes both require and challenge paternalism in HCPs. The CTO requires the restriction of freedom and responsibilities of patients by stripping them of the ability to make treatment decisions in the areas set out by the Community Treatment Plan. The mechanisms of the CTO do not allow for middle ground, (e.g., processes like supported decision making instead of substitute decision making), thereby forcing physicians into 'all or nothing' situations.

An HCP grappled with the way in which the evolving legal structures around a CTO pushed them into a corner:

> Case law is making the CTO worse, not better. Making it more complicated. The legal world is different than the medical world. And although some people would say the medical world is too paternalistic, still, what the legal world is looking for in terms of technical glitches, making the process ever more nit-picky—does not seem to be in the best interest of anybody. (P10)

This participant struggled with what it meant to be constructed as paternalistic. In his view, the laws which formed the patients' legal protections made the sort of collaborative approach which is needed to keep paternalism in check more difficult rather than less difficult. To implement or renew a CTO, physicians needed to mount an unassailable case about patients that may dismiss patients' own interpretation of their situation. By constructing this as an adversarial process, the 'legal world' was in fact necessitating paternalism on the part of the physicians. Another HCP considered this concept, stating,

> I think for the people who are taking an active role in their own health care, then the CTO, it's almost like this paternalistic, yeah, its paternalistic. (8)

CTO processes override a collaborative approach, so that in individual who is interested in 'taking an active role in their own health care' is no longer able to. Interestingly, however, this participant appeared to discursively single out people actively involved in their own care as judges of whether mandated interventions constitute paternalism, implying that such judgment is not applicable to other patients with less involvement.

Another HCP referred to paternalism in this way:

> And I think some people [physicians], if they're potentially overreaching, they're not necessarily doing it in, you know, with evil intentions, right. Some doctors just necessarily practice in a much more paternalistic way than others. (P16)

Physicians need to walk as tight a line as possible between clients' best interests and clients' wishes, while also building the patient's capability to engage collaboratively. The CTO does not allow for such nuances. Instead, it constructs a context in which a doctor is obliged to emphasize the ways in which patients are risky, dangerous, oppositional, uncollaborative or unreasonable. This however can permanently damage the patient's willingness to engage collaboratively in care. This quote suggests an apologetic attitude towards paternalistic behaviour. Use of the word 'potentially' casts doubt on whether acts are indeed overreaching; the term overreaching is itself vague and does not describe the types of actions used by doctors. Use of the extreme term 'evil' works to portray critiques as exaggerated, undermining their legitimacy, and the words 'just necessarily' suggests that physicians acting paternalistically is unavoidable. Thus, the statement works to dismiss both the frequency and the significance of the issue.

A document citing "CTO myths" also infers a tendency in HCPs to act in a way that is paternalistic. It marks as "false" the statement:

> Reissuing a CTO outside of the 30 day renewal period is a good way to avoid CCB hearings. (D5)

It then provides an alternative "true" statement:

> Reissuing a CTO resets the clock on CCB hearings, and prevents a deemed hearing (which happen every second renewal). Purposely reissuing a CTO instead of renewing it within the 30 days is not in the best interest of the client. (D5)

These statements construct the HCP as sneakily trying to evade legal requirements, either because they are lazy (and therefore trying to avoid a hearing), or because they are canceling a patient's opportunity to contest a CTO, which can imply a paternalistic approach. The language of this document is patronizing: it makes assumptions about the needs and intentions of both the providers and the patients; it reduces and (over)simplifies readers' interpretations of HCPs decision making; and it promotes strict adherence to a rigid procedure, without allowing that individual situations, needs and contexts may require different approaches. In this it provides another example of how CTO processes and procedures promote paternalistic thinking at the point in clinical decision-making where it is most difficult for practitioners to exercise a balanced and responsive approach.

5.3.5.3 Fall-guys

Insofar as the CTO is a tool intended to manage risk (as seen above), it constructs HCPs—in particular, psychiatrists—as persons expected to control that risk. In constructing HCPs as responsible for the containment of risk related to mental illness, the public divests responsibility for a large and diverse social problem. One HCP talked about how the CTO decreases the overall agency of the public in responding to mental illness in a holistic way:

> P8: It's almost like they, people, look to the government and say—you've got to do something about this. Um, and it, again, it's that, it's that--
> F: They look to psychiatry
> P8: They look to psychiatry, and they say, almost...
> F: You shouldn't have let this happen
> P8: Exactly, it's like, they don't, and again that takes away from personal agency. (P8)

In this quote, an HCP struggled to form a thought around something that had been bothering him in the way that society responds to mental illness. Prior to this exchange, he had been talking about the way that the CTO took away not only freedom but also a sense of responsibility from the patient; in this quote, he recognized that the same was true for society. Because it is the role of psychiatry to manage risk to the public, 'people'—that is, the public—felt divested of the need to develop an empathetic and inclusive approach to mental illness. Instead, they looked to the psychiatric system to 'do something about this'. The CTO, in that it was a one-sided intervention that demanded a one-sided change, removed responsibility from the community to respond with skill, resources or empathy to individuals' experiences of mental distress. This of course, as seen above, had an effect on the constructed identity of the patient, but it also had a profound effect on the constructed identity of the HCP: it constructed the HCP as the person who had a duty and a professional responsibility to protect the public from the pain of witnessing pain, from the distress of “panic in drugstores and havoc/among the barbeques” (Atwood, 2007).

5.3.5.4 The patient’s adversary

As touched on earlier in the chapter, the CCB hearings in particular constructed HCPs as adversaries of the patients. As seen in the section on hearings, the CCB hearings mimicked the judicial process found in the mainstream legal system. The psychiatrist and the client presented their opposing cases, and were both expected to argue (sometimes through lawyers) for their side of the case. Earlier participant quotes suggest that the CCB (in the form of a panel consisting of a lawyer, a psychiatrist, and a community member) chose a ‘winner’ and a ‘loser’ based on the evidence presented. As these systems evolved, the CCB system appeared to be moving in a direction that was making it more, not less, adversarial. An HCP reflected on this:

> The CCB system has become increasingly adversarial. We had a few lawyers come, I think, from a criminal background, and some of the hearings have had, there’s been name calling, like the other professionals, and, ah, I have been disappointed, I would say, within the last two years with the hearings—some of the lawyers really focusing on, kind of getting the client off the CTO at all costs. Whereas my experience before that was, that the lawyers generally had a bit more of a balanced approach with regards to, um, like I’m going to try to sort of help this person and try to sort of navigate the system and help them get the fairest deal possible in the context of their care. But it’s moved a little bit more towards, like, okay, let’s do this, lets win this, let’s get you off it, without a lot of consideration for what’s going to happen if this person is off a CTO. (P16)

This HCP pointed out a dilemma (CTO hearings becoming more adversarial) while at the same time pointing out a potential rationale for the dilemma. In the past, this participant suggests, lawyers had a bias in favour of the CTO, and they worked to help the client ‘get the fairest deal possible in the context of their care.’ This suggests a process that was heavily biased against the patients, for whom a ‘fair deal’ did not include a vigorous argument regarding the cancellation of their CTO. This raises the question of what constituted a ‘fair deal’ in that context. To ‘correct’ for this, the process became more adversarial: that is, lawyers fought vigorously for their patient’s right to be off the CTO, against their official adversary, the doctor. In practice, this approach created bizarre scenarios that highlighted the absurdity of constructing a doctor and patient as adversaries of each other when taken to its natural end. This is evidenced by several quotes already mentioned in this chapter, such as the doctor who found the hearings to be tantamount to abuse to patients (section 5.3.6.4), and the client who reported that he would never attend a hearing because they would ‘tear me apart in there’ (section 5.2.4). The adversarial nature of the process, heightened by the approach of lawyers ‘from a criminal background’, led to frustrations for everybody. However, the cost of avoiding these tensions, as was done in the past by lawyers who sought the ‘fairest deal for patients in the context of their care’ was borne by patients.

5.3.5.5 Consumers of shallow evidence

Information documents prepared for HCPs regarding the CTO presented very lean summaries of the existing evidence or instructed HCPs about their role in the process with a focus on their logistical function. This further constructed HCPs as functional, robotic (as opposed to reflective, thoughtful) participants in a defined and hyper-determined process that was largely outside of their control. For example, a presentation aimed at Psychiatric Residents explained the steps in initiating a CTO, then ended with two slides labelled “What are the potential benefits of CTOs for patients/clients?” and “What are the potential benefits of CTOs for families?” (D6). In the busy hospital environment where these psychiatry residents were training, a function-focused presentation has a logic to it; however, this function-focus has the potential to lead to an absence of critical reflection. Notably, these documents did not examine the potential negative effects of CTOs, although it seems that considering the side effects of an intervention would reasonably form part of the discussion. Neither did these presentations pause to consider the wider social contexts which may prompt the use of CTOs; the presentation’s focus on function did not leave room to consider the social problems that patients and families grappled with, a topic that may have made HCPs feel powerless and impotent. These documents were created to account for the nature of a specific culture (busy hospital environment), and in turn potentially contributed to a culture where HCPs avoided complex and nuanced constructions of the problem of mental illness in favour of seemingly tangible, straightforward, and practicable solutions.

Along the same vein, an “Evidence Brief” directed at HCPs regarding CTOs was entitled, “The Positive Effects of the Community Treatment Orders on the Mental Health System” (D2). The title of this brief on its own was revealing, first, because of its unencumbered focus on the ‘positive effects’ of CTOs, and second, because of its focus on their effect on the mental health system rather than on patients and/or their family. Despite its title, this document claimed to examine evidence from 2012-2017 that assessed the effectiveness of CTOs; of these only 3 of 83 studies were deemed to be relevant by the document’s authors. The relevant studies did not include, for example, the 2013 RCT (one of three RCTs ever completed on the effectiveness of CTOs), which concluded,

> this is the third, and largest, randomized trial of CTOs, and, similar to its predecessors, did not find any evidence that CTOs achieve their intended purpose of reducing readmission in so-called revolving door patients with a diagnosis of psychosis. The evidence is now strong that the use of CTOs does not confer early patient benefits despite substantial curtailment of individual freedoms. (Burns et al, 2013, p.1632)

It also ignored a Cochrane meta-analysis published during this time frame, which had a similar conclusion. One of the studies included in this review of the evidence states, “given the widespread introduction of CTOs into Canada, it is surprising how little research has been conducted into their effectiveness” (Kisely, 2016, p.13) and “it is unlikely that any other group of patients would be subjected to an equally invasive intervention in the absence of an adequate evidence base” (p.13). However, the evidence brief does not find a similar conclusion. Instead, it’s conclusions, summarized in a box labelled ‘Need to know’, state:

> - Community treatment orders (CTOs) can have a positive impact on the mental health system, and people with CTOs generally see their value.
> - CTOs are associated with a reduction in hospital visits and improved adherence to medication for treatment.

> - Some individuals taking part in a community treatment order may feel coerced and/or stigmatized because of the mandatory nature of treatment and the involvement of a legal authority. (D2)

By presenting a shallow and misinterpreted summary of available evidence, this brief constructed HCPs as uninterested in the complexities of CTO research, the difficulties with designing quality, representative studies, and the ongoing controversy in the research and clinical communities regarding CTO use. This construction can ultimately lead to a situation where HCPs are underequipped to understand and wrestle with the real potential for positive and negative outcomes, and where they are unequipped to consider or to change the social contexts which necessitate CTOs.

5.3.6 The Experienced Identity of the Health Care Provider

As with patients and family members, HCPs experienced these constructed identities in a variety of ways.

5.3.6.1 Frustrated

HCPs experienced the bureaucratic demands of the CTO as time consuming and sometimes overwhelming. They felt uncomfortable or irritated with the evolving bureaucratic and legal structures, even when they were very familiar with CTOs and comfortable with their clinical management. One commented, “There are so many pieces of paper. There are so many steps” (P16). This suggests the degree to which the logistical steps in the CTO process can consume the time and attention of the involved practitioner. Another commented:

> The system is still expecting the hearing to go on, so I still have to prepare a report and I still have to show up at the hearing and then sometimes the hearing doesn’t happen and then that’s more of a waste of my time, etcetera, etcetera, so it’s costing the system a lot more money in work and resources and my time. (P13)

This HCP showed frustration with the requirement that she prepare and show up at a CCB hearing every six months, even when the patient had no interest in contesting their CTO; adding to the frustration were the logistical struggles of coordinating with the other involved systems (‘and then sometimes the hearing doesn’t happen’), resulting in situations where hearings were moved or postponed. The time-consuming, fussy, bureaucratic workload of the CTO is another instance of the way in which CTO processes limit HCPs ability to engage in deeper or more critical reflections on the process, or the role of CTOs in healthcare.

One participant explained that HCPs don't always have the time or expertise to keep up with case law related to the CTO. Most often, psychiatrists presented their arguments without legal representation; this meant that if they were not up to date on all the case law (which was usually the case, as this was itself a gargantuan task), the patient's lawyer could present a legally nuanced argument uncontested:

> Occasionally you'll end up with two different...because of an appeal you'll end up with two different conflicting rulings, so the lawyer can choose to use one and just not mention the other, so if the doctor doesn't know the other, right, you know. (P16)

It is odd and unrealistic to expect that physicians would have the time or ability to be cognizant of legal cases in a way that would put them on equal footing with a lawyer. However, the CTO process sets up this implicit expectation, creating a whole new arena in which practitioners need to be versed to be 'good' or 'well-rounded'. This situation caused frustration for HCPs, who interpreted the system as arbitrarily committed to technical, legal rationalizations. The result of this was more work for the HCP, who was left to manage the clinical consequences of this ruling—often by re-submitting the CTO, or by engaging another element of the MHA. One HCP stated:

> When clients get off the CTO for legal reasons, it's over a technicality. This is frustrating for the physician, who then just rewrites the CTO, meaning even more paperwork. (P10)

This HCP used the term "technicality" to denote an argument against the CTO that is based in a legal nuance. He saw legal arguments as irrelevant to the degree to which they did not take the patient's clinical needs into account; this was demonstrated by the statement that the physician 'just rewrites the CTO'. This quote is indicative of both the power and the impotence of the legal protections for patients: on one hand, a legal argument can make a CTO null, no matter the clinical consequences; on the other hand, if the physician believes the patient needs mandated treatment, they will find another way to ensure that they receive this. Another HCP cemented this point:

> We've definitely had CTOs revoked and the person needed to go back on a CTO relatively shortly thereafter. I had one hearing where they revoked the CTO on the spot, for a ridiculous reason, and the physician looked over and said, 'Fine, I'm putting you on a Form 1 right now.' (P16)

This quote again illustrates the previous points: that physicians are frustrated when a CTO is revoked for a technical, legal reason, and that the result of this type of defence is not freedom for the patient, but increased workload for providers, and this can further pit physicians against patients. It also highlights the HCP's reaction to legally technical arguments; they find them 'ridiculous'.

One participant commented that the bureaucratic requirements of the CTO sometimes made them so administratively difficult to use, that it was no longer feasible to integrate them into practice, even if the HCP found them to be in the best interest of the client:

> Recent changes to the bureaucracy around CCB hearings—the dates being set in advance, not accommodating physician's schedules—has caused some physicians to simply stop using them. The overhead is just too high. (P10)

Another participant commented,

> It definitely has become more adversarial, more time consuming, and definitely a factor in physicians saying yes or no to monitoring CTOs. (P16)

These quotes evidence a system of patient protections that are so frustrating to navigate that they may make the CTO impracticable despite its perceived clinical purpose and therefore lead to physician disengagement. This frustration was heightened by the discordance HCPs felt between, on the one hand, wanting patients to have legal protection, and on the other hand, perceiving that the legal protections were working in a way that was not in the best-interest of the client. One HCP expressed her frustration with the idea that a patient may go without a clinically recommended treatment, not because the legal system made an argument that it was not in their best interest, but due to the legal exploitation of an administrative error:

> Right. So now it's, okay, so they don't, we're not going to do something in their best interest because someone forgot to put a date on a legal form? (P6).

For HCPs, the focus on legal nuances strained their relationship not just with patients but with the legal system, creating a context in which they experienced that system as neither working in the best interest of the patient, nor theirs.

5.3.6.2 Powerless

HCPs' concerns about CTO processes were often coupled with a sense of powerlessness to change those processes. In part, this was because of a belief that protecting clients' rights was an important and worthy endeavor, and that ultimately, they believed this was the role of the legal system. One HCP commented,

> I think it's important, I think we'd be living in a completely different kind of country, if we didn't have of some kind of means for people to contest something like this. (P16)

HCP participants' accounts reflected a commitment to cooperating with legal mechanisms. Even when HCPs were frustrated by how legal proceedings unfolded, they had a sense that the legal proceedings were important in some way. One participant stated, referring to the mandatory CCB hearings,

> That's definitely good, because, you know, at least it's going to be looked at least once a year, even if the client doesn't request one. (P15)

Both quotes indicate support for and an intention to cooperate with legal protections; they also allude to another potential role of these legal processes, which is to manage anxiety and guilt about removing patient rights. The phrases 'some means for people to contest' and 'at least it's going to be looked at' allude to a minimum standard that is necessary for a sense of ethical propriety to be met, regardless of whether these protections had a positive impact on the patient.

This need for ethical propriety contributed to feelings of powerlessness; that is, it led HCPs to engage in practices that they regarded as having a negative impact on their patients in order to maintain what they perceived as ethical propriety. As an addendum to a statement one HCP made about her frustrations with the legal protections (section 5.3.6.4), she said the following:

> I mean, I think it's very important that the clients be represented and have their rights respected and I don't know how I would do it differently or better. (P13)

This statement came right after an explanation of how these very protections could be abusive to clients, suggesting that HCPs had an understanding of ethics in which a legal protection of 'rights' overshadowed the need to prevent harm. This understanding left P13 in a paralyzed state, unable to enter into a true critique of either system, her own clinical perspective or the legal perspective.

Commenting on the system in place to protect patients' rights in the context of a CTO, another HCP reflected:

> It's hard to say if I think their rights are really being protected. I mean, there's a system in place. Is it perfect? No...I don't know, I mean, what can you do if they're refusing what's there for them [rights advice], right. (P7)

This participant acknowledges imperfections in the legal systems, but then shifts the responsibility for their ineffectiveness on the patients. This is indicative of one way that participants managed feelings of powerlessness, by transferring blame. In this case, the blame was transferred to the most vulnerable party. In this way, the patient was blamed not only for their mental illness (by defining it as individual problem that rests in their own biology, as considered in sections above), but also for the failure of legal system to protect in them in a meaningful way. This failure becomes constructed as a failure of the patient to access the protective services in place, such as the provision of right advice. This type of patient-blaming could be seen as one consequence of a system in which HCPs feel powerless.

5.3.6.3 Acquiring a CTO related skillset

HCPs developed a set of skills specific to caring for patients with CTOs; these skills often involved managing, negotiating, and reconciling multiple priorities during the delivery of care.

For example, HCPs found ways to show respect for their clients' personal spaces, even while acknowledging that they were entering into those spaces uninvited:

> How I do it, is, I meet with her the first time and she'll refuse. She won't let me into her domain. That's her safe place. And, oftentimes I'll say I'll be back. You know, and, we can talk tomorrow. You know, so I come back and she's dodging the bullet, she's trying not to, you know, run into me, yet, when she does, she is dealing with a

> lot of internal stimulation, so she's responding a lot, and it's all religious, and, so, my approach is: Hi, how are you, how are you doing, you know. Today's the day [that she will receive her injection]. And then, I say nothing else after that. There's no...um...interaction. Whatsoever. None. ...I allow her that time, to process it, and then, it's like thank you very much, I'll see you next month. (P9)

This HCP described the strategy that she used to manage the point in care where she became an 'agent of the injection and of the law' (section 5.3.6.3). She used an approach that showed awareness and respect for the patient's perspective, including the patient's perception of her, and the tensions inherent in this perception. This participant described how the CTO manifests in particular moments of care, and the specific actions that she took to manage this moment of care to take it to its legally required outcome. She referred to the patient's protection of her personal space ('she won't let me into her domain') and acknowledged the patient's experience: 'that's her safe space'. She described giving the injection in a way that she perceived as giving the patient maximal autonomy considering the constraining parameters of the situation, in that she gave the patient time and space to refuse. For this HCP, remaining silent was a way to acknowledge and defuse the tensions inherent in the situation; her silence also showed respect for the complexity of the relational strain that the patient was experiencing, that is, that the patient likely felt angry at the nurse for being the agent of the injection at the same time as she desired to preserve this relationship in some way. In this account, the nurse took on another identity, she became the patient's guide and companion through the distress of the injection (and everything it stood for) even as she was also the agent of the injection.

Another HCP also spoke about how she approached giving the injection:

> I definitely try to make the injection or the medication not the focus of the interaction or visit. So even if, say, I'm going out to see the client to give their injection, I don't start the visit with: I'm here to give your injection. (P15)

In this quote we witness how this HCP stays attuned to the patient experience and uses this information to adjust her approach. She reflected an understanding that showing up at someone's place of residence with a singular, unmoveable agenda ('I'm here to give you your injection') could be perceived as coercive or confrontational. Instead, although from the perspective of the state, or even the care team, the injection might be the priority task, the nurse subverted this priority, and reconfigured the patient-nurse interaction so that it had multiple priorities, with the injection being only part of a more extensive set of aims.

Another HCP reflected on ways to help patients reflect on their own reasons for taking or not taking medication, that went beyond the CTO:

> Part of my role was to say, hey, what does it mean to you to take medication. What does it mean to, uh, and get at that more subtle level, not for the purpose of let's say compliance so much as...having the individual sort of...take more interest in their own wellbeing. (P8)

In this quote, the HCP demonstrated that despite the CTO, he actively worked with a patient to develop their own understanding, goals and priorities. His shift in wording ('not... compliance so much as') suggests that he is aware that the term 'compliance' evokes a patient that passively accepts and follows through on the treatments ordered by a physician, accepting an unengaged and unempowered position in the patient-physician relationship. He speaks of 'the individual', suggesting an interest in differentiating the variety of experiences people have of mental health care, and an interest in understanding the individual meaning that the patients attach to their care ('what does it mean to you').

Another HCP, similarly, reflected on the importance of finding the value in medication for the individual client, from their own perspective:

> Sometimes I've had success in explaining their symptoms and what symptom will stop if they accept the injection...And you can often get that by, 'What brought you into hospital the first time, what do you remember when you first came into hospital. What brought you there, what were your experiencing.' And sometimes it's...however they describe that feeling, knowing what that is, and then, this is the symptom that will stop with this injection...I have a client who said meat tasted really bad. That's why they went into hospital. And I said, well you've been taking the injection and now you eat meat. Yeah, because it's stopped it. And so that's the thing. (P6)

This excerpt illustrates how this HCP valued and entered the patient's perspective, giving this perspective value in the care negotiation, alongside the values of the system as they were expressed through requirements of the CTO. This example, and the prior examples, contain a paradox: that valuing and giving credence to the patient's perspective, and giving it weight, in the end made the HCP more successful in carrying out the mandated elements of care. In this quote, the nurse used the word 'success' to denote that valuing the patient perspective brought the patient to a place of accepting the injection. This is a tricky negotiation not only externally, but internally; nurses must enter the patient's perspective and develop empathy for their viewpoint, while maintaining an understanding of medico-legal imperatives. They must then not only manage this dissonance, but use this dissonance, and the authenticity that it allows them, to bring the patient into a place where they are also able to manage their own dissonance around medication and around their relationship with the nurse, who is at once an agent of coerced treatment, and their companion at the moment of coerced treatment.

5.3.6.4 Distressed by role

Despite being 'skillful' and 'successful' navigators of CTO requirements and complex provider-patient relationships, many participants nonetheless experienced distress over their role as enforcers and adversaries, and the effect that this had on their therapeutic relationships with patients. Once HCP described:

> We're left to pick up the pieces after, and it's okay if I'm a psychiatrist and I end up being a bad cop and a worker from the community team can step in and be the good cop, and support them, but what about those people out there who don't have that team, that other allied health member, to go and help them through that, right? Because it can be quite traumatizing to the clients to go through that process, and then still have the CTO upheld and then, who supports them after. Because then your rapport with the client is now damaged, right. (P13)

This HCP draws attention to the artificial nature of the adversarial relationship created with the patient through the CTO processes. After the hearing, the patient's relationship with their lawyer, who had the role of patient advocate during the hearing, came to an end. However, the relationship between the HCP and the patient remained, wherein the HCP had to go from adversary back into the role of provider. This role required supporting the patient through the very process in which both parties had faced off.

Another HCP participant also commented on the way the CTO affected their ability to enter into a therapeutic role with patients:

> So, in my experience, it really depends on the client, but in general, there has sometimes been more tension in those therapeutic relationships with clients who are on an injection, on a CTO, and aren't happy with it. Um, so that's been challenging. Just, because, part of the whole, like, therapeutic rapport building of being a nurse in a mental health setting is development of that trust. (P15)

This nurse emphasized the foundational role that building therapeutic rapport takes in mental health care. The absence of trust is an impediment to other care activities; in this way, the role necessitated by the CTO becomes an impediment to taking on other roles with the patient. Another HCP expanded on how taking on the role necessitated by the CTO could interfere with the other supports that she was attempting to provide for the client:

> So I'm still trying to work on them on getting to a doctor for their physical health. I'm trying to get them to an eye specialist or a dentist or take them grocery shopping and if, if they only have a negative experience with me, and we do have some on CTOs where it's better if the nurse never sees them other than for the injection because that is what they think of when they see us. (P6)

This participant found that in some cases, the provider who engaged in the physical act of providing the injection was precluded from providing other basic services for the patient. This quote emphasizes how foundational therapeutic rapport is to engagement in routine care; it also reveals the kind of personal tasks in which a mental health care team engages with patients. These tasks have intimacy to them (going to the doctor, going grocery shopping) and they evidence the degree to which patients let care providers into their daily lives, and the way that a mental health care team, in working with people with SPMI who often do not have strong social supports, end up acting in many functional and relational roles, such as support person, driver, and therapist. Implementing the CTO interrupted the relational capacity necessary for these roles, thereby compromising the very supports that were needed to assist someone with successfully managing life in the community.

5.3.6.5 Living with dissonance

Many HCP participants managed their own mixed thoughts and experiences of the CTO. On one hand, they felt CTOs were beneficial for some patients, but on the other hand, CTOs interfered with the values and approaches they were committed to applying to care. One HCP stated:

> We [the treatment team] don't like CTO's...Well, because it takes all the power of decision making out of the clients and it makes relationships very difficult. They're absolutely necessary and we have no, like I personally don't have any illusions that they're not necessary, I believe they are necessary. (P7)

This quote evidences how a sense of powerlessness about the CTO could lead to an experience of dissonance. This participant believed that, for some patients, CTOs were necessary; he also observed that they disrupted relationships and took power away from clients. HCPs who felt powerlessness about the negative aspects of CTOs (which interrupted creative or proactive thinking about how the CTO could be changed or adjusted to better meet patient needs), experienced dissonance. It is also notable that this participant switched from the plural to the singular, at first making a statement on behalf of the group, and then, as the thought became more complex and more incongruous, shifting to 'I'. This implies, potentially, a culture where individuals publicly reconciled their dissonance with the CTO by engaging in critiques of its methods and its incongruity with the stated aims of care, while privately, the values and beliefs foundational to CTOs had infiltrated into their thinking. Seeing the CTO as 'absolutely necessary' provided an alternate way to manage and reduce the dissonance felt around CTOs through a rationalization of its raison d'être.

Another HCP experienced dissonance regarding police involvement with mental health care:

> Um, getting picked up by the police, is usually how, um, with, what I struggle with with CTOs, although I know it's a good thing, if people are refusing treatment, and are on CTOs, that they do get picked up, but it can be very traumatizing, so, I can see, how, um, that's something that, um, it rings a bell, when I hear CTOs, that, there's that power and control over the client that is always very difficult for families and for the client, themselves, so although there's great things about CTOs, I can see how that can be very traumatizing for some clients. (P5)

This HCP described her discomfort with CTO patients being picked up by the police, immediately followed by the disclaimer 'I know it's a good thing'. This suggests a culture where HCPs are tentative about expressing critiques; and where they feel the need to constantly account for the possibility that expressing a critique about an element of the CTO will be misconstrued as a critique of CTOs in general.

This tendency fuels disengagement with creative thinking about the CTO process, and how it could be improved.

One HCP balanced her concerns about how the CTO was affecting their relationship with their patient with the benefits that she believed it brought:

> It’s a challenge, definitely, as a clinician, but I, again look at that history behind where she is without the medication and that to me is okay. (P6)

On one hand, this quote reveals the balancing act that providers engage in when providing CTO care; on the other hand, it is further evidence of a type of thinking that mutes creativity and problem solving: since the CTO has a positive effect on some level, this makes the associated negative outcomes acceptable. Another HCP spoke of balancing her concerns this way:

> The balance of wanting a client to have a CTO because you can see how it benefits them, but then also, the balance of well, it’s kind of an infringement on their rights, and like, where, it’s kind of a grey area in that sense of like, as a nurse, you kind of want to be protecting their rights but at the same time see that they, have something protecting them. So, its, I guess that’s my reflection on it. It’s always kind of touchy area. I can see how it benefits them but also, not. (P15)

This HCP, like the others quoted in this section, acknowledged negative aspects to the CTO. However, as with the others, she had a general belief that one needed to live with these negative aspects to experience the positive elements of the CTO. She used the phrase ‘kind of’ twice (‘kind of an infringement on their rights’ and ‘kind of a grey area’), minimizing these negative aspects at the same time as acknowledging them. This hesitancy around critique limited participant’s likelihood of engaging fully in reflection about the negative aspects of the CTO, as they saw this as futile and even counterproductive, considering their other deeply held belief: that for some patients, the CTO was simply necessary.

5.4 Solutions

Through the data collection process, I asked participants for their suggestions and ideas for how CTO processes could be improved. In this final section, I will present and analyze these responses, looking at them on two levels: 1) how they augment or fit with the rest of data, i.e., as potential solutions to the problems that emerged from the data. 2) how the responses provide further evidence of the ways that the participants may be constrained by certain discourses or thinking patterns.

5.4.1 Police Intervention

Several participants expressed in interest in changing or managing police intervention during the use of Form 47s. One mused:

> If there was police who were a little bit more trained and had the resources to be a little bit more patient and have some conversations with them, I think that, maybe, the whole experience wouldn't be as traumatic. (P6)

HCPs saw the benefit of having form 47s executed by clinical staff instead of police, or some combination of the two. However, they also perceived this as unrealistic. Although the police force in the municipality in which this study was completed does have a mental health unit, they are often not available at the point in time when a Form 47 is issued, and the opportunities for collaboration, in the case of CTOs, remain limited. Another HCP stated:

> So, I think there are all sorts of nicer ways that potentially involve more clinical staff, and not the police for Form 47's that are part of a larger conversation about how we respond to mental health emergencies in general, but I think, I think there really does need to be consideration sometimes of how badly things can escalate, when you're, um, in that moment [when police are picking up a patient and transporting them to hospital]. (P16)

Another lamented,

> Ah, I just wish there was a way for us to take them to the hospital without having the police doing it. I know there isn't. (P5)

Despite the fact that there are various configurations and collaborations between the MH care systems and the police, this participant quickly makes an assumption that there are no alternative options. When asked to imagine what an alternate solution might look like, this HCP said:

> Well if it was just the ACT team taking them to the hospital. You know. But then, there's no force. Cause the police is very forceful, right? So, yeah, I don't know. I just feel like that force is a lot for somebody that's already very vulnerable and sick, and so, I don't know (P5).

This feeling of helplessness, that is, the expression of a feeling or belief that things needed to be changed coupled by a belief that it could not be changed, was a common thread in the responses. This could be seen as evidence that in general, HCPs have fully integrated a discourse about the riskiness of the patients. It may also be evidence that HCPs take for granted the actions and interventions of legal and enforcement groups, e.g., they see system oversight and system change as outside of their purview or jurisdiction. These quotes also evidence the degree to which police involvement feels to the HCPs as a separate from or in addition to MH care, when in fact earlier sections (5.1.4 and 5.2.5), provided evidence that enforcement bodies are deeply integrated into the workings of the mental health system. If HCPs do understand them as deeply entrenched, it is without a clear understanding of their role in managing the liabilities create by this partnership, and with hesitations about addressing the whole set of problems that this entrenchment creates.

This data suggests that there is need to improve the mental health systems understanding of the degree to which police are integrated into mental health care, and to rethink the relationship between psychiatry and the police, and suggests that changes to the CTO process need to involve interprofessional and inter-agency collaborations and discussions.

5.4.2 Consent and Capacity Board hearings

Others made suggestions regarding the CCB hearings. One HCP suggested:

> What could make them better in general is really not getting caught up in this technical stuff about exquisitely minor minutiae sort of thing. Because most of the time physicians aren't looking for business. If somebody's on a CTO, generally, the person needs to be on one. So obviously one of reasons they [the lawyers] are focusing on the technical issues is that most of the time, clinically, they're pretty sound. (P16)

This quote demonstrates the belief that patients are put on a CTO as a last resort ('physicians aren't looking for business'), and that this is done hesitantly and with forethought by the involved physicians ('clinically, they're pretty sound'). The assumption made by P16 is that if the physician went through the trouble of putting someone on a CTO, then they need to be on one. The CCB hearings, in reaction to these practices, had become focused on ‘minor minutiae’. Another HCP built on this, suggesting that the hearings needed to take into account the therapeutic needs of the patient:

> Ideally, protection of clients’ rights would involve a clinical review, not just legal jurisprudence. (P10)

The term ‘clinical review’ implies an auditing of the clinical judgment used by the medical practitioners initiating or renewing a CTO, as opposed to a focus on their ability to abide by complex legal rules. This quote echoes the impression that currently, CCB hearings are focused on legal matters in a way that ignore the patient’s overall wellbeing.

Another participant suggested it would be beneficial to find a way to make the hearings less intimidating for patients:

> That’s probably a really difficult situation to be in, too, there’s probably a better way they could be interviewed... what if everybody wasn’t present. What if the psychiatrist...what if it was their right to attend when the psychiatrist attended, but it was also the patient’s right for us not to be present. I don’t know. If there was a way for them to present their side without having a huge panel per se. (P6)

The participant makes the point that most of the patients she works with respond much better to one-on-one scenarios. Therefore, providing them with better options about how and when they could present their story may improve their experience.

Another HCP suggested a stronger family role in the hearings:

> I think I would, um, somehow involve the SDM a bit better in the hearings, I think that is something that I find is lacking.... Maybe having the family present a statement as well...or having them...because you know how we have to prepare a report—we don’t have to, but we prepare a report. It may be really neat to have the family, and/or their caregivers in whatever settings they’re living in prepare a report. In terms of how this is benefiting their loved one or their, or the client that they are serving. Um, as evidence. And I never thought of doing that. So, um, but that may be kind of a system-wide thing to do, then maybe if it’s an expectation, it would be easier to implement. (P13)

P13’s suggestion of an increased role for families can be contrasted with the statements made in an earlier section, in which some family members expressed that they felt expected to speak out against the patient, and that this was perceived by the patient as a betrayal. In this quote, P13 is forming new thoughts and ideas about how the hearing could be improved. It is clear (‘I never thought of doing that’) that this is not something that they have spent a lot of time reflecting on and considering. Taken along with the other quotes in this section, and considering the patient experiences discussed in sections 5.2.4 and 5.3.2, this suggests that providers in general take the hearings for granted, and have few ideas about alternate mechanisms to replace the hearings, despite the fact that they are unified in the degree to which they find such hearings logistically, psychologically and therapeutically appalling. This level of change requires the intervention of the MOHLTC in collaboration with judicial bodies.

5.4.3 Better collection and use of administrative data

Several sources pointed out that there appeared to be poor collection of administrative data regarding the use of CTOs, making it difficult to assess trends in their use that may help administrators better conceptualize the evolving purpose of the CTO, its role in the mental health system, or to evaluate CTO processes in light of this evolving role. For example, one HCP participant perceived an increase in the number of racialized individuals who are on CTOs; it is difficult to understand and address what may be causing this trend without the administrative data to confirm the existence of that trend. The 2012 Malatest review of CTOs, commenting on the review done in 2005, states:

> The Dreezer and Dreezer review noted that the data on CTO consumers and their care was “dispersed, fragmented and incomplete”. The current review found that this approach to CTO data had not largely changed. There continues to be confusion among stakeholders about the data being collected. (D1)

A participant talked about the MOHLTC reporting forms that are intended to be submitted with each renewal. They stated:

> What’s going on in those patients’ lives is not at all reflected in those forms and still I think half of people don’t do them anyway. (P16)

This suggests that the data which is currently being collected is limited and what little data is collected is not relevant to patients’ lives, making such data unhelpful. Sloppy collection and distribution of administrative data regarding an intervention that represents a serious impingement on people’s right is a comment on the degree to which patients with SPMI are valued by existing systems.

As it is legally mandated that there be a review of CTOs every 5 years (commissioned by MOHLTC but completed by independent contractors), during the course of this research, I searched extensively for the expected 2017 legislated review. I sent several emails to the MOHLTC and spent time on the phone being shuttled between agencies who were intended to provide me with information regarding government actions and publications.

> First call-public number for Government of Ontario related inquiries. On hold for 38 minutes. They had no reference point for the legislated review. Put me through to another agency in charge of publications. On hold for 14 minutes. They also had no idea what I was looking for. Put me through to another number that was supposed to deal directly with MOHLTC, on hold for 22 minutes. The person who answered me here wanted to put me through to the first number again. (FN8)

Eventually, in response to one of my emails, I was sent a copy of the review, which had been published in 2019. This review, less extensive than the 2012 review, confirms that little has been done to correct this sloppy collection of data:

> Despite CTOs being available for almost 19 years, little is being done to measure client outcomes in a consistent way, both within health facilities and in the community by the MoH... The information systems designed to collect data on client outcomes contain gaps. Some client outcome measures are collected and compiled in the CTO-IR [Community Treatment Orders Information Record]. The common feeling among mental health professionals was that the MoH does not express an interest in collecting, analyzing or disseminating data on an aggregate level. The CTO-IR system is an attempt to collect such data, but considerable gaps in the data are apparent. Despite the best efforts of MoH staff, two months were required to prepare CTO-IR data for analysis. Moreover, the CTO-IR data appears incomplete when compared with data from other sources. It is estimated that the CTO-IR contains a record for approximately 38% of CTO issues, renewals and reissues. (D8)

This review, commissioned by the MOHLTC, is overtly critical of the MOHLTC. It points to several problems: data is not being collected by health care professionals in a consistent way, the system to collect data has gaps, and health care workers identify a lack of interest by MOHLTC in collecting, aggregating, or disseminating this data. Finally, gathering data from the MOHLTC for the very purpose of the review was not timely. This is suggestive of a deeply disorganized and ineffective bureaucracy, and that such information gathering and analysis is not prioritized by the Ministry. Earlier sections in this chapter (section 5.2.1 and 5.2.3, for example) discussed the way in which the bureaucratic elements of the CTO were overwhelming for patients and professionals, and how these bureaucratic elements may serve to distract professionals from a deeper examination of the CTO. This, coupled with the documented carelessness and inefficiency of the system behind the bureaucracy further suggests that true reflection about the CTOs impact is being obscured by dysfunctional administrative and logistical structures. The burden of this dysfunction is to some extent shouldered by several parties: the PPAO and the CCB, who have been managing increasingly more CTOs per year without increases in funding; the health care workers who rush around to fill out forms, attend meetings, and feel anxious about the need to keep up with new legalese; and the patients and families who are subject to a system that is not intent on improving its aberrations. The biggest weight of this burden is borne by the most vulnerable, the patients, whose lives are controlled in real and significant ways by governmental agencies that are failing to keep basic paperwork.

5.4.4 Systemic Change

Some participants suggested that better upstream interventions would limit the need for CTOs. They pointed to the need for increased social services that can act to prevent mental health problems, including increased services to young people, and social safety nets around housing:

> CTOs are not the panacea, they are a band-aid. And I think that the solution is more social, psychosocial, and sociological, and I think, you know, going back to education, the education system, going back to Housing First, going back to a whole bunch of those predisposing factors is way more important than thinking that CTOs are going to solve that problem. (P13)

P13 identifies a number of social programs that could act as primary prevention for CTOs, including Housing First, a program in which health care dollars are used to aid individuals with chronic mental health conditions in accessing housing through supplementing their rent of market apartments. Another shared a similar sentiment:

> Yeah, or even just, yeah, exactly, youth services and things like that. Heading off mental health problems. Like, in my, I have two sisters that are teachers, and the, the oh my god, the problems they have trying to get mental health help for their

> students. And in working....and sometimes they end up being like, the counselor. (P8)

One participant reflected that if more comprehensive social services were available for her family member, the CTO may not be necessary:

> F: So if your family member was in housing where he was getting, people were watching and making sure he was taking his meds
> P4: Right.
> F: Where he had, ah, where he was provided with a room for himself that he liked, and recreation activities that he liked, say, not locked because that's just, not the way of the future at this point in time, so he would have freedom of movement, but hopefully those sorts of services would motivate him to stay where he was—we can only...hope...?
> P4: Yeah, exactly.
> F: Do you think that then...would the CTO still be necessary?
> P4. (Sigh. Pause.) No.
> F: No?
> P4. No. Because he would have no reason to walk away. (P4)

These quotes evidence a perception that individuals on CTOs have experienced and continue to experience inadequate social supports, and that better social supports, including wide availability of prevention measures and counseling for individuals experiencing psychological distress, better options for housing, and availability of recreational and social opportunities would limit the need for CTOs. Yet, CTOs continue to focus only on and address only the deficits contained *within* individuals. This is consistent with the data found in this research study. These quotes also evidence that HCPs and family members feel helplessness and powerlessness in this area.

5.4.5. Renewal timing

One HCP suggested changing the renewal from every 6 months to yearly would help reduce the impact of the CTO on patients with long-term CTOs:

> It's quite disruptive, the CTO process. People often decompensate in the context of renewals because they're ticked off that people are poking into their lives again, and they're getting calls from people they don't know, and it's disruptive. And for that reason alone I would rather see it be a year and then have CTOs terminated if necessary. CTOs are almost never not renewed at least once. So, I think it would be easier for everybody if it were a year. (P16)

A family member echoed this approach, but nuanced it by deeming it applicable to a specific subpopulation of people with SPMI only:

> I feel sort of a reasonable judicious approach might be to decrease the frequency. Especially if someone has had x number of renewals, rather than doing it every six months come hell or highwater, that it become an annual thing after two years, or something like that. (P17)

Although on one hand, increasing the timing between renewals may improve the experience of individuals with CTOs, on the other hand, it seems to address the problems with the hearings in an incomplete way, e.g., to cut a bad process in half, instead of changing it. It also does not address the issue that some patients do value the hearings, and the opportunity it gives them to contest their CTO. The data in this study suggests that the renewal process needs re-examination on many levels.

5.4.6 Approaches to care

Participants shared approaches to care that they valued. Sometimes these were shared as an approach that worked in lieu of CTOs, and sometimes as an approach in conjunction with a CTO. One HCP described the approach she thought worked best in the treatment of SPMI:

> Well, persistence (laughs). Ah, assertive assistance, for sure. Ah, compromising... Openness. Listening. Ah, being open and listening. But also being firm. A lot of DBT [Dialectical Behavioural Therapy] type stuff, actually. Without the person needing to have, you know, a personality disorder, especially, but just using a lot of that empathy, but with expectations. You know, that kind of push forward kind of give and take. Negotiation. That's all recovery model, right. That's the high level skills you don't see easily. You don't build those skills easily. (P13)

This participant speaks to the types of relational skills that are most effective in the treatment of SPMI. Although the data showed that CTOs often create a barrier to strong therapeutic relationship, patient participants confirmed that even within the context of the CTO, they appreciated a respectful and caring relationship with their providers. One patient, when asked if there was anything he could point to that had worked really well for him, put it this way: “Just, ah, nice people” (P12). In fact, relationships were noted as a critical element both to making CTOs work more effectively, and to the care of individuals with SPMI in general. One patient noted, commenting on what made their CTO work for them:

> Well the thing is it depends on who enforces it. Like Dr. [current psychiatrist] is very calm, and she's not like, over talking to me. Like Dr. [previous psychiatrist] I felt was a very aggressive person and I'm glad he's out of my life. (P18)

A family member also reiterated the importance of a kind approach:

> Every moment, where they're, you can sense bit of kindness and empathy, with people that I deal with, in the system, it, it always really, it always really makes a huge difference to me. (P20)

Another patient stated:

> And another positive thing about that would be that they're very kind. And that's something that speaks volumes to people who are patients of the system, or whatever. So like, if you had some guy just show up and like, with a mask on, and just stare you down and give you an injection, then leave, you'd be fucked up, really fucked up. You know. At least they talk with you and stuff, and they try to weigh out your problems and shit like that, and I'm not going to lie, they're there to give you medication and to make sure you take it, which kind of sucks in its own light, but they're kind, and that to me, it speaks a lot of volume. (P22)

Each of these quotes provide evidence that calmness, respect, kindness, and empathy mediate some of the negative effects of the CTO process on the identity of both patients and family members, while also acting adjunctively to improve the positive, stabilizing effects of CTOs. This is consistent with the data from this study, which suggests that certain approaches to care can mediate some of the negative effects of the CTO on identity construction.

5.4.7 Mediating Factors

Several participants in this study reported positive effects of the CTO on patient identity, often concurrently with the negative effects. At the time of the study, many of them lived in a community situation which was to their liking. They described relationships with family members, friends, or HCPs that they found rewarding, and they had achieved a level of stability. When expressing these positive effects on their sense of identity, they often revealed specific experiences or perceptions that had allowed them to resist or mange negative constructions of self implicit in the CTO. Analysis of these reports reveals certain factors which appeared to mediate negative identity constructions.

At times, the CTO brought stability to the client, engendering a secondary effect of improving relationships. One patient reported:

> So now I think my family life is doing a lot better, and, it probably is because of the medication, now. So now everything is calm in my family now, everything is going really well, yeah. (P18)

This participant, despite several negative experiences associated with the CTO (sections 5.2.4 and 5.3.2.1) also identified that consistency of treatment, facilitated by the CTO, allowed him to maintain a positive relationship with his family. He described how much he enjoyed and valued time with his family:

> But now everything is going well with my mom. I go see her every second weekend, now, to help babysit, ah, we have a couple of new children in the family now. My sister—my sister has a two year old now...And a six months old. A boy and a girl. ...So now what we do, we help them out. So my mom takes the two year old and they keep the baby, and I just help watch, while my mom's cooking, I'll entertain him... So anyway I just help watch him while my mom...the next day she goes to church. So, she likes to take a shower before she goes to church, so usually I just watch him for an hour in the morning. Just to help her out, because she's getting that old. She's sixty something now. Sixty-one. (P18)

The participant's account suggests a sense of belonging and ownership of family events: 'we have a couple of new children in the family now'. He also has a sense of purpose ('we help them out'), and an awareness of the needs of the other members of the family ('because she's getting old'). He takes pleasure in his ability to participate in meeting family needs. These details provide a clue about the type of identity-work in which this participant has engaged, connecting these improvements to the CTO. This participant, who at times felt betrayed by his family and hounded by his psychiatrist, who was constructed as being risky and defective, and experienced being criminalized, appeared to have managed this dissonance and come to accept his CTO. His willingness to accept the CTO at this point in his life appears to be at least partly due to the high value he places on his family relationships, and the perceived effect of the CTO on those relationships.

This participant also provided another clue as to what may facilitate the management of dissonance in another statement. In explaining why he didn't mind his CTO anymore, he stated, "but Dr.

[current psychiatrist], I enjoy her company, now" (P18). Here, the patient appears to have built a working relationship with his doctor. This suggests that as much as the CTO has an effect on relationships, relationships also have an effect on his perception of the CTO: strong relationships can be what makes the CTO acceptable, and therefore effective. In this simple statement, the participant expresses his subjective experience of the psychiatrist (I enjoy), suggesting that he is giving value to his own likes and dislikes.

Another participant made a similar reflection about their family member on a CTO:

> And um, but now with the community, with the [community care team] involved, he's more appreciative, I think, of what's happening and what they've done for him...so I think it's kind of helped, having those people involved. And he doesn't ever talk about not wanting to be on it, right now... Cause he's getting benefits too; they've helped him out in a lot of ways. (P21)

This quote again evidences that relationships, (in this case shown through the participant's feelings of appreciation towards her son's healthcare providers), make the CTO palatable, and that making it palatable helps to mitigate the negative effects that it can have on identity formation. The HCPs that had formed a supportive relationship with this mother were no longer perceived by her as part of 'the system'; they differentiated as people who 'helped', and who were 'involved'.

Another patient participant who explicitly stated he did not want to be on a CTO nonetheless spoke of how appreciative he was of his relationship with his HCPs:

> There are some positives, though. Um, like if there wasn't people who were able to, you know, check in every now and then. Shit like my door and stuff [upon arrival, he commented on a hole in the door that he had made when upset], would be exponential. Like there's a hole in the kitchen wall, too. So I mean stuff like that. Because you never know when you need someone to just be like, hey, tomorrow, maybe think about it again, maybe um, be cool about it and maybe just move on with your night, and stuff like that. Basically just people to care for you when you need it. Everybody here [community mental health team]...is really very nice. Very very nice. And like I said, sometimes you just need somebody to be kind. (P22)

This participant provided insight into the specific approaches and actions that made the HCPs presence tolerable and identity preserving. He described them as people who 'check in every now and then', suggesting that they manage to be there without the client feeling surveilled. The approach was not heavy-handed; when he punched holes in things, they reminded him to ‘be cool’ and ‘tomorrow maybe think about it again’. This evidences an approach that is not overly risk-adverse: in such interactions, this participant did not appear to feel labelled as risky, despite occasional violent expressions of rage. His word choice suggested he did not feel a loss of control in regard to HCP involvement, but that, he instead saw them as being there when he ‘needs it’. Finally, he identifies that the HCPs are ‘nice’ and ‘kind’; qualifiers that allow the CTO to coexist with an experience of connectedness and agency.

A participant described how well her son was doing while on a CTO, compared to previously:

> But now that he’s with the ACT team and the community order, they seem to be working really well together, like he is not 100%, but I’ll tell you how it works with the [outreach] team, and the community order in place, because the nurse goes to his place now to give him the needle, every second week on Monday. My son, has the tendency to do marijuana, and this is what I know, this is what works for him, that because he knows that he is going to be confronted with somebody, now for him it is twice a week, because, he has someone that comes in on Monday and checks in on him, and then on Wednesday they go on an activity, so he may choose to do his marijuana maybe Friday night, but kind of be back to normal on Monday. I’ll see the results of it, but they won’t, and I have to explain that to the workers. So, but, if there was nobody involved, and the community order wasn’t involved, well he would just be on marijuana, he would just keep being on it and on it and on it, and really deteriorate badly. So they kind of keep him on track by just being there and by keeping an eye on him, that keep him on his toes, I guess you would call it. (P21)

This quote provides some interesting details about how and why care is deemed successful in this case. The patient referred to here has a CTO, a rent supplement, and a community treatment team working in concert. The presence of the treatment team in his life, not just for injections, but for other activities as well, is said to help him maintain a positive mental space. Though this is not a targeted addiction treatment, this presence in his life seems to be having a positive effect on his substance use. This approach is not highly technical, and yet it requires a sophisticated skill set on the part of the HCPs: to ‘check-in’ without creating an atmosphere of surveillance, to motivate (‘they go on an activity’) without duress; and to create routine and structure through their own practice of consistency, as opposed to through instructions and demands. This suggests that the negative effects of surveillance and monitoring can be reduced when these activities are approached skillfully.

One participant had a sister who had been living in a shelter prior to the CTO, and due to a fear that someone in the shelter was going to kill her, a fear that was magnified by her illness, she had stopped leaving her room, even to go to the bathroom, and was constantly suffering from intrusive thoughts that were causing her a great deal of suffering. Her brother described the overall effect of the CTO this way:

> Well, you know, she has had a number of hospital stays in the interim, ah, so it's not been perfect, but the level of support, the consistency of support, the fact that it was in the intervening years, the 20 or so years, that have passed, I would say, 90% of the time, she was functioning quite well. And ah, it reached the point where, in 2008 or so, she had been hospitalized for a time, and when she got out she was living with her then ex-husband. By then they had divorced, but they were still on friendly terms, and she, moved in with him, and eventually I was able to get a larger apartment for them so they had enough space. And they were living in that situation, independently, and supported, through to about a few years ago. (P17)

This quote provides a report of a significant positive change after the initiation of a CTO. It also provides some clues as to what accompanying mechanisms allowed the CTO to have a positive effect. Again, subsidized (this time by a family member) independent housing was a big factor. This patient had ongoing relationships with her brother, her ex-husband, and a treatment team. Both relationships and housing are positive identity-producing factors.

5.5 Conclusion

The data from this study exposes the various processes that make the CTO fraught with dissonance and contradiction. These practices have the goal of making life in the community possible for people with SPMI, a life which is deemed to be less restrictive than life in an institution. It is intended to offer the person with SPMI the full availability of resources, independence, and opportunities to live a meaningful life. The data from this study confirms that de-institutionalization created scenarios for many individuals where their needs were not being met, and that the question of how to care for people with SPMI while facilitating community integration continues to pose challenges to providers and families; it also shows that at times, the CTO can act as a clinical tool which brings a level of stability to extremely distressing and untenable patient contexts. At the same time, the data from this study demonstrates that various elements inherent in the CTO (e.g., its many steps, involvement of police, adversarial hearings, conflicting priorities, etc.) act to limit the opportunities, the self-concept, and the agency of individuals in ways that constrain their ability to integrate into communities, to engage in relationships, to feel safe and secure, and to live meaningful lives. Further, the very legal protections intended to protect the patient from misuse of the CTO, in their current form, set up healthcare providers as the adversary of the patient and thereby undermine critical therapeutic work. The implications of this are discussed in the following chapter.

Chapter 6

Discussion

This research study critiques a current medico-legal practice used in Ontario and around the world; I formed the questions that guided this study as a working mental health nurse who took part in this practice, with an awareness that I was employed in a healthcare area that had a difficult and at times ignominious history, and with an interest in facing head-on the potential negative outcomes of this practice. This study is an opportunity to reflect, without flinching and without defensiveness, on the possible harms CTOs may cause, with an understanding that this is an essential part of reflective practice (Goldman et al., 2014; Webster et al., 2020). This engagement in critique is an optimistic and hopeful undertaking, born out of the conviction that reflection has the potential to lead to clearer thinking, improved processes, and improved outcomes. Becoming aware of the potential harms of the CTO, as well as coming to terms with the areas in which we (HCPs) are simultaneously powerful and powerless (Broer et al., 2014)—counter-intuitively, perhaps—has the potential to make our practice less harmful, check the degree to which we use our position of power, and give our patients a little relief from our insufferableness and our hubris. Being aware of our flaws and our shortcomings makes us better at the art of accompaniment (Whelan, 2015), shifting us away from conceptual frameworks which drive us to try to fix people, to dismiss or diminish the suffering of those we are not able to fix, and to feel the need to maintain control or the illusion of control; and moving us toward conceptual frameworks which drive us to become better at walking with our patients and their families through the good and the bad, the elements of their suffering that we can help with and the elements that we cannot.

This study examines the CTO through an exploration of the conceptual structures and narrative fictions that form the mental health system, and which, most of time, are presumed to be self-evident. My hope was that by creating greater consciousness of the values and beliefs that underlie the CTO (through an examination of how it constructs identity) and the impact of these values and beliefs on individuals and society (through an examination of how this identity is experienced), I could loosen and untangle this conceptual knot and thereby bring into question the logic that led this practice to ‘make sense’ in the current landscape of mental health-care. I also hoped that this untangling would bring into question the logic that led to binary examinations of both the CTOs efficacy and its ethical soundness (e.g., Does the CTO work or not work? and How do we balance autonomy and well-being?)—examinations that seemed to lead to decreased clarity and increased inscrutability. This approach seemed germane in that the CTO itself is a complex conceptual apparatus, an intersubjective and immaterial reality formed out of other conceptual structures, which nonetheless affects material beings and temporal events (e.g., an injection given to a patient by a nurse). In this study, I attempted to break open the black box of the CTO in order to examine its constitute parts, both conceptually (that is, its many interwoven discourses) and practically (that is, the many steps that make up the CTO process). I then considered the impact of these discourses and these steps in the CTO process on the day-to-day experiences of the people involved. This revealed that the CTO is made up of several foundational and sometimes contradictory conceptual structures—including the assumptions and beliefs that underscore the mental health system, and the assumptions and beliefs that underscore the legal system. Ultimately, considering the research data, I do not think that coercion, although it is a superficially uncomfortable concept for our individualistic society (Molokysnski et al., 2016; Paradis-Gagné et al, 2021), is in and of itself the harmful part of the CTO; some type of mandated care is consistent with valuing and caring for people with SPMI. Instead, the data reveals that it is more insidious concepts, including concepts that are superficially comfortable, such as ‘reducing risk’ and ‘protecting rights’, that become harmful as they manifest throughout the course of the steps of the CTO process. Being open to the possibility that there are sometimes where mandated care is of value creates an opportunity to crack open the practice of coercion and develop a better understanding of what circumstances lead to the use of coercion, and what practices mitigate the harm of coercion (both to the individual and to society). Willingness to suspend judgment as well as legal or moral dicta could, in this way, lead to both a reduction in its use and a reduction in the harm it causes when used.

In this discussion, I begin by relating the data analyzed in the previous chapter back to the theoretical framework and existing literature for this study, considering explicitly how this analysis aligns with the understanding of how the CTO can affect personhood as was proposed in chapter three. I consider how, in light of the data, the steps of the CTO can be seen as an expression of governmentality, and what consciousness of this could mean for the health-workers who are participating in these manifestations of power. I then discuss how, considering the data, the steps in the CTO can affect the process of developing a self-image as proposed by Grosz, and how awareness of this could affect the way we conceive of the efficacy of the CTO or its potential side effects. I consider how these two ways of looking at the CTO—as an expression of political power, and as a factor in psychological experience—are like two sides of a mobius strip, two elements leading into each other and affecting each other. I consider how dissonant voices or expressions of alternate values appeared in the data and propose that any reconsideration of the CTO process (in light of this understanding of the interconnectedness of political and psychological realities) needs to be rooted in a conscious consideration of what values we wish to imbue into this process. Drawing from the data, as well as from the literature, I propose an alternative value structure, one that judges the CTO process based on its effect on connection-disconnection. Finally, I consider the limitations of this study, and make recommendations for practice, policy, education, and future research.

6.1 Step 1: Becoming aware of our own and others' constructed identities ultimately allows us more freedom

In chapter three, I reflected on how governmentality, a concept developed by Foucault to explicate the means and objectives of power in modern western states, could inform our understanding of the CTO. This critical ethnographic account of the CTO and the culture within which it is used further exposes features of the CTO that can be related to a governmentality framework.

Governmentality involves a "specific, albeit complex form of power" (Foucault, 1991, p.102), such as the power which travels through pastoral agencies, (e.g., health care bodies, churches, schools).

Through pastoral power, the amorphous agenda of the state becomes unconsciously carried out through care activities; pastoral agents (e.g., ministers, teachers, healthcare providers) inadvertently engage in control of populations for the benefit of the state (Foucault, 2007). Other researchers have examined ways in which power travels specifically through the provision of psychological services; psychology, as a field of knowledge and a field of practice, is a powerful means through which to constitute the subject, a process which can mold individuals to better serve the needs of the state (Dreyfus, 1987; Perron et al., 2010; Roberts, 2017). In this study, health care providers' power emerged in several ways. They had the ability to declare who was considered a risk and decide the degree to which they were going to respond to that risk. The concept of risk was vague enough that its interpretation rested on the judgment of the HCP, while allowing the deployment of intricate state apparatuses, including the police, in order to control this perceived risk. Governmentality includes, as "its essential technical means, apparatuses of security" (Foucault, 1991, p.102). The results of this study demonstrated that the CTO relied on a collaboration between mental health providers and police, making the police agents of psychiatric power. HCPs had the power to decide what was in the best interest of the patient, and the ability to deploy sophisticated justifications in the form of clinical discourses to make their opinion and belief about a course of action appear to be absolute and self-evident.

The intricate rituals in which HCPs' judgments were brought into question (the CCB hearings) were in fact designed in a such a way that they often amplified their perspective; in this ritual, cloaked in the guise of a fair process, the HCP had the appearance, the comfort level, and the skills to manoeuvre convincingly and therefore successfully; they also had little to lose. Their 'opponent' on the other hand—the patient—came to this ritual without a highly developed ability to know and discursively manipulate clinical discourses, without the apparel or attire to convey power (institutionalized poverty plus a dearth of employment options limited the patient's ability to 'power dress'), and much more to lose. In this ritual, personal information about the HCP was off-limits, whereas personal information about the thoughts and feelings of the patient were scrutinized, analyzed, and categorized using another sophisticated discourse, that of psychiatric diagnosis and labelling. Use of this sophisticated language, believed to be neutral and scientific, was considered more credible than other methods of describing powerful personal experiences, and patients were penalized for failing to understand their experiences through the lens of psychiatric discourse, even though this was a discourse that labelled them and reduced their power. This was evidenced through use of words like ‘insight’, a term that referred to the patient’s willingness and ability to interpret their inner life specifically through the lens of psychiatry, and a willingness to see themselves as needing psychiatric treatment. As further evidence of the degree to which this relationship was unequal, HCPs’ private spaces (like their private thoughts and feelings) were off-limits, but patients’ were not. In the course of providing community-based care and treatment, HCPs regularly entered into patients’ homes. Their presence was sometimes welcomed and sometimes not, but either way, they brought an element of surveillance and psychiatric interpretation into patients’ personal spaces.

The exercise of this power is rooted in a logic based in the government of populations, another key feature of governmentality (Foucault, 1991). This population view emerged through the discourse of ‘resources’. CTOs were seen as beneficial to the mental health system because of their ability to reduce the risk of ‘revolving-door’ patients, and therefore to halt the flow of certain resources to patients who may use them unpredictability and in excess (Barron, 2016; Malatest, 2012). Herein lies evidence of the economic purpose of the CTO: it was a method of controlling and regulating the movement of fiscal resources. A CTO itself required extensive resources–including psychiatrists, nurses, lawyers, the CCB, the PPAO and the police. However, the CTO used resources more predictably and therefore manageably, often in the form of wages for professional services; this had overall benefits for the economic system.

The logic of population management is also seen in the discourse of ‘risk to others’; the idea that restraining some individuals due to their potential for harm (differing from the criminal justice system, in which non-psychiatrized people can only be restrained based on the actual harm they have caused) was justified to keep the general population 'safe'. Violence perpetrated by people with mental illness makes up a very small percentage of the of violence perpetrated by people among the general population (Appelbaum, 2020); however, mental illness, especially schizophrenia, continues to be associated with increased perception of risk of violence in the general public (Pescosolido et al, 2019). This perception is reinforced by the colloquial name that the CTO takes on in different jurisdictions. In Ontario, for example, it is called 'Brian's Law', after a newscaster who was killed by someone experiencing untreated psychosis. This may indicate that coerced treatment of people with mental illness is a means not to reduce violence per se, but to calm the collective anxieties of the population without needing to address root causes of mental illness or societal violence, or to change social structures that may promote them. This study revealed that the language of risk has permeated mental health care environments and infused a sense of responsibility into HCPs toward populations. Since, in this study, participants with CTOs had often experienced previous violence, instability and trauma, the CTO's actual function could be seen in a more insidious way—as protecting the population not from violence, but from witnessing and responding to the emotional and cognitive distress of hurt people, something that may in fact prompt them to see the failures within the current system.

This power is exercised through the application of complex knowledge. Foucault argued that knowledge, truth and power are intricately intertwined: power allows the powerful to develop knowledge about subjects; knowledge in turn creates and increases power (Mills, 2004). When initiating a CTO, HCPs accrue large amounts of detailed information about patients, recording this information in medical charts, legal forms, and provincial records; this one-sided acquisition of knowledge creates and cements their power over individuals and helps transform them into psychiatric subjects. In this study, for example, one patient spoke about things that had been recorded about him in his chart several years ago by his doctor, and how he still refrained from speaking about some topics for fear of having this previous physician's interpretation reapplied to his thinking process. He was conscious that not only was this information documented and unchangeable, but that it would continue to follow him through his life. Because this document called into question his self-knowledge, his own interpretations of his experience became a taboo subject, something that could lead to serious consequences. The HCPs' knowledge of him, in contrast—knowledge translated into truth through the use of complex clinical language, professional status, and documentation practices—was capable of rallying institutional power and being translated into the use of physical and chemical restraints, ongoing surveillance, police actions, and forcible detainment.

The CTO processes themselves represent complex webs of bureaucratic steps, legal nuances, and clinical practices (especially medical and nursing practices). As shown in this study, a CTO required HCPs to understand and manipulate information about a complex web of legal forms, case law regarding applications of the mental health act, diagnostic criteria, complex pharmaceutical technology, and the patient's (and sometimes their family's) illness and social history. In contrast, HCPs were not under similar imperatives to understand and manipulate information about treatment side effects or alternatives; this was evidenced by the way HCPs in this study struggled to articulate their thoughts about the negative consequences of the CTO, about the negotiations in which they engaged to make the CTOs work, or even about the alternative, relational skill set that is used in the care of people with SPMI. The CTO created a bureaucratic imperative where technical, organizational, regulatory, formal knowledge functionally trumped personal, specific, informal knowledge. The first type of knowledge was vague and ill-defined in a way that allowed it to have broad, sweeping implications (e.g., posing a risk; provision of care and treatment) and at the same time had a form and a language that masqueraded as precision. It was superficially complex without depth of meaning. The second type of knowledge was personal, nuanced, and definite, and yet could be challenging to articulate; it could sound superficially simplistic (e.g., being kind, showing respect), but had depth of meaning. This study provides an example of how prioritizing one kind of knowledge over the other comes at a cost to relationships: when an HCP was required to focus in on blunt, technical forms of interpreting their patient's thoughts or behaviours, for a regulatory purpose, they became less attuned and responsive to the patient's personal experience. In addition to this, when a patient was exposed to a blunt, technical interpretation of themselves, for example during a CCB hearing, it was apperceived as a betrayal of their depth and nuance. HCPs described this as being traumatizing to patients, and patients reported feeling targeted and dominated. This adds to and is consistent with findings in previous studies that show that patients feel that the CCB processes are not procedurally fair (Paul et al, 2020), feel ambivalence about the CTO (Light et al, 2014; Newton-Howes & Banks, 2014); and see it as remote to their goals and individual preferences (Strensrud et al, 2015).

Foucault's definition of governmentality states that the exercise of this power results "on the one hand, in the formation of a whole series of specific governmental apparatuses, and, on the on other, in the development of a whole complex of saviors" (Foucault, 1991, p.103). The CTO relies on multiple complex apparatuses: hospital emergency rooms, community care teams, police, the CCB, and the PPAO. These organizations themselves are complex outbranchings of governmental, medical and legal entities. The CTO is also enmeshed within the complicated web of social services and semi-private housing services that provide livelihood and residence to the population of people with CTOs. In addition, the CTO has an interdependent relationship with a host of *savoirs* that emerged over the course of this study: the discourse of evidence-based practice, the hopes and ideals of de-institutionalization, the discourse of risk, the clinical discourse of diagnosis, a bio-chemical understanding of the human experience, and the discourses of individualism and neo-liberal economics, all of which assign a precarious position to persons with SPMI.

Seeing the CTO through the lens of governmentality is on one hand a philosophical exercise that pushes us to consider the host of ideologies, scientific and social discourses, and legal and medical structures that are interwoven with the CTO, and to consider how the amorphous web of governmental power flows through the work of institutions, clinical interventions, heuristics, and individuals (often without their conscious awareness). The logic of power is to maintain itself, to protect its interests, to maintain the status quo. This is why

> It is the hardest thing in the world to maintain an individual dissident opinion, as a member of a group. . . (Those who are able to do so) are few. Very few. On them depends the health, the vitality of all our institutions (Lessing, 1986, p. 50,54, as quoted in Andersen, 1990).

On the other hand, the purpose of governmentality, as it was conceived by Foucault, is very practical. It is to "make it possible to bring out the freedom of the subject and its relationship to others—which constitutes the very stuff of ethics" (Foucault, 1997a, p.300). The CTO, as it decreases the amount of time that patients spend confined in hospital, is intended to make patients more free; the concept of governmentality, however, exposes the nuanced and less visible ways in which freedom can be constrained. In the previous chapter, I considered how the processes that make up the CTO constructed an identity for each of the participants, creating actions and attitudes for each of them that seemed inevitable; by becoming aware of the complex apparatuses and *savoirs* entangled with the CTO, participants in this process have the opportunity to become more able to discern the influence of these apparatuses on their choices and actions, and as a result, become more free to choose the way in which they will relate to themselves and to others. This is the first step in a process in which the end goal is to choose which values we want to influence our actions, and then set out to design processes that are in alignment with these values.

6.2 **Step 2: Sensitivity to how constructed identities are experienced helps us to establish our values**

The identities constructed for patients, family members and clinicians by the CTO process existed at an experiential, phenomenological level for the participants involved. In chapter three, I used the work of Elizabeth Grosz (1994) to consider how the CTO may influence the experienced identity of the participants. In her work, she discusses how an individual develops a mental representation of themself within a particular environment or context; in other words, that self-knowledge is gained through interaction—that we discover our own contours by becoming aware of where we abut with the world. Self-image has a material reality, a physical, biological, neuro-chemical existence within a person's brain; self-image also has real effects on the way a person interacts with their environment, or milieu—that is, on their agency (Grosz, 1994). One relevant example of this can be seen in the theory of social defeat, a theory regarding the etiology of schizophrenia (also described in more detail in chapter three) that proposes that defeating social experiences lead to changes to brain chemistry that develop into the set of symptoms considered diagnostic for schizophrenia (Selten & Cantor-Grae, 2005; Selton et al., 2016), symptoms in which the person encounters their own thoughts as if those thoughts were outside of themselves (i.e, disruptions to a cohesive identity), resulting in a severe loss of perceived agency (Kingdon & Turkington, 2005; Grosz, 2017)

The theory of social defeat requires us to consider the social experiences of individuals prior to symptom manifestation and diagnosis. However, the literature demonstrates that individuals who experience the symptoms of and receive a diagnosis of schizophrenia, continue to experience defeating social interactions. People with SPMI often experience entrenched poverty in a well-off society, lack of employment, lack of romantic relationships or children (when these are desired) and lack of stable or independent housing (Luhrmann, 2007; Zaske et al, 2018). Social defeat is further entrenched when social markers (vocation/employment, home, family) become replaced by experiences of the system, in which the patient occupies a singular, non-reciprocal role in which they have absent or diminished power. Because of the stigma associated with mental illness in our society, a diagnosis of psychiatric illness can itself be an experience of defeat, a humiliation that challenges one's ability to maintain a positive self-identity and changes the way one relates to themselves and others (Aakre et al., 2015; Goffman, 1961; Inder et al., 2008; Taylor & Perkins, 1991). This study provides evidence that the processes that make up the CTO in themselves form an experience of social defeat. In this study, multiple patient participants discussed their experience of the CCB hearing as an experience where they felt ganged up on and defeated. Experiences with the police, where any argument that they made about their ‘innocence’ was discounted as further proof of their insanity, were also experiences of defeat. Participants experienced humiliation and a loss of feelings of power and control when the police showed up at their home, handcuffed them, and brought them to the hospital, or when they appeared before the CCB and had to submit to a predetermined process and outcome. Family members also reported struggling with experiences of stigma around their loved one’s illness, and around the experience of CTO related processes. These experiences had consequences for their sense of themselves (e.g., feelings of shame), and for their relationships with friends and spouses; they also manifested in their relationships with care providers and with the system in general.

Further to this, identity-forming experiences of social defeat are entrenched by isolation and ameliorated by social connections (Selton & Cantor-Grae, 2005). While the rhetoric around CTOs suggests that they preserve patients’ ties with their communities, this study provides evidence that they act to disconnect people from their families, support people, and community involvement in several ways. Patients with CTOs integrated an understanding of themselves as risky, as criminal, and as outsiders to mainstream society more broadly. They reported feeling disconnected from family members due to their participation in a CTO. HCPs as well report negative effects to their relationships with patients because of the CTO processes. A community treatment order is intended to support people living in the community, to provide an opportunity for greater integration into communities and greater access to opportunities that would be available within mainstream society. However, the institutionalized poverty sustained by weakened social support systems combined with ongoing social stigma created a situation where many of the patients in this study lived in the community without experiencing integration or the full benefits of community participation. They continued to live in institutionalized living environments, and to experience a lack of personal safety, exposure to hardships such as abuse or illegal substance use, lack of access to social or work activities, lack of social opportunities, and cramped living arrangements.

In some instances the increased stability brought by the CTO, in concert with other supports, showed evidence of having a net positive effect on the patient's relationships—their connectedness to their family, friends and care providers. Considering the potentially ameliorating role of social connection to the experience of social defeat, it is worth noting what factors played a role in this. Where mandated community treatment had a positive effect on patients, the approaches that supported relational connections in the context of a CTO were those that directly counter-acted the ethos of the CTO in its current form: being risk tolerant; reducing the bureaucratic hurdles that must be experienced by the family and patient; showing kindness and empathy in interactions; giving the patient autonomy about how much they wanted to express of their interiority; giving the patient ownership of the patient-provider interaction; providing alternative activities (e.g. not all interactions with providers being centred around treatment); fostering environments that were comfortable for the patient; reducing hierarchy through communication styles, and language; normalizing/humanizing (as opposed to medicalizing) experiences of distress; providing for basic needs; modelling consistency; and fostering self-worth.

In the study, HCP participants expressed dissonance about participating in situations that they saw as potentially defeating to patients, while still seeing mandated care as serving an important purpose. This is consistent with other studies that highlight the conflicting feelings HCPs have about CTOs (Edan et al., 2019; Stuen et al., 2018). They saw relationships as fundamental, and the damage to relationships done by the hearings as damaging to the work they did with patients as well as possibly causing trauma in the patient. They saw the patient's voice as quieted within the setting of the hearing, and the pick-ups by the police as traumatizing and humiliating. They saw their therapeutic rapport with patients eroded to the point where they could no longer provide essential supports to them regarding needs like housing, and physical health. This dissonance is itself evidence of the HCPs sensitivity to the nature of the experience for the patient, as well as evidence of the alternative value structure that they are maintaining (one that values connection) despite their involvement in a process that they see as disconnecting. Family members, despite the relief the CTO brought them, expressed concerns about the way that acting as an SDM may be seen as a betrayal, and may jeopardize their role as an advocate for their relative. They had ongoing concerns about their loved ones' wellbeing and frustrations about the way that the social service, mental health care and legal systems worked, and they reported that they felt their concerns were dismissed or undervalued when expressed to health care providers or legal professionals.

Each of these experiences—the patient's experience of defeat, the HCP's experience of dissonance, and the family member's experience of frustration—resulted, in varying degrees, in a sense of powerlessness. As shown in the last chapter, the CTO acted to instrumentalize and reduce the role of the HCP, to functionalize and instrumentalize the role of family members, especially SDMs, and to label and restrict the identity of the patient. These constructed identities restricted the agency of each group; their actions were defined and constricted by their role in the CTO processes. This is a manifestation of the way in which identity can affect agency; agency—the extent to which one understands oneself as being able to impact one's surrounding community, or milieu—is a dependent on the degree to which one understands and experiences one's role in that milieu. The perceived inevitability of certain outcomes creates an inevitability to actions; and reflection on the prevailing factors feels so complex and nuanced and big that one can get lost in it. In such contexts, individuals can lose sight of their values, and their ability to act in a way that supports their values diminishes. By default, they become invested in the smooth operation of the day-to-day processes of the larger system (Rudge, 2011). Health care providers, patients and family members learn to value both themselves and those around them for the degree to which they are compliant and keep the system working.

6.3 **Step 3: Owning our agency—**

As our context creates our actions, our actions create our context

Through a review of governmentality, I discussed how the CTO process could be understood as an outgrowth of the ideologies and values that exist within large, amorphous cultural and political systems and practices, and how these systems construct the identity of their subjects (including patients, family members and HCPs). I then discussed the experience of these constructed identities, and how they could have an overall effect on agency. In this way, this discussion, so far, has been focused on the effect of environments and contexts on individuals. However, the connectivity between systems and individuals necessitated by this view means that individuals also have an effect on systems. Systems can affect an individual's role, self-perception, and action; inversely, individual's actions affect their self-perception, which affects their function in the larger system, which ultimately can affect the functioning of the larger system. In this way, although human beings are intricately interconnected with each other and with the material and conceptual environments that they inhabit, they are also constantly recreating that material and conceptual environment, like cells on a living body which are constantly renewing themselves (Foucault, 1997a; Grosz 2017).

When HCPs, family members and patients take part in the practices necessitated by the CTO, they may reinforce its logic and self-evidence. Small everyday actions have a capillary effect; they seep into and through the overall system (Foucault, 1976; Grosz, 1994). These small actions can work to reinforce and recreate existing power structures; for example, when HCPs' time is spent focused on the bureaucratic elements of care, complying with necessary paperwork more than reflecting on care practices, this reinforces the power and importance of the legal and administrative structures. Small actions, however, can also work, through their capillary effect, to enact change, especially when originating simultaneously and regularly from multiple sites. For example, when a nurse refuses to cooperate with a police officer who is inserting themselves into a patient's personal space, or a family member questions their relative's overall quality of life under their CTO, or a patient refuses a construction of themselves as 'risky', this has the potential to disrupt the current structures and cause a ripple effect that may lead to gradual but larger changes over time. Literature that draws attention to and critically reflects on the way that the language and the processes of the CTO act to define and construct individuals can also be disruptive of current structures (Barron, 2016; Fabris, 2011).

Foucault states that “in power relations, there is necessarily the possibility of resistance because if there is no possibility of resistance (of violent resistance, flight, deception, strategies capable of reversing the situation), there would be no power relations at all” (Foucault, 1997a, p.292). He goes on to argue that some conditions, in which power is unequal, make freedom more difficult. However, “liberation paves the way for new power relationships, which must be controlled by practices of freedom” (1997a, p.293-294). Along the same vein, Grosz acknowledges that there are circumstances that diminish or enhance our ability to engage ethically. However, she speaks of the role of ethics as defining the way one “live[s] in the world, act[s] in the world, make[s] things and oneself, while also creating values that enhance oneself and one’s milieu, not through pre-existent values but through acting, making, and doing that generate new values” (2017, p.255). Combining Foucault’s focus on the politics of relationships and Groz’s focus on the ethics of being provides a multi-faceted approach to reflect on the ethics and politics of identity construction and the production of agency.

With this in mind, taking the time to consider how the CTO constructs identities for the parties involved, how these identities are experienced, and how they limit the participants’ agency is the precursor to carving out space and language for the consideration of what value set we wish to consciously enact. “Ethics is the considered form that freedom takes when it is informed by reflection” (Foucault, 1997a, p284). Moreover, making careful, conscious changes to CTO policy and practice has the potential to influence the structures and concepts (the apparatuses and *savoirs*) that have been fundamental to creating the logic and form of the CTO in the first place, thereby taking steps towards new structures and new power relationships which are less oppressive, and less constraining to individual agency.

6.4 **Step 4: Defining our values**

Over the course of this research study, alternative values emerged. Consistently, HCPs, patients and family members favoured actions and concepts that fostered connection and expressed distress about actions and concepts that led to disconnection and alienation; CTO processes were seen as positive to the extent that they led to connection and negative to the extent that they led to disconnection. For example: a patient expressed distress about the potential for his CTO to be disruptive to a new romantic relationship, several HCPs were concerned about the damage that the CTO did to therapeutic rapport, and a family member spoke of how her brother saw her signing of the CTO as a betrayal. Alternatively, when the CTO was viewed as positive, it was due to its ability to foster connections. For example, a patient reported that the CTO was likely a factor in allowing him to participate in a consistent way in family activities, a family member found the CTO had allowed a connection between himself and his sister that had been impossible when she was in a psychotic state, and HCPs reported increased engagement with some patients while they had a CTO. This is also consistent with literature that reports on patient, family and clinician experiences of CTOs (Canvin et al. 2014; Corring et al., 2017; Corring et al. 2018a; Corring et al. 2018b; Pridham et al., 2018)

Drawing on the work of Foucault and Grosz (Foucault, 1991, 1997; Grosz, 1994, 2017), literature regarding the treatment of SPMI (Kingdon & Turkington, 2005; Longden, 2012), literature addressing the importance of social connections in SPMI (Green et al., 2018; Rice et al.; 2018; Prince et al., 2017), literature regarding mental health systems (Chapman, 2013; Roberts, 2017; Rose, 1990), as well as the values that emerged in the data from this study, I propose that the mechanism by which the CTO causes connection or disconnection can be understood by looking at the relationship between identity, agency and community (or milieu). I use the term ‘community’, in this case, not to mean a general sense of ‘the community’ as the opposite of the ‘the institution’, but instead to mean the persons and settings that directly make up an individual’s environment. One’s identity is constructed by the role they play in the setting they are in; the way in which one’s identity is constructed by the role one plays in one’s immediate environment effects the degree to which one understands themselves as able to act upon the world. In other words, it affects one’s agency. This is an infinite loop: the nature of one’s actions affects one’s environment, which affects one’s identity, which affects one’s agency, which affects the nature of the actions and their effect on one’s environment, and so on and so forth. However, as seen in the data, the link between identity and agency, or agency and community, or community and identity can be weakened or strengthened. For example, when an individual is pepper sprayed in their driveway by police, has handcuffs put on them, and is put into a police cruiser, they are constructed through this interaction as a criminal, an outsider to society. This construction changes the degree to which they understand themselves as having a legitimate voice within their milieu, the degree to which they see themselves as aligned with and able to affect the world around them, and the degree to which they see planning their day, their week, or their life as within their control. The increased suspiciousness or fractiousness they display because of this perception will in turn have an effect on their milieu, and so on and so forth. These events and processes will harm their ability to engage in 'normalcy' because others (such as neighbours) will henceforth ascribe this identity to them and shift their thinking and behaviours accordingly, which will also serve to reinforce this identity. Alternatively, when an individual is responded to with patience, warmth, and consistency, they are constructed by this interaction as belonging and as being of value. This construction leads to increased affiliation with and tolerance for one's own thoughts and feelings, increased belief in one's authority over one's own future, and an increased sense of responsibility within relationships. This leads to more decisive, conscientious actions, which in turn have influence one's milieu, and so on and so forth.

This value set (i.e., the valuing of concepts and action that foster connection, as opposed to disconnection, between identity-agency-community) provides a means for HCPs and policy makers to consider their actions and interventions. The steps in the CTO process can be judged by their ability to foster connection or disconnection, as opposed to being judged by vague and contradictory ethical principles. These simple principles, to the degree that they affect both the individual and their environment, are both psychological and political in nature, and they allow us to consider both the psychological and political effects of our actions in tandem. In considering how we foster a sense of connection for the individual, we can use psychologically sophisticated reasoning (currently lacking in the CTO process) to understand the effects of the experiences constructed by the CTO on the person. In considering the effects of an intervention on the environment, we can use politically sophisticated reasoning, accepting and understanding the consequences of our actions on the prevailing structures (as opposed to the feelings of powerlessness that are currently common).

This research demonstrates that many of the CTO processes foster disconnection, even though for some, the overall impact of mandated treatment, mainly in the form of medication administration, appears to be of net benefit. This research suggests that it is not mandated care itself, but issues with the methods which accompany mandated care, and prevailing contextual structures that are most problematic. Acknowledging this has the potential to move our attention away from an impenetrable macro-ethical dilemma, and toward a solvable design problem, full of myriad microethical dilemmas: that is, the question of how to shape and implement a better, more coherent and supportive process. Designing and implementing such would in turn have the effect of challenging the concepts and structures that are foundational to the mental health system and our society in its current form. In this way, redesigning the CTO could lead to better social contexts, that could reduce the need for the CTO.

The study data suggests certain characteristics of the concepts and practices that foster connection and disconnection. Interventions and processes that foster connection embody the following features: big picture thinking, collective ownership of issues, identity is fluid, experiences of defeat are momentary, an individual’s mental distress is a problem of the group, goals are specific, and benefit/intention is explicit. Alternatively, interventions and processes that foster disconnection embody these features: obscuring of the big picture, blaming/scapegoating of individuals, identity is rigid, experiences of defeat are devastating, goals are obscure and impenetrable, and benefits are vague. Examples from the study data of each of these features are offered below.

There are several ways, identified in this study, that current CTO processes act to create the features of disconnection as defined above. CTO processes obscure the big picture; both patients and family members repeatedly spoke of how they felt the CTO process was one sided, and how they felt they did not have the opportunity to tell their side of the story and to be understood. HCPs also felt that the process focused on legal nuance to the detriment of a holistic understanding of the needs of the patient. The current process focused on the deficits of one individual: the patient. The patient's failures were made explicit, while HCP, family and system failures remained hidden. The solution posed by the CTO addressed only the biochemistry of the individual, and their context was left under-considered. The process did not make room to acknowledge shared responsibility, leaving the patient feeling at-fault and blamed. In addition, the role that the CTO gives to the HCP—the expectation that they will mediate risk to the community—is also a blaming role: HCPs became the 'fall-guys', someone to be blamed when the 'hurt child' bites (Atwood, 2007, p.71). Family member participants also stated that they felt blamed at some stages of the CTO process; the culture of individual blaming left all parties feeling restrained and impotent. The current process encouraged a rigid conception of identity: the adversarial nature of the hearings, for example, required that the individual patient be defined by their worst features. Social defeat is devastating when it becomes part of a rigid identity system and is followed by isolation; the current processes required a patient to see their worst experiences as identity defining, and it encouraged isolation by constructing the patient as an outsider. It had obscure and impenetrable goals, e.g., 'risk reduction' and the benefits were general and vague e.g., 'receive care and treatment'; notions that meant different things to patient's, family members, and HCPs.

An improved process would be protective and encouraging of the features of connection, as defined above. This would require looking at the 'big picture'; for example, the hearings themselves could acknowledge the patient's illness history in context, recognizing the difficulties the patient had experienced over the course of their life and how these contributed to their current experience of emotional distress and/or cognitive distortion. The hearing could acknowledge and validate the frustrations the patient and family have had with the care or the social services they have (not) received, and note the myriad environmental factors that may have contributed to their illness progression. The mental health-care providers could be forthright about the degree to which they were unable or limited in their ability to manage experiences of human distress; this in itself could cause considerably more clarity and perspective for families. The patient could be framed as a member of a larger, struggling community, a community out of equilibrium. In this context, their illness could be seen as only one element of their identity, with emphasis put on their role in the community as a member of a family, as a friend, as a tenant or homeowner, as a volunteer or a professional (sometimes these may not exist, but their potential or their lack would still be still important to acknowledge). The patient’s emotional suffering and cognitive disconnect could be expressed and felt as the pain of the group, with the group expressing their sincere interest having the patient experience relief from this suffering, through a variety of means, that could include social, relational, psychological and pharmaceutical interventions. Other members could commit to responsibilities in this process as well. Goals would be patient specific and the way that the proposed actions were supposed to meet those goals would be explicit as well. This would ensure that everyone involved would have a chance to articulate their understanding of the purpose of the intervention.

This is by no means an impossible standard, and there are several examples in the literature of therapeutically conscientious processes achieving legally binding results; of approaches to care of people with SPMI that focus on finding a shared language with which to articulate their experience; of approaches to substitute decision making that maximize collaboration; and of approaches to regulation that prioritize wholeness and trust within communities. Therapeutic jurisprudence is a field of law that emphasizes the effect of legal processes on the psychology of the participants in legal processes. Several scholars have applied a therapeutic jurisprudence analysis to mental health tribunals, examining the dignitary potential of a pro-therapeutic approach (Diesfield & McKenna, 2007); considering its effects on the therapeutic relationships (Donnelly et al., 2011); and seeing it as potentially efficacious in recognizing and managing the contradictions and inadequacies between the social service, medical and legal systems (Perlin & Gallagher, 2018). An open dialogue approach recognizes psychotic illness as an apprehensible response to challenging internal and external circumstances, and focuses on finding shared language and shared understanding of that experience that is inclusive of both the patient and their family or other immediate community member, seeing the potential for language to create connection (Alanen, 2009; Buus et al., 2017; Bergström et al., 2018; Gordon et al., 2016). Emotional-CPR, developed by the National Empowerment Institute in the US, is an approach to mental and emotional distress that is meant to be used by lay people and non-medical professional (e.g., lawyers, police officers) and that stresses de-escalation, connection, and empowerment (Emotional CPR, 2020). Shared or supported decision making has been explored as a way to increase collaboration and reduce decisional conflict (Metz et al., 2015), and is called for by the United Nations Convention on the Rights of People with Disabilities (United Nations, 2006). Restorative justice is an approach to law enforcement and justice activities that is explicit about the goals of rules and rule enforcement for the restoration of community, that is, it has the goal of increasing feelings of trust and wholeness between community members, so that the community can move on from a disruptive event and regain equilibrium (Braithwaite, 2002). This requires both the disruptor and the person who was disrupted to consider their role in the disruptive event, to articulate the value they place on wholeness and trust in the community and in the relationship, and to conceptualize a potential way to regain a sense of connectedness and trust. Moreover, restorative justice draws on traditional practices from around the globe, drawing attention to the fact that a retributive, adversarial legal system is a fairly recent development in human history, and that its self-evidence is contestable. The tenets of restorative justice are articulated in a growing body of literature which both explicitly states the foundational values and methods of the approach, and provides evidence to support the efficacy of this approach (Braithwaite, 2002; Dekker, 2015; Saulnier & Sivasubramaniam, 2015; Thomas et al., 2019).

The fact that alternative processes exist, and yet are underdeveloped and underutilized, speaks to culturally held value structures that stigmatize and diminish people with mental illness, and culturally held beliefs that mental distress is evidence of a problem that exists within an individual, as opposed to evidence of a shared problem that exists within a larger community. These values and beliefs can translate into a lack of political will to effect change, and a lack of opportunities to voice dissident observations. Nurses are remarkably well positioned to witness and understand the nature of the flaws with our current processes; they have an educational background that attunes them to the medical perspective, they understand the biological, neuro-chemical, and pharmaceutical elements of the process. Due to the nature of their role, they are also the ones in direct contact with patients receiving injections, in direct contact with pharmacists, in direct contact with treating psychiatrists, in direct contact with the police, and in direct contact with family members. Nurses are deployed at and bear witness to intersections between the social-medical-legal-enforcement-family-patient systems. They are crucial to maintaining the flow of information between these systems, and have built up a sophisticated skill set around managing, translating and formulating information in a way that is palatable and understandable to different parts of this system—a skill set that requires the practice of empathy and authenticity, as well as comprehension of a monumental amount of information about a variety of systems and the ways these systems interact, and of how to access and manipulate this information according to the priorities of the moment. Notably, the current literature around CTOs, even the small body of nursing literature that does exist, does little to articulate or reflect on the nursing skill set or the nursing role that arises int the context of mandated treatment. This lack of clarity around the nature of the skillset and value set employed by nurses in the delivery of mandated care is an impediment to nurses understanding their role and embracing their agency in affecting change to the systems and processes of mandated care.

Current literature demonstrates that nursing practice within the context of coercive practices in general involves complex ethical decision making, and that there is an expectation that nurses will manage risk by engaging in coercive practices (Pariseau-Legault et al., 2021). This study demonstrates the types of knowledge nurses gain during the course of day-to-day care in a coercive context, and that this knowledge is generally not clearly articulated and not widely shared with other team members, or with institutional decision makers. Nurses in this study, from their epistemologically privileged position, made observations about the nature of police presence, saw irreparable damage to therapeutic rapport, reported negative outcomes of the hearings, and described the emotional and psychological gymnastics that they undertook in order to connect with patients on CTOs while continuing to give them unwanted injections of antipsychotic medications. This is consistent with other studies that reported dissonance about the CTO in staff who used CTOs in recovery-oriented environments (Edan et al., 2019; Stuen et al., 2018). Yet, these nurses did not have a sophisticated or well-developed understanding of their role in changing the systems in which they were participating. They did not have established mechanisms for communicating that to which they bore witness. Although they sought the best outcomes for their clients, and they saw flaws with the current system, they generally did not see themselves as having a potent or important voice in changing these systems. They communicated power but in one direction only. They used their knowledge in order to expertly complete tasks prioritized by their institutional and by medico-legal orders, in a way that was most palatable to the patient; however, they did not use their knowledge to change the health care or social services environments in which they functioned. They acted in a way that was consistent with an identity of 'team-player', and 'helper', but was not consistent with the identity of 'agent of change'.

This speaks to the need for better bidirectional systems of communication and influence within health care. This study suggests that the structure in which the CTO operates has an internal logic that is resistant to change, and moreover, is cumbersome, bureaucratic, and technically arcane. Nurses (or other HCPs) who wish to communicate the need for change back to this structure have no clearly defined or simple way to do this, and this issue is not addressed in the current literature on CTOs. Moreover, when HCPs tacitly support the assumption that mental health care is unquestionably the answer to the problem of mental illness, and that the mental health care system is functional and in appropriate working order, they block awareness of underlying systemic issues. In this study, HCPs were willing to express critiques of the CTO, but generally framed these critiques by citing their belief that CTOs were still a good clinical tool; since HCPs believed they were an effective tool in some circumstances, they saw their own critiques as unimportant or irrelevant. They also believed that they had no power to change the ways that CTOs worked, and their commitment to ethical propriety generally made them hesitant to question the legal structures around the CTO, and the potential damage that these might be causing clients. This reluctance to find fault with the CTO is mirrored in much of the literature, where dissonance around the CTO is superseded by the general impression of the CTO's important role in treatment (Corring et al., 2018a; Stuen et al., 2018; Mfoafo-M'Carthy et al., 2018; Pridham et al., 2018). This hesitancy around critique may function to dissuade action and advocacy that could address underlying systemic concerns that have bearing on the primary prevention of mental illness, the social supports for people with mental illness, and societal stigmas which continue to exist about mental illness and people with psychiatric diagnoses. Alternatively, if nurses and other mental health workers were to use their position within the power structure to acknowledge the systemic failures which leave them feeling powerless, they may open the door for other HCPs, family members, patients, and other members of society to better conceptualize and address these problems. If family members, patients, HCPs and others start to gain and to create knowledge of the system and its flaws, a shift in the balance of power ensures. A new truth has the potential to emerge, a truth that lays bare the destructiveness and pain brought on by, (and in some respects necessitated by) our socio-economic structures, and by fear of change.

Ironically, it can be our desire to protect our identity as moral, able helpers that acts as a barrier to allowing this connection (Lawn et al., 2015). The patient's identity is constructed as part of a narrative that involves not just the patient, but also the family member, the HCP, and to some extent the larger social and political system in which they all exist. In a narrative—a conceptual and discursive framework for understanding events and people—a change in one individual's role requires a change in the others' roles as well (Combs & Freedman, 2016). Political will to change, therefore, means HCPs and family members also need to be open to changes in their own identity, some of which may be welcome and others which may not. For example, HCPs—such as the one who watched the police enter their patient's bedroom—may need to acknowledge their complicity with police. Family members—such as the father who projected his anxiety onto his son to the point where he saw everything as a manifestation of his son's mental illness—may need to acknowledge or accept their own emotional distress. The 'big picture' thinking suggested earlier requires vulnerability of the HCP and family member not required by the current process, which works to allay vulnerability through a 'risk-management' framework. It tugs at a thread that may unravel the clothing of competence, confidence, and correctness. Although at times the unravelling of this identity may be a relief (after all, it includes the roles of adversary and enforcer) at other times, it may be challenging. Family members, as well, who may see themselves as healthy, able helpers and advocates, may find it difficult to have to come to terms with the way in which their own assumed role may be maintaining the patient in a particular role or identity. For some, the openness, exposure and susceptivity required to shift roles may feel less comfortable than the rigidly guarded identities constructed by the current process.

6.5 Limitations

This study had a number of limitations. It included only two research sites, and therefore represents the culture of those site. As an ethnographic investigation of the CTO, this study examines the culture and beliefs around the CTO and it can only partially comment on the CTO's efficacy for standardized outcomes such as quality of life, treatment compliance, and admission to hospitals. One research strategy, intended to begin a dialogue to explore potential concrete solutions, became unfeasible; this study originally planned to include a mixed focus group in which I would present the initial result of the data and then ask participants to participate in co-constructing the future of the CTO, considering both the values they would want represented in the process, and the process elements themselves. The global pandemic that occurred in the middle of data collection impacted my access to research sites and to means of recruitment, and ultimately led to the decision to remove this focus-group step from the study. The pandemic also limited the amount of time I spent in direct observation of CTO processes and care. I am a nurse with experience in this practice area; although this had some positive impacts on the study, it also meant that I entered the data collection process with pre-existing experiences and ideas about CTO processes. Nonetheless this study involved interviews with a wide variety of participants, document analysis, and direct observations, and thereby offers evidence based in a variety of perspectives and depth of analysis.

6.6 Recommendations

A number of recommendations emerged from this research, including recommendations for practice, policy, education, and for further research.

6.6.1 For health care practitioners:

Nurses and other HCPs should approach care in a way that fosters connection and not disconnection. There are practices and perspectives which can ameliorate the disconnecting elements of the CTO and improve its effect on connection. These require a highly skilled approach that, as emerged in the data, tolerates risk; shows respect for people's personal spaces; does not punish non-disclosure (e.g. allows some level of interior privacy); teaches patients about emotional and cognitive boundaries (e.g. encourages some level of interior privacy while also creating the context for self-valuing, self-worth, and intrinsic goals); role models consistency; uses routine support, accessibility, and listening (i.e., to the patient) as a mode of monitoring for signs of relapse (in place of surveillance); and utilizes psychologically sophisticated reasoning in relating to families (e.g. does not fall into the simplistic dynamic of sick person/well person). This approach reinforces the dignity, humanity and worth of the patient through kindness, and tolerates assertions of autonomy, even when they increase risk to some degree (e.g., the desire to live independently, the desire to see providers less). It involves including patients and families in discussions about instigating a CTO or renewing a CTO, when it will be of therapeutic benefit; making the CTO as much a part of the background as possible, when this is of therapeutic benefit; minimizing use of the police when possible; and managing the use of the police when possible (e.g., directing police action to be least forceful, humiliating and disruptive). This is especially relevant for nurses as, since nurses are the ones to give the mandated injection to the patient, they are often the ones to engage in communication with the police when the patient refuses the injection, or act in collaboration with the police (either in the community or in a hospital setting) to provide the injection.

An approach to care that fosters connection includes actively seeking out opportunities to debrief with patients after police involvement and after CCB hearings; revealing dissonance about inadequacies of the psychiatric and social systems when this is of therapeutic benefit; encouraging narratives of the self that allow the patient to conceive of themselves as more than a ‘patient’, even when these narratives may make patients less acquiescent or less co-operative with care activities; and actively dissuading a sense of the CTO as a moral statement or a punishment, even when this perception creates compliance in the patient. This approach uses a team model in a way that respects the patient’s feelings about the CTO (e.g., the support person is different than the person who acts as adversary in the hearing or gives the long-acting injection (LAI) to the patient), doesn’t use participation in psychiatric care activities as the main definition of wellness, and facilitates and advocates for accessible means of community participation (e.g., accessible and inclusive employment, accessible and inclusive recreation, accessible and inclusive housing, accessible and inclusive places of worship). HCPs participate in co-creating language for the patient’s experiences (including the experience of the CTO) that does not rely on diagnostic categories or ‘symptom’ words. In addition, HCPs admit errors, mistakes and weaknesses; does not employ the circular logic of gaslighting (e.g., ‘You’re angry’. ‘I’m angry because you’re saying I’m angry’. ‘I told you you were angry’; or ‘You have a mental illness.’ ‘No I don’t.’ ‘See? Your lack of insight shows how sick you really are.’), and work with patients to create a shared understanding of the ‘big picture’ (e.g., the patient’s personal and illness history, the environmental and genetic factors that may have led to illness, the positives and negatives that have made up their experience of psychiatric care, and the continued struggles that may be contributing to their illness presentation). In team meetings, care-planning, and documentation these values can be displayed and reinforced through the way that language is used and priorities are established for care. The same values can be role modelled to community agencies who work with this population including social supports, public guardian and trustees (PG&T's), medical care providers, police, the CCB, and housing providers.

One recommendation that emerged from the data was for providers to be honest with patients about their own feelings of powerlessness within an imperfect system, with the rationale being that sharing this experience of powerlessness chipped away at the façade of power that kept us, as HCPs, from looking at and developing knowledge about the inadequacies of the system, knowledge that could be of use in addressing these weaknesses in the long run. However, doing this in a way that is safe for a patient does require that the provider remain protective of therapeutic boundaries, and that they reveal their powerlessness in a way that has therapeutic benefit for the patient. This requires that the provider utilize excellent communication skills with patients and with other providers. For example, if a nurse discloses to a patient that she feels powerless within a system that appears to punish people for their mental illness, then the nurse must also have the integrity, acumen, and skills to articulate why she still participates in this system, what she perceives as the overall benefit to the patient, and the ways she is participating in system change. She must also have the courage and skills to voice her feelings of powerlessness to other providers with the intent of creating reflective communities of practice which also seek out ways to advocate for system change. An unhealthy disclosure of powerlessness could leave the patient feeling weighted down by the provider's problems, and could lead to a sense of alienation from one's communities of practice; when a provider aligns themselves with a patient against other providers, it ultimately leads to disconnection, not connection, for both the provider and the patient.

Providers have insider knowledge of the social and psychiatric systems and their effects on patients/families, and this knowledge needs to be utilized in policy and planning. This research demonstrated a one-way flow of information from systems to providers to patients/families. To be consistent with a patient centered approach, there should be established means for information to flow back from patients, families and providers to systems; meanwhile, providers can still design and implement means to share what they witness. It is not realistic to think of this level of political advocacy as an individual responsibility that happens in the course of HCPs’ work time or outside of it; therefore, I recommend that HCPs who are instrumental in the design of healthcare agencies or the management of healthcare teams consider methods by which to make advocacy an institutional priority, and that this advocacy utilize the voice of front-line providers. For example, agencies could develop inter-disciplinary working groups which identify priorities for system reform and engage in political action to advocate for system reform.

This research identified an apparent gap in oversight of legal practitioners; that is, legal protections exist to make sure that medical providers are not overstepping their jurisdictions and that they are acting in the best interest of patients, but there does not seem to be effective systems in place to monitor the actions of the legal professionals and legal bodies intended to be protecting the rights of patients, and to consider whether or not these protections 1) are effective and/or 2) do harm. In fact, there seemed to be a sense of innate authority given to legal practitioners by HCPs that kept them from voicing their concerns about legal practices. Because HCPs understood themselves as being monitored by the legal system, they were hesitant to speak up about the harms caused by that system. Processes should be in place that allow HCPs to speak up and report concerns when they see something that is harmful to a patient, inclusive of when the harm is being done by legal actors who ostensibly have a role in protecting the patient’s rights. The law does not have any innate ‘rightness’ or moral authority that trumps the values and concerns of HCPs, families and patients; and ‘it’s the law’ is not a valid reason to continue engaging in harmful practices.

Institutions and teams must keep records about the CTOs that they implement. Ideally, there would be a standardized method for this across the province (see policy recommendations in this section), but since there is not, there is room for this at the institutional level. The benefit of doing this at an institutional level, regardless of the actions of the Ministry of Health and Long-Term Care (MOHLTC), is that the data can be more efficiently translated into meaningful, targeted information about the team’s practice. For example, one HCP in this study suspected that there was a growing number of racial and ethnic minorities on CTOs, and that part of the reason for this was a lack of voluntary services that were able to meet the needs of this population, one that often included refugees with little social support, and people who were not fluent in English. This is an incredibly relevant piece of information for policy and service development, but since this HCP's institution did not keep statistical records, they were not able to back up their observation with data. I recommend that institutions that do not have the time or the skills to keep this data partner with universities and with masters and doctoral students in the health disciplines to engage in this process. Such partnerships have the potential to provide valuable access to data and exposure to research opportunities for students, while also providing clinical sites with new ways of utilizing and understanding the information they collect in the course of clinical work (Devido et al., 2020)

HCPs should also be in regular contact with family members, providing clear information about the abilities and the limits of psychiatric care to alter the circumstances of their relative, and should listen attentively to, and document the reports and the concerns of family members, respecting their experience with their relative's illness and their expertise in their needs. HCPs treating a patient with mental illness need to be savvy about the dynamics in families and how these dynamics may be impacting their patient; if they notice an unhelpful dynamic, they need to address this with the family, and not use it as a rationale to dismiss or invalidate the family member's concerns. Some family member participants in this study reported lingering concerns that they would experience judgment because of their relative's condition; HCPs need to be reflective about what judgments or biases they may hold about families of people with mental illness, and then assess these against current evidence. Ultimately, when possible, HCPs' goal can be to address familial issues in a way that fosters connection within families.

HCPs also need to be savvy consumers of evidence. This study demonstrated that briefs, summaries, and in-services were not adequate on their own to inform HCPs about the current evidence on CTOs; in fact they quite markedly distorted this evidence due to the way that they excluded key information about the limitations of CTOs and potential harms to patients.

Finally, I recommend that HCPs be reflective about the common discourses in which they participate. This study highlights several discourses which are used commonly within the mental health system, and which HCPs integrated into their language and thinking. For example, the discourse of risk, the discourse of evidence-based care, and the discourse of resources.

6.6.2 For administrators/policy makers:

I strongly recommended a redesign of the current processes for collecting data regarding CTOs, with a focus on gathering epidemiological data that could be useful for future research and policy development. Because we only have the ability to change the things we have knowledge about, the data needs to be inclusive of the patient and the system. This would include information about 1. Social traumas (e.g., are there higher rates of social traumas experienced by individuals with CTOS, such as, war, immigration, childhood traumas, income level, sexual or domestic violence); 2. Social supports (e.g., what supports did individuals receive to help them manage these situations, and where were the gaps?); and 3. Mental health supports (e.g. when did mental illness manifest and what approach did services take? Could a more comprehensive, coherent approach have made a difference?). By gathering information not just about the traits of the patient but about the traits of the system, we would position ourselves to find solutions that are not centred only in the biology of an individual but involve social change that both decreases and ameliorates experiences of cognitive and emotional distress. This would allow administrators to increase targeted funding for primary and secondary prevention, reducing the need for CTOs. In addition to this, meaningful indicators for whether CTOs help or do no help could be determined in partnership with patients and families. This is consistent with literature that recommends the use of data driven research and practice collaborations (Menger et al., 2016), the use of evidence in mental health policy development (Alla et al., 2018) and the involvement of service users and families in policy decisions (Daya et al., 2020).

I recommend active partnerships with researchers, stakeholders, and legal and medical experts to investigate potential redesigns of the CTO process (further comments about this below, in the recommendations for researchers). However, there are some changes that could be made without further research. There is currently enough evidence to change the timings to yearly, or rather, a lack of evidence that semi-annual renewals are providing any benefit, and evidence that they are harmful. There is also currently enough evidence that the system for rights advice is of very little benefit to patients or families and consumes a disproportionate amount of time and energy.

6.6.3 For educators

Core education programs for registered nurses, as well as other HCPs who work in mental health care, would benefit from teaching mental health content from a critical perspective (Adam & Juergensen, 2019). This would allow students to come to an understanding of the mental health system and an understanding of its limits concurrently, better preparing them for work in this complex area. For example, core programs should teach both diagnostic categories and the limits of diagnostic science in psychiatry. They could teach about the value of pharmaceutical interventions and yet also expose students to the danger of seeing mental illness as purely biological, that is, teach about the ways in which mental illness can be related to environmental, social, and economic realities. Along with teaching about environmental causes, students need to be exposed to a broad understanding the historical and political roots of these; otherwise, this can become another way to blame individuals or communities. Isolation, lack of resources, school environments, lack of acceptance, lack of tolerance for difference, gender inequality, racism, unsafe political contexts, unsecure housing contexts, and entrenched social disadvantage, among others, can all play a role in the formation and progression of mental illness. These are issues that need to be tackled from a collective socio-political perspective; they are not the problems of individuals but the problems of groups, that manifest in certain individuals.

Core programming in nursing, and other allied health professions, should teach about the history of mental health-care, including failures and injustices perpetrated in the name of mental healthcare, in order to create cautiousness in a new generation of providers. Such programming should include patient perspectives, including an overview of consumer-led movements. Teaching must take an anti-stigma approach (since many students arrive in their core mental health care classes with biases already in place) and explicitly challenge a discourse that blames and shames individuals and families (Bingham & O'Brien, 2018). Students should be taught a collaborative approach to care and treatment that expressly advocates for inclusion of patients and family members in decision making (Durand & Fleury, 2021).

Mental health teaching must shift to include alternative models of care, such as emotional CPR (Emotional CPR, 2020) and the Open Dialogue approach (Buss et al., 2017), considering the potential role of these types of interventions in the mental health system. At the same time, educators need to teach practical skills for managing working in an environment that does not always align with these principles (Varcoe et al., 2012). This requires an ability to live with dissonance, an anti-perfectionist approach (as perfectionism encourages conformity to thinly evidenced standards), communities of practice (Peternelj-Taylor, 2013), a language of microethics (Komesaroff, 2008), risk tolerance, willingness to engage in advocacy, and the maintenance of inquisitiveness about how things could be better. Students should be taught the usefulness of engaging with theoretical works in forming an understanding of complex issues such as power dynamics and impacts on identity.

Teaching about CTOs directly, which often happens in the workplace, can include information about the potential negative effects of CTOs, along with suggestions about how to mitigate or manage these negative effects. This teaching opens the door for practitioners to have open and honest discussions about their use of CTOs, as well as open and honest critiques about what they find harmful or problematic about the CTO process. This is consistent with literature that advises methods for evidence use and knowledge utilization in practice environments (Bitter et al, 2019; Mallidou et al., 2018), and literature that positions the micro-level actions taken by nurses during care as politically relevant and politically charged (Perron, 2013).

6.6.4 For researchers

This study provides evidence that current CTO processes can be psychologically damaging for the client, and, culturally, cement the exact pre-existing biases we are trying to address. Drawing on the existing literature (Boyle & Walsh, 2020; Corring et al., 2013; Nyttingnes et al., 2016; Paul et al., 2020; Nakhost et al., 2012; Weller, 2020; Winnick, 2003), I recommend that researchers, in collaboration with mental health and legal experts, and in collaboration with the MOHLTC, develop pilot studies which explore alternative designs for the legal and enforcement elements of the CTO. For example, a study that examines the effects of using a therapeutic jurisprudence model for the CTO hearings, and/or a study that uses a model based in Restorative Justice principles. I recommend that this redesign use ‘connection’, as outlined above in section 6.4, as a guiding value.

Researchers could use the improved data being collected on CTOs to better understand patterns in who the CTO is being used for, and how this may indicate gaps in services. For example, if children that come to this country as refugees have higher rates of being on a CTO as an adult, this may indicate the need for more support services for school age refugees, which could lead to upstream interventions. If children diagnosed with ADHD have higher rates of being on CTOs in adulthood, this may provide evidence for earlier diagnosis and targeted interventions with this group. Better data could also tease out the prevalence and efficacy of certain practices or environmental conditions, for example, how the presence of adequate housing changes outcomes.

This research provides evidence that the police are deeply entangled with mental health services, and that this has potentially negative effects on patients (trauma, increasing their sense of being criminals/outcasts, increased feelings of humiliation/paranoia, increased sense of powerlessness, loss of feelings of privacy/safety). More research needs to be done into the involvement of police in mental health services, and possible alternatives. For example, research could compare the difference in patient experiences between using mental health police vs police with no mental health training. There are several policing models intended to facilitate interactions between police and client or police and services (Lamb, 2002; Spaite, 2005; Puntis et al., 2018); research could compare different police service models to help determine which worked better for particular contexts or populations. This study also showed that family and community members called the police during mental health crises; researchers could examine what type of social education and service availability might decrease this tendency. A better understanding of the nature and impact of police involvement in mental health care is a critical question for the future of community based mental health care. This could add to other literature that addresses the ‘judiciariazation’ of the psychiatric patient (Paradis-Gagné & Jacob, 2020; Paradis-Gagné et al., 2020).

I recommend further research by legal scholars which examines the various legal approaches to the MHA: for example, two mindsets seemed to emerge in this data (as reported by HCPs), one where the lawyer ‘goes along’ with the hearing and the one where the lawyer tries to get the patient off the CTO at all costs, with a limited view of the big picture. Both of these seem counter to the legal point of the proceedings, which is ostensibly to protect the patient’s human rights. Although the legal system has played a positive role in monitoring psychiatric services, this does not mean that legal practices themselves have the license to be harmful. The law needs to be reflective about its role in our social world and its own values.

Research into CTOs would benefit from using exploratory frameworks that are outside of the conventional frameworks used in healthcare, for example, that of ‘risk-management’. By pushing our thinking about interdisciplinary research further, we can apply sophisticated concepts developed by philosophers and sociologists to CTO related practices, allowing for a more layered understanding of CTO-related phenomena.

The nursing role in CTOs and in mandated care more broadly has been understudied and would benefit from further investigation. Nurse involvement in mandated care requires the nurse to integrate a variety of sophisticated skill sets and complex ethical reasoning, yet nursing values and standards, such as those expressed by the College of Nurses of Ontario (CNO) do not provide guidance specific to mandated care. Nurses have an underdeveloped sense of their own agency in this area; yet, they are key to making CTOs ‘work’, and further, often act as managers of the community based mental health teams which deploy CTOs. Nursing research into CTOs could help to further define their role and provide a means to express and address nursing concerns about mandated care, concerns based on being with the client at critical moments during the process of mandated care.

6.7 Conclusion

Many patients, family members of people with SPMI, and HCPs are struggling to find ways to hold on as they move from crisis to crisis: suffering and vulnerable patients who do not have the means to search out and access supports; family members who worry every day about where their loved one is and whether they are safe; police officers and corrections officers who never intended to become de facto mental health professionals; and HCPs who enter into endless negotiations with both their patients and the system, working long hours in an attempt to achieve the better of several lousy options.

A caring society that values all members will provide some sort of care to people with SPMI, and this care may at times involve coercion of some type, as one of the features of SPMI is a resistance to treatment. On one level, the CTO does represent our culture’s interest in integrating people with SPMI into community environments, and a willingness to consider methods of treatment that do not involve the severe restrictions to freedoms, and the severe restrictions to a sense of identity that come from an institutionalized environment. However, as it stands, the CTO has significant flaws that constrain its effectiveness and cause serious negative effects for patients, and which, moreover, evidence faults in the larger apparatuses of mental health care and mental health law. These flaws include the adversarial and imperious nature of the hearings, the bureaucratic workload, the method for the provision of rights advice, the nature of police involvement, and the unidirectional focus on the actions and behaviours of the patient. The serious negative effects include damage to relationships (therapeutic and otherwise), the stigmatizing effect of the process, the trauma of the process, the loss of a sense of overall agency, the effect on self-worth, and the degree to which this process further entrenches a view of mental illness as a biological defect in an individual, and distracts us from the need for both local and systemic social change.

These negative effects have a direct impact on the true integration of people with SPMI into communities where they feel understood and valued. Through the research data, guiding values emerged that can be applied to changes to policy, practice, and education; namely, assessing interventions by their ability to create connection, not disconnection, between identity, community and agency. Further research is needed to develop and trial altered processes. This will demand a willingness on the part of HCPs, law-makers, policy makers, researchers and educators to look at mental illness as a collective issue, to consider the broader social and personal contexts of patients and families, and to accept examination and critique of our own systems and practices. Through this, we can arrive at better processes, ones that have both psychological and political coherency, and that demonstrate our valuing of vulnerable individuals experiencing distress by using social, pharmacological, psychological, relational and political approaches to prevent and address this distress.

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Appendix A
Informed Consent Forms

Informed Consent Form for Participation in a Research Study

Study Title: The day-to-day impact of community treatment orders on service users’ sense of identity in relation to systems of care: An ethnography

Principal Investigator:	Fiona Jager, RN, PhD(c) School of Nursing Faculty of Health Sciences University of Ottawa XXXXXXX@uottawa.ca (613) XXX-XXXX

INTRODUCTION

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Please take your time in making your decision. You may find it helpful to discuss it with your friends and family.

Taking part in this study is voluntary. Deciding not to take part or deciding to leave the study later will not result in any penalty

IS THERE A CONFLICT OF INTEREST?

There are no conflicts of interest to declare related to this study.

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to gather the experiences of individuals involved with CTOs. This includes individuals with CTOs, their family members, and clinicians or legal professionals who work with them. By looking at individuals’ experiences we intend to better understand the day-to-day impact of the CTO. This could include effects on the wellbeing of the individual with the CTO, and their relationship with the health care system.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

It is anticipated that about 25-30 people will take part in this study. This are two research sites for this study.

This study should take approximately one year to complete and the results should be known in about one year after study completion.

WHAT WILL HAPPEN DURING THIS STUDY?

Observations:
If you agree to participate in this research, your work with clients with CTOs may be observed by the researcher during regular clinical care with the client's permission. For example, the researcher may observe a family meeting, or a Consent and Capacity Board hearing.

Interviews:
The researcher will also ask you to participate in a one-on-one confidential interview. During this interview, you will be asked to discuss your experiences with clients with CTO. You will be asked to express your thoughts about and your opinions of these experiences. The interview will be 30 to 60 minutes long, depending on your availability and what experiences you wish to share.

This interview will take place at a location of your choice that is conducive to a private and confidential conversation: your office, the researcher's office, or a community location such as a coffee shop. At the start of the interview, you will also be asked to fill out a short demographic questionnaire (2 minutes).

This interview will be audio recorded, unless you refuse, in which case hand-written notes will be taken. Audio recorded interviews will be transcribed.

Please indicate whether you consent to having the interview audio-recorded:

Yes, I consent to having the interview audio-recorded ☐
No, I do not consent to having the interview audio-recorded ☐

Your real name will not appear on the transcript and questionnaire and a pseudonym (fake name) of your choosing will be used instead. Any identifying information will be removed from the transcript. The researchers adhere to the strictest confidentiality and privacy regulations when conducting research. Details about the retention and storage of study documents can be found below.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?

There are no associated responsibilities that come with participating in this study.

HOW LONG WILL PARTICIPANTS BE IN THE STUDY?

Your participation on this study will last for about one year.

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You can choose to end your participation in this research (called withdrawal) at any time without having to provide a reason. If you choose to withdraw from the study, you are encouraged to contact the researcher.

You may withdraw your permission to use information that was collected about you for this study at any time by letting the researcher know. However, this would also mean that you withdraw from the study.

If you decide to leave the study, you can ask that the information that was collected about you not be used for the study. Let the researcher know if you choose this.

CAN PARTICIPATION IN THIS STUDY END EARLY?

Your participation on the study may be stopped early, and without your consent, for reasons such as:

- New information shows that the research is no longer in your best interest
- The research team decides to stop the study
- The research ethics board withdraw permission for this study to continue

If you are removed from this study, the research team will discuss the reasons with you.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

There are no medical risks to you from participating in this study. However, the researchers are aware of the possibly intrusive nature of this study and the potential discomfort caused by discussing your experiences and opinions. Some questions about your experience of working with individual's with CTOs may cause you some distress. You are free to refuse to be observed, to refuse to answer certain questions, to ask that the recorder be turned off, or to put a stop to the interview at any time. You are expected to share only the information you are comfortable disclosing. As this is an independent study, the information you provide will not be shared with anyone other than the research team. Your real name will not appear anywhere.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

There may be some benefits to you from participating in this study. For example, it will give you an opportunity to tell your story and share your experiences. It may also help impact services and public policy.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

If you decide to participate in this study, the research team will only collect the information they need for this study.

The information you share will remain strictly confidential. If, during the course of the interview, you mention an intention to harm yourself or someone else, the researcher will by law be required to tell appropriate authorities. The contents of the observations, interview, and questionnaire will only be used for the purpose of this study. Access to the research data will be limited to the researchers. During the transcription of the interview, all names mentioned in the course of the interview will be eliminated (persons, cities, community resources, etc.). Data (transcripts, questionnaires, audio recordings, consent forms, notes) will be kept in a locked filing cabinet in Dr. Perron, the researcher's supervisor's, private office at the University of Ottawa. The research data will be kept in this manner for 10 years after the publication of the results, after which they will be destroyed.

Authorized representatives of XXXXXX research ethics board may request access to consent documents to ensure the consent process was followed and that the research team follow proper laws and guidelines for the ethical conduct of this study.

This research study is collecting information on race and ethnicity as well as other characteristics of individuals because these characteristics may influence how people respond. Providing information on your race or ethnic origin is voluntary.

During the discussions, participants will be encouraged to refrain from using names. If names or other identifying information is shared during the discussion, it will not be included in the written records.

Once the study is completed, results will be published in Fiona Jager's PhD thesis. They may also be published in academic journals or books. They may be presented at conferences. They may also be used to support teaching activities. In all of these cases, you will not be identified. When needed, the pseudonym (fake name) you were assigned will be used.

Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated.

WHAT IS THE COST TO PARTICIPANTS?

Participation in this study will not involve any additional costs to you.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY? .

At the beginning of the interview you will receive a $20 grocery gift card for your participation. You can keep the compensation if you choose to stop the interview.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You will be told, in a timely manner, about new information that may be relevant to your willingness to stay in this study.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please contact the research team.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

By signing this form you do not give up any of your legal rights against the researcher or involved institutions for compensation, nor does this form relieve the researcher or their agents of their legal and professional responsibilities.

You will be given a copy of this signed and dated consent form prior to participating in this study.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study, or if you suffer a research-related injury, you can talk to the research team, or the person who is in charge of the study at this institution. That person is:

__~~XXX~~XXXXXX____________	XXXXXXXXX______
Name	Telephone

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. That person is:

XXXXXXXXX
Clinical Research Support Manager
XXXXXXXXXXXXXXXXX
Tel: 613.XXX.XXXX Ext. XXXX
XXXXXXX@XXXXX

Study Title: The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography

SIGNATURES

- All of my questions have been answered,
- I understand the information within this informed consent form,
- I do not give up any of my legal rights by signing this consent form,
- I agree to take part in this study.

Signature of Participant/	PRINTED NAME	Date
Signature of Person Conducting the Consent Discussion	PRINTED NAME & ROLE	Date

Study Title: The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography

Participant Assistance

Complete the following section only if the participant is unable to read or requires an oral translation:

☐ The consent form was read to the participant. The person signing below attests that the study as set out in this form was accurately explained to the participant/substitute decision maker, and any questions have been answered.

Signature of Impartial Witness	PRINTED NAME	Date

Relationship to Participant

Complete the following declaration only if the participant/substitute decision maker has limited proficiency in the language in which the consent form is written and interpretation was provided as follows:

☐ The person signing below acted as an interpreter and attests that this study as set out in the consent from is accurately sight-translated and/or interpreted and that interpretation was provided on questions, responses and in additional discussion arising from this process.

Signature of Interpreter	Printed Name	Date

Please note: More information regarding assistance provided during the consent process should be noted in the medical record for the participant if applicable, noting the role or relationship of the impartial witness.

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Yes, I consent to having the interview audio-recorded ☐
No, I do not consent to having the interview audio-recorded ☐

Your real name will not appear on the transcript and questionnaire and a pseudonym (fake name) of your choosing will be used instead. Any identifying information will be removed from the transcript. The researchers adhere to the strictest confidentiality and privacy regulations when conducting research. Details about the retention and storage of study documents can be found below.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?

There are no associated responsibilities that come with participating in this study.

HOW LONG WILL PARTICIPANTS BE IN THE STUDY?

Your participation on this study will last for about one year.

CAN PARTICIPANTS CHOOSE TO LEAVE THE STUDY?

You can choose to end your participation in this research (called withdrawal) at any time without having to provide a reason. If you choose to withdraw from the study, you are encouraged to contact the research team.

You may withdraw your permission to use information that was collected about you for this study at any time by letting the research team know. However, this would also mean that you withdraw from the study.

If you decide to leave the study, you can ask that the information that was collected about you not be used for the study. Let the research team know if you choose this.

CAN PARTICIPATION IN THIS STUDY END EARLY?

Your participation in the study may be stopped early, and without your consent, for reasons such as:

- New information shows that the research is no longer in your best interest
- The research team decides to stop the study
- The research ethics board withdraw permission for this study to continue

If you are removed from this study, the research team will discuss the reasons with you.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

There are no medical risks to you from participating in this study. However, the researchers are aware of the possibly intrusive nature of this study and the potential discomfort caused by discussing your experiences and opinions. Some questions about your experience of your family member's CTO may cause you some distress. You are free to refuse to answer certain questions, to ask that the recorder be turned off, or to put a stop to the interview at any time. You are expected to share only the information you are comfortable disclosing. As this is an independent study, the information you provide will not be shared with anyone other than the research team. Your real name will not appear anywhere.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

There may be some benefits to you for participating in this study. For example, it will give you an opportunity to tell your story and share your experiences. It may also help impact services and public policy.

HOW WILL PARTICIPANT INFORMATION BE KEPT CONFIDENTIAL?

If you decide to participate in this study, the research team will only collect the information they need for this study.

The information you share will remain strictly confidential. If, during the course of the interview, you mention an intention to harm yourself or someone else, the researcher will by law be required to tell appropriate authorities. The contents of the observations, interview, and questionnaire will only be used for the purpose of this study. Access to the research data will be limited to the researchers. During the transcription of the interview, all names mentioned in the course of the interview will be eliminated (persons, cities, community resources, etc.). Data (transcripts, questionnaires, audio recordings, consent forms, notes) will be kept in a locked filing cabinet in Dr. Perron, the researcher's supervisor's, private office at the University of Ottawa. The research data will be kept in this manner for 10 years after the publication of the results, after which they will be destroyed.

Authorized representatives of the XXXX research ethics board may request access to consent documents to ensure the consent process was followed and that the research team followed proper laws and guidelines for the ethical conduct of this study.

This research study is collecting information on race and ethnicity as well as other characteristics of individuals because these characteristics may influence how people respond. Providing information on your race or ethnic origin is voluntary.

During the discussions, participants will be encouraged to refrain from using names. If names or other identifying information is shared during the discussion, it will not be included in the written records.

Once the study is completed, results will be published in Fiona Jager's PhD thesis. They may also be published in academic journals or books. They may be presented at conferences. They may also be used to support teaching activities. In all of these cases, you will not be identified. When needed, the pseudonym (fake name) you were assigned will be used.

Even though the likelihood that someone may identify you from the study data is very small, it can never be completely eliminated.

WHAT IS THE COST TO PARTICIPANTS?

Participation in this study will not involve any additional costs to you.

ARE STUDY PARTICIPANTS PAID TO BE IN THIS STUDY? .

At the beginning of the interview you will receive a $20 grocery gift card for your participation. You can keep the compensation if you choose to stop the interview.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You will be told, in a timely manner, about new information that may be relevant to your willingness to stay in this study.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please contact the research team.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

By signing this form you do not give up any of your legal rights against the researcher or involved institutions for compensation, nor does this form relieve the researcher or their agents of their legal and professional responsibilities.

You will be given a copy of this signed and dated consent form prior to participating in this study.

WHOM DO PARTICIPANTS CONTACT FOR QUESTIONS?

If you have questions about taking part in this study, or if you suffer a research-related injury, you can talk to the research team, or the person who is in charge of the study at this institution. That person is:

__XXXX XXXXX______________ Name

______(613) XXX-XXXX_________ Telephone

If you have questions about your rights as a participant or about ethical issues related to this study, you can talk to someone who is not involved in the study at all. That person is:

XXXXXXXXXX
Clinical Research Support Manager
XXXXXXXXXXXX
Tel: 613.XXX.XXXX Ext. XXXX
XXXXX@XXXXXX

Study Title: The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography

SIGNATURES

- All of my questions have been answered,
- I understand the information within this informed consent form,
- I do not give up any of my legal rights by signing this consent form,
- I agree to take part in this study.

______________________________	________________________	__________________
Signature of Participant/	PRINTED NAME	Date
______________________________	________________________	__________________
Signature of Person Conducting the Consent Discussion	PRINTED NAME & ROLE	Date

Study Title: The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography

Participant Assistance

Complete the following section only if the participant is unable to read or requires an oral translation:

☐ The consent form was read to the participant. The person signing below attests that the study as set out in this form was accurately explained to the participant/substitute decision maker, and any questions have been answered.

Signature of Impartial Witness	PRINTED NAME	Date

Relationship to Participant

Complete the following declaration only if the participant/substitute decision maker has limited proficiency in the language in which the consent form is written and interpretation was provided as follows:

☐ The person signing below acted as an interpreter and attests that this study as set out in the consent from is accurately sight-translated and/or interpreted and that interpretation was provided on questions, responses and in additional discussion arising from this process.

Signature of Interpreter	Printed Name	Date

Please note: More information regarding assistance provided during the consent process should be noted in the medical record for the participant if applicable, noting the role or relationship of the impartial witness.

Appendix B
Guiding Interview Questions

Participant ID_____

Date____________

Guiding Interview Questions

Guiding Interview Questions: Clients

What do you see as the purpose of your CTO?

What is your experience of your CTO?

Can you tell me about your first CTO? your last CTO hearing?

How has your CTO impacted your relationships with your service providers? With your family? With your friends/employers/landlord/others?

How has the CTO impacted the way you think about yourself and your future?

How has the CTO helped with your recovery?

If you could change one thing about your CTO, what would it be?

What have your experiences of receiving Rights Advice been like?

Guiding Interview Questions: Family Members

What do see as the purpose of your family member's CTO?

What has been the impact of the CTO for your family member?

Have you been SDM for the CTO? What has this experience been like for you?

What parts of the CTO process do you find the most helpful? What parts of the CTO process are the least helpful?

How has the CTO impacted your relationship with your family member?

How has the CTO impacted the way that you think about your family member and their future?

How has the CTO impacted the way you interact with your family members health care team?

How has the CTO impacted the way you and your family interact with the mental health system?

How has the CTO helped with your family members recovery?

If you could change one thing about the way the CTO was administered, what would it be?

Guiding Interview Questions: Professionals

What is your experience with clients with CTOs?

What do you see as the purpose of CTOs?

How do CTOs affect the work that you do with clients?

How do you talk about the CTO to the client? To family members?

What steps in the process of initiating or maintaining a CTO (in your practice) do you find most helpful for clients? Which are the most difficult?

Can you talk about how CTOs have impacted your practice?

What contextual elements are necessary for the success of CTOs?

What are your thoughts about the safeguards in place to protect clients’ rights (the CCB hearings, the PPAO)?

What are the common features in clients that you find have benefited the most from CTOs?

What are the steps that you take that make the CTO work?

Appendix C
Sociodemographic Questionnaire

Participant ID__________
Date ___________________

The day to day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography

Socio-demographic Questionnaire

Socio-Demographic Questions for Clients

What is your age?

What is your gender?

What is your race/ethnicity?
First Nations, Métis or Inuit; Black (incl. Caribbean and African origin); Latin American; Asian (incl. West Asian, East Asian and Southeast Asian origin) or Pacific Islander; Middle Eastern or North African; White (incl. European origin); Other (to be specified).

What is your first language?

What is your level of education?

What type of housing do you reside at?
(Independent (market or subsidized), with family, supported housing, shelter/homeless)

How long have you had a mental health diagnosis?

How long have you had a community treatment order?

Socio-Demographic Questions for Family Members

What is your age?

What is your gender?

What is your race/ethnicity?
First Nations, Métis or Inuit; Black (incl. Caribbean and African origin); Latin American; Asian (incl. West Asian, East Asian and Southeast Asian origin) or Pacific Islander; Middle Eastern or North African; White (incl. European origin); Other (to be specified).

What is your first language?

What is your level of education?

How long has your family member had a mental health diagnosis?

How long have they had a community treatment order?

Socio-Demographic Questions for Professionals

What is your age?

What is your gender?

What is your race/ethnicity?
First Nations, Métis or Inuit; Black (incl. Caribbean and African origin); Latin American; Asian (incl. West Asian, East Asian and Southeast Asian origin) or Pacific Islander; Middle Eastern or North African; White (incl. European origin); Other (to be specified).

What is your first language?

What is your professional designation?

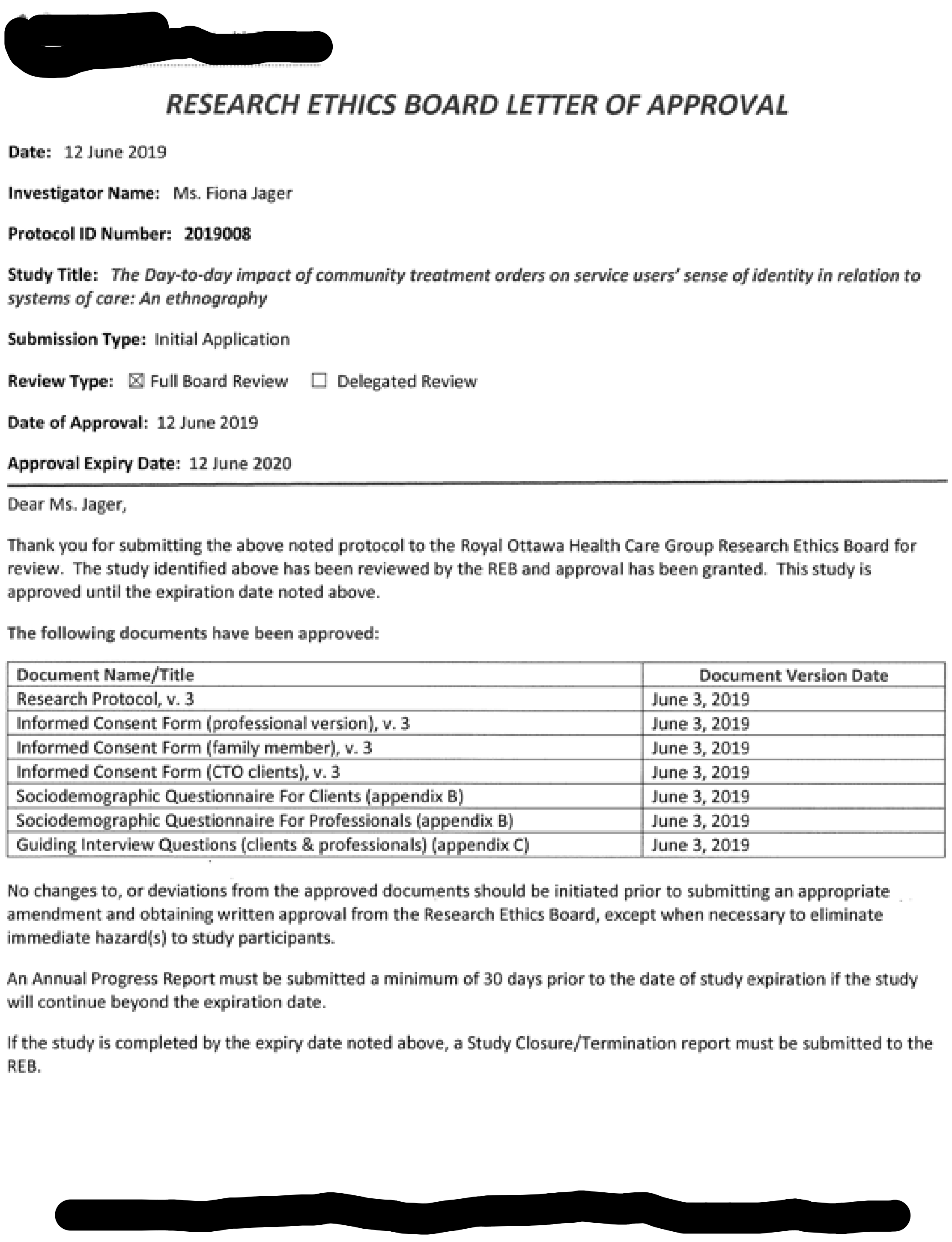
What is your level of education?

How long have you worked in your profession?

How long have you worked within the mental health care system?

How long have you worked with clients' with community treatment orders?

Appendix D
Ethics Approval



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RESEARCH ETHICS BOARD LETTER OF APPROVAL

Date: 12 June 2019

Investigator Name: Ms. Fiona Jager

Protocol ID Number: **2019008**

Study Title: *The Day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography*

Submission Type: Initial Application

Review Type: ☒ Full Board Review ☐ Delegated Review

Date of Approval: 12 June 2019

Approval Expiry Date: 12 June 2020

Dear Ms. Jager,

Thank you for submitting the above noted protocol to the Royal Ottawa Health Care Group Research Ethics Board for review. The study identified above has been reviewed by the REB and approval has been granted. This study is approved until the expiration date noted above.

The following documents have been approved:

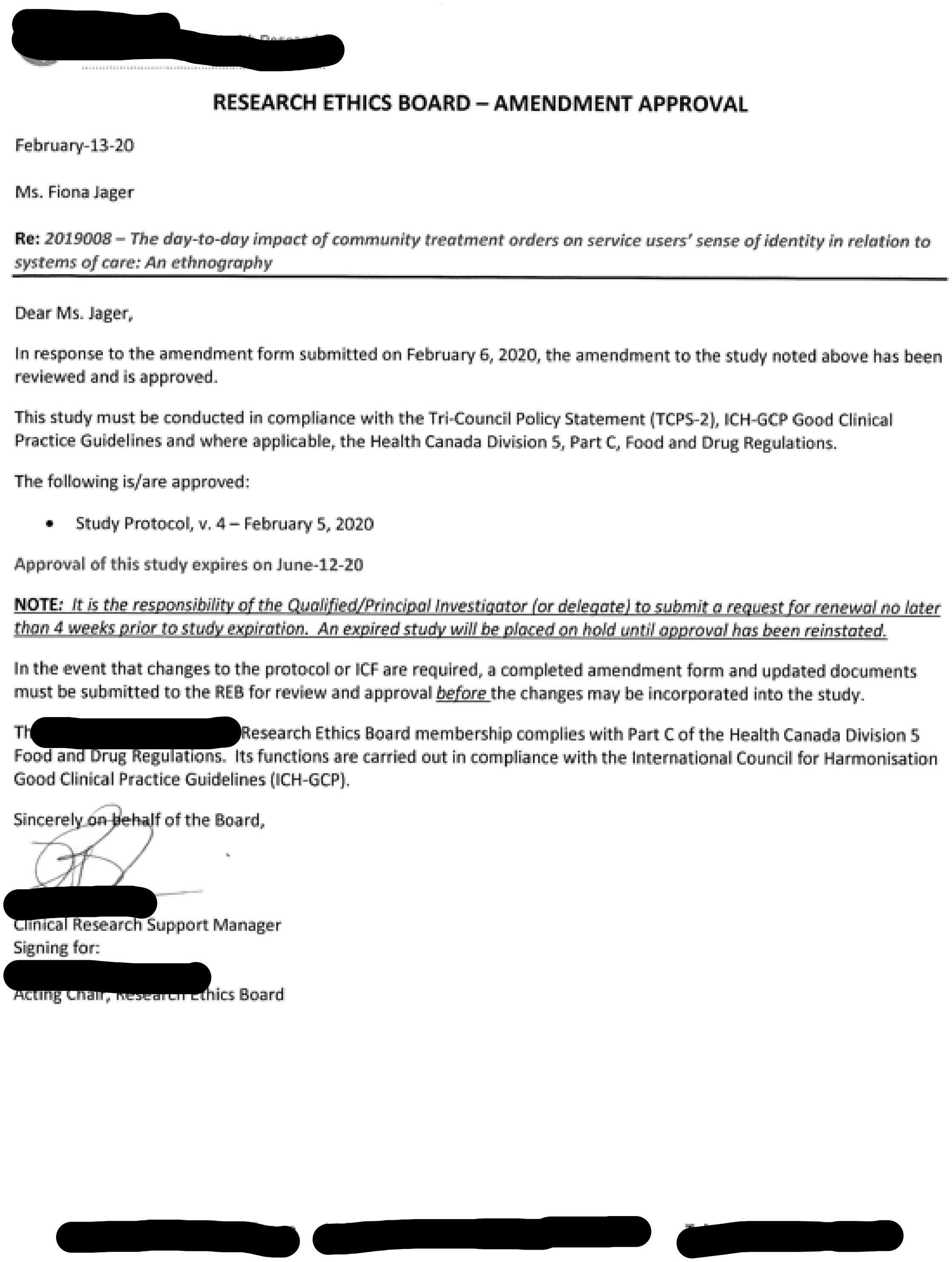
Document Name/Title	Document Version Date
Research Protocol, v. 3	June 3, 2019
Informed Consent Form (professional version), v. 3	June 3, 2019
Informed Consent Form (family member), v. 3	June 3, 2019
Informed Consent Form (CTO clients), v. 3	June 3, 2019
Sociodemographic Questionnaire For Clients (appendix B)	June 3, 2019
Sociodemographic Questionnaire For Professionals (appendix B)	June 3, 2019
Guiding Interview Questions (clients & professionals) (appendix C)	June 3, 2019

No changes to, or deviations from the approved documents should be initiated prior to submitting an appropriate amendment and obtaining written approval from the Research Ethics Board, except when necessary to eliminate immediate hazard(s) to study participants.

An Annual Progress Report must be submitted a minimum of 30 days prior to the date of study expiration if the study will continue beyond the expiration date.

If the study is completed by the expiry date noted above, a Study Closure/Termination report must be submitted to the REB.

[redacted]



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RESEARCH ETHICS BOARD – AMENDMENT APPROVAL

February-13-20

Ms. Fiona Jager

Re: *2019008 – The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography*

Dear Ms. Jager,

In response to the amendment form submitted on February 6, 2020, the amendment to the study noted above has been reviewed and is approved.

This study must be conducted in compliance with the Tri-Council Policy Statement (TCPS-2), ICH-GCP Good Clinical Practice Guidelines and where applicable, the Health Canada Division 5, Part C, Food and Drug Regulations.

The following is/are approved:

- Study Protocol, v. 4 – February 5, 2020

Approval of this study expires on June-12-20

NOTE: *It is the responsibility of the Qualified/Principal Investigator (or delegate) to submit a request for renewal no later than 4 weeks prior to study expiration. An expired study will be placed on hold until approval has been reinstated.*

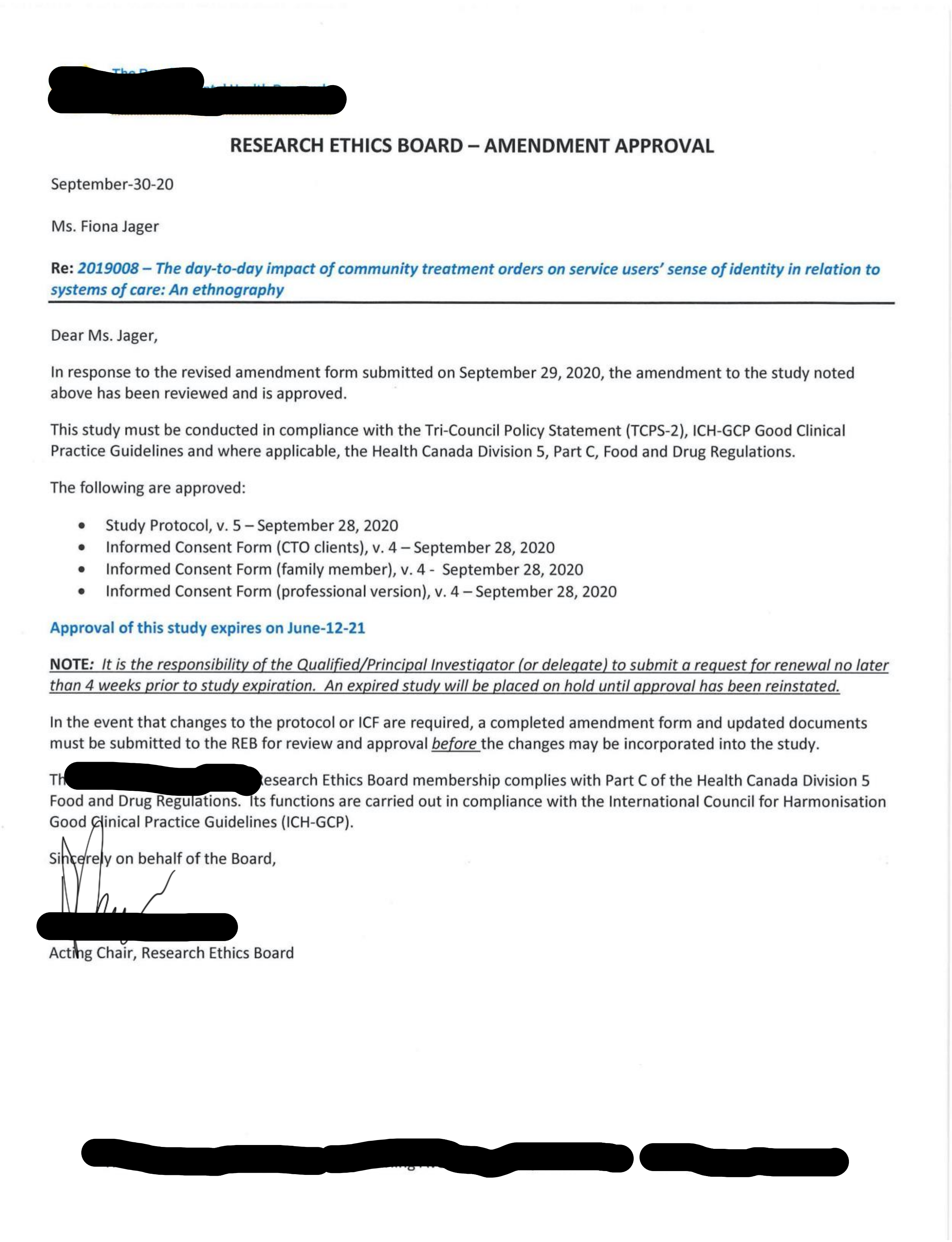
In the event that changes to the protocol or ICF are required, a completed amendment form and updated documents must be submitted to the REB for review and approval *before* the changes may be incorporated into the study.

Th[redacted] Research Ethics Board membership complies with Part C of the Health Canada Division 5 Food and Drug Regulations. Its functions are carried out in compliance with the International Council for Harmonisation Good Clinical Practice Guidelines (ICH-GCP).

Sincerely on behalf of the Board,

[redacted]
Clinical Research Support Manager
Signing for:
[redacted]
Acting Chair, Research Ethics Board

[redacted] [redacted] [redacted]



[redacted]

RESEARCH ETHICS BOARD – AMENDMENT APPROVAL

September-30-20

Ms. Fiona Jager

Re: ***2019008 – The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography***

Dear Ms. Jager,

In response to the revised amendment form submitted on September 29, 2020, the amendment to the study noted above has been reviewed and is approved.

This study must be conducted in compliance with the Tri-Council Policy Statement (TCPS-2), ICH-GCP Good Clinical Practice Guidelines and where applicable, the Health Canada Division 5, Part C, Food and Drug Regulations.

The following are approved:

- Study Protocol, v. 5 – September 28, 2020
- Informed Consent Form (CTO clients), v. 4 – September 28, 2020
- Informed Consent Form (family member), v. 4 - September 28, 2020
- Informed Consent Form (professional version), v. 4 – September 28, 2020

Approval of this study expires on June-12-21

NOTE: *It is the responsibility of the Qualified/Principal Investigator (or delegate) to submit a request for renewal no later than 4 weeks prior to study expiration. An expired study will be placed on hold until approval has been reinstated.*

In the event that changes to the protocol or ICF are required, a completed amendment form and updated documents must be submitted to the REB for review and approval *before* the changes may be incorporated into the study.

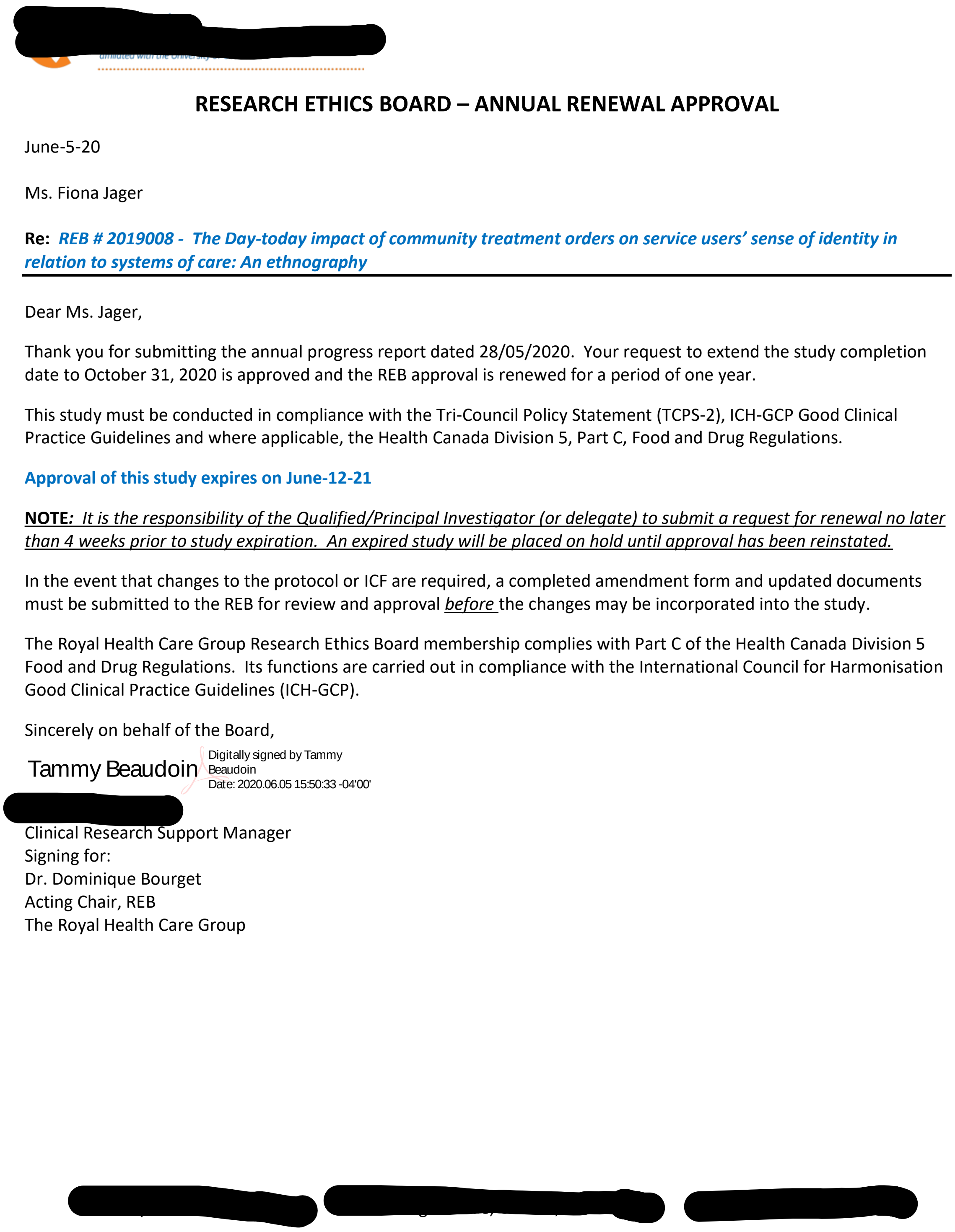
Th[redacted]esearch Ethics Board membership complies with Part C of the Health Canada Division 5 Food and Drug Regulations. Its functions are carried out in compliance with the International Council for Harmonisation Good Clinical Practice Guidelines (ICH-GCP).

Sincerely on behalf of the Board,

[redacted]

Acting Chair, Research Ethics Board

[redacted]



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RESEARCH ETHICS BOARD – ANNUAL RENEWAL APPROVAL

June-5-20

Ms. Fiona Jager

Re: ***REB # 2019008 - The Day-today impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography***

Dear Ms. Jager,

Thank you for submitting the annual progress report dated 28/05/2020. Your request to extend the study completion date to October 31, 2020 is approved and the REB approval is renewed for a period of one year.

This study must be conducted in compliance with the Tri-Council Policy Statement (TCPS-2), ICH-GCP Good Clinical Practice Guidelines and where applicable, the Health Canada Division 5, Part C, Food and Drug Regulations.

Approval of this study expires on June-12-21

NOTE*: It is the responsibility of the Qualified/Principal Investigator (or delegate) to submit a request for renewal no later than 4 weeks prior to study expiration. An expired study will be placed on hold until approval has been reinstated.*

In the event that changes to the protocol or ICF are required, a completed amendment form and updated documents must be submitted to the REB for review and approval *before* the changes may be incorporated into the study.

The Royal Health Care Group Research Ethics Board membership complies with Part C of the Health Canada Division 5 Food and Drug Regulations. Its functions are carried out in compliance with the International Council for Harmonisation Good Clinical Practice Guidelines (ICH-GCP).

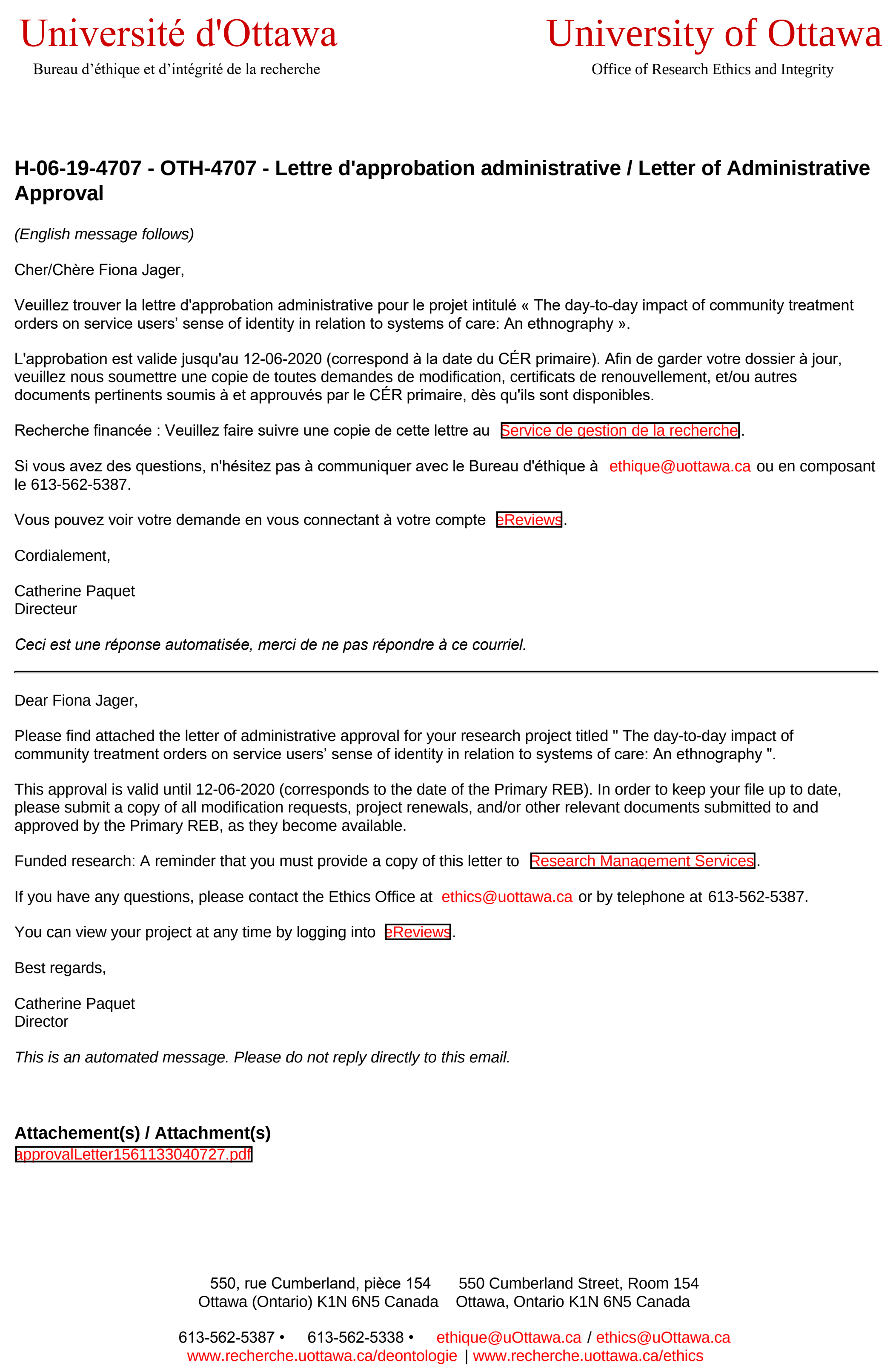
Sincerely on behalf of the Board,

Tammy Beaudoin
Digitally signed by Tammy Beaudoin
Date: 2020.06.05 15:50:33 -04'00'

[redacted]
Clinical Research Support Manager
Signing for:
Dr. Dominique Bourget
Acting Chair, REB
The Royal Health Care Group

[redacted] [redacted] [redacted]

[redacted]



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

H-06-19-4707 - OTH-4707 - Lettre d'approbation administrative / Letter of Administrative Approval

(English message follows)

Cher/Chère Fiona Jager,

Veuillez trouver la lettre d'approbation administrative pour le projet intitulé « The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ».

L'approbation est valide jusqu'au 12-06-2020 (correspond à la date du CÉR primaire). Afin de garder votre dossier à jour, veuillez nous soumettre une copie de toutes demandes de modification, certificats de renouvellement, et/ou autres documents pertinents soumis à et approuvés par le CÉR primaire, dès qu'ils sont disponibles.

Recherche financée : Veuillez faire suivre une copie de cette lettre au Service de gestion de la recherche.

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique à ethique@uottawa.ca ou en composant le 613-562-5387.

Vous pouvez voir votre demande en vous connectant à votre compte eReviews.

Cordialement,

Catherine Paquet
Directeur

Ceci est une réponse automatisée, merci de ne pas répondre à ce courriel.

Dear Fiona Jager,

Please find attached the letter of administrative approval for your research project titled " The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ".

This approval is valid until 12-06-2020 (corresponds to the date of the Primary REB). In order to keep your file up to date, please submit a copy of all modification requests, project renewals, and/or other relevant documents submitted to and approved by the Primary REB, as they become available.

Funded research: A reminder that you must provide a copy of this letter to Research Management Services.

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or by telephone at 613-562-5387.

You can view your project at any time by logging into eReviews.

Best regards,

Catherine Paquet
Director

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approvalLetter1561133040727.pdf

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Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada

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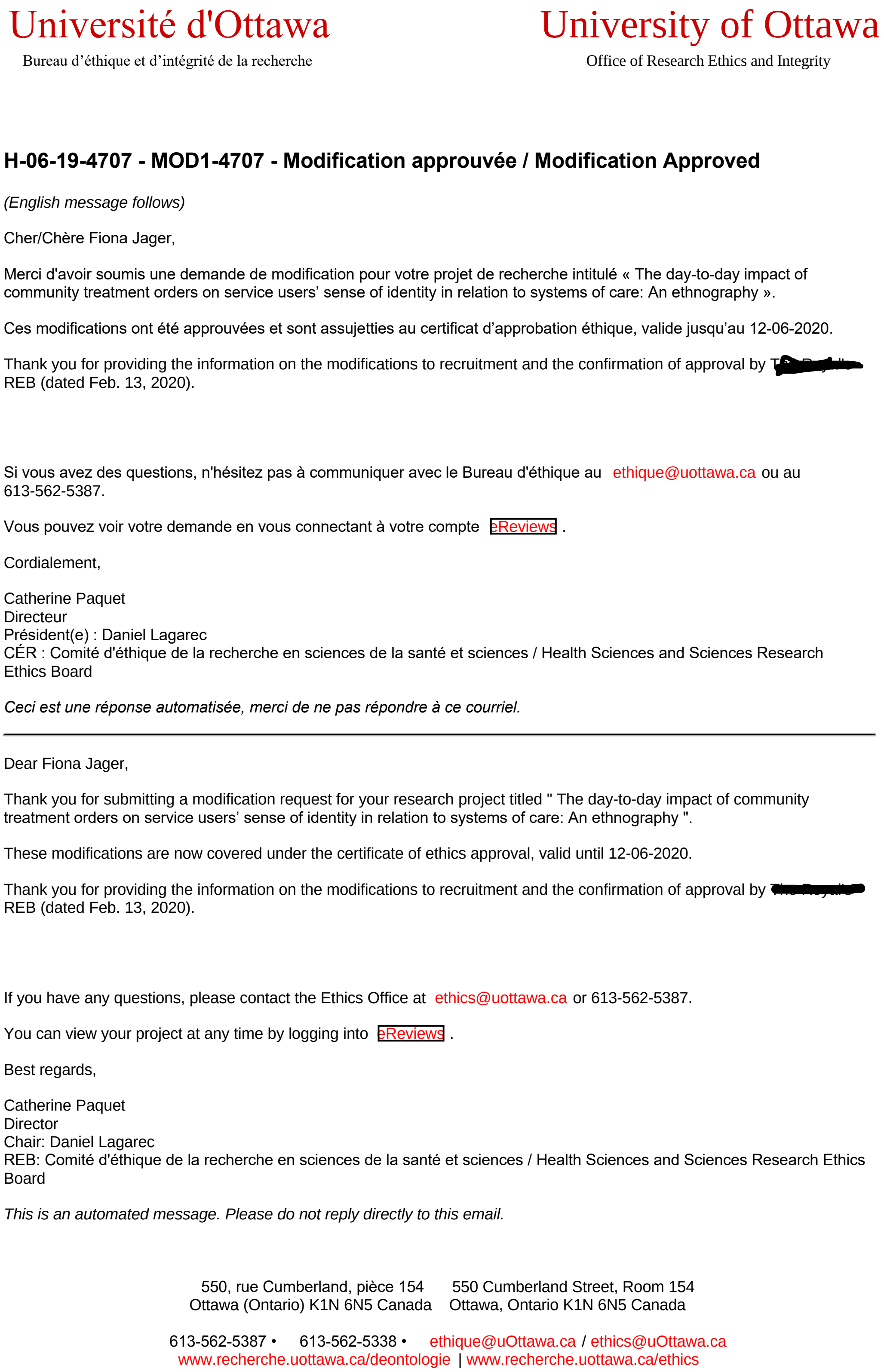
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics



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Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

H-06-19-4707 - MOD1-4707 - Modification approuvée / Modification Approved

(English message follows)

Cher/Chère Fiona Jager,

Merci d'avoir soumis une demande de modification pour votre projet de recherche intitulé « The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ».

Ces modifications ont été approuvées et sont assujetties au certificat d'approbation éthique, valide jusqu'au 12-06-2020.

Thank you for providing the information on the modifications to recruitment and the confirmation of approval by [redacted] REB (dated Feb. 13, 2020).

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique au ethique@uottawa.ca ou au 613-562-5387.

Vous pouvez voir votre demande en vous connectant à votre compte eReviews .

Cordialement,

Catherine Paquet
Directeur
Président(e) : Daniel Lagarec
CÉR : Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board

Ceci est une réponse automatisée, merci de ne pas répondre à ce courriel.

Dear Fiona Jager,

Thank you for submitting a modification request for your research project titled " The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ".

These modifications are now covered under the certificate of ethics approval, valid until 12-06-2020.

Thank you for providing the information on the modifications to recruitment and the confirmation of approval by [redacted] REB (dated Feb. 13, 2020).

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or 613-562-5387.

You can view your project at any time by logging into eReviews .

Best regards,

Catherine Paquet
Director
Chair: Daniel Lagarec
REB: Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board

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Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada

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www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics

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Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

H-06-19-4707 - ANN1-4707 - Renouvellement de l'approbation administrative / Renewal of Administrative Approval

(English message follows)

Cher/Chère Fiona Jager,

Merci d'avoir soumis une demande de renouvellement pour votre projet de recherche intitulé « The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ».

Veuillez trouver ci-joint la lettre d'approbation administrative renouvelée, valide jusqu'au 12-06-2021.

Recherche financée : Veuillez faire suivre une copie de cette lettre au Service de gestion de la recherche.

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique à ethique@uottawa.ca ou en composant le 613-562-5387.

Vous pouvez voir votre demande en vous connectant à votre compte eReviews.

Cordialement,

Marc Alain Bonenfant
Coordonnateur de l'éthique

Ceci est une réponse automatisée, merci de ne pas répondre à ce courriel.

Dear Fiona Jager,

Thank you for submitting a renewal request for your research project titled " The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ".

Please find attached the renewed administrative approval letter. This approval is valid until 12-06-2021.

Funded research: A reminder that you must provide a copy of this letter to Research Management Services.

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or by telephone at 613-562-5387.

You can view your project at any time by logging into eReviews.

Best regards,

Marc Alain Bonenfant
Ethics Coordinator

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approvalLetter1592241761166.pdf

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Ottawa (Ontario) K1N 6N5 Canada

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Ottawa, Ontario K1N 6N5 Canada

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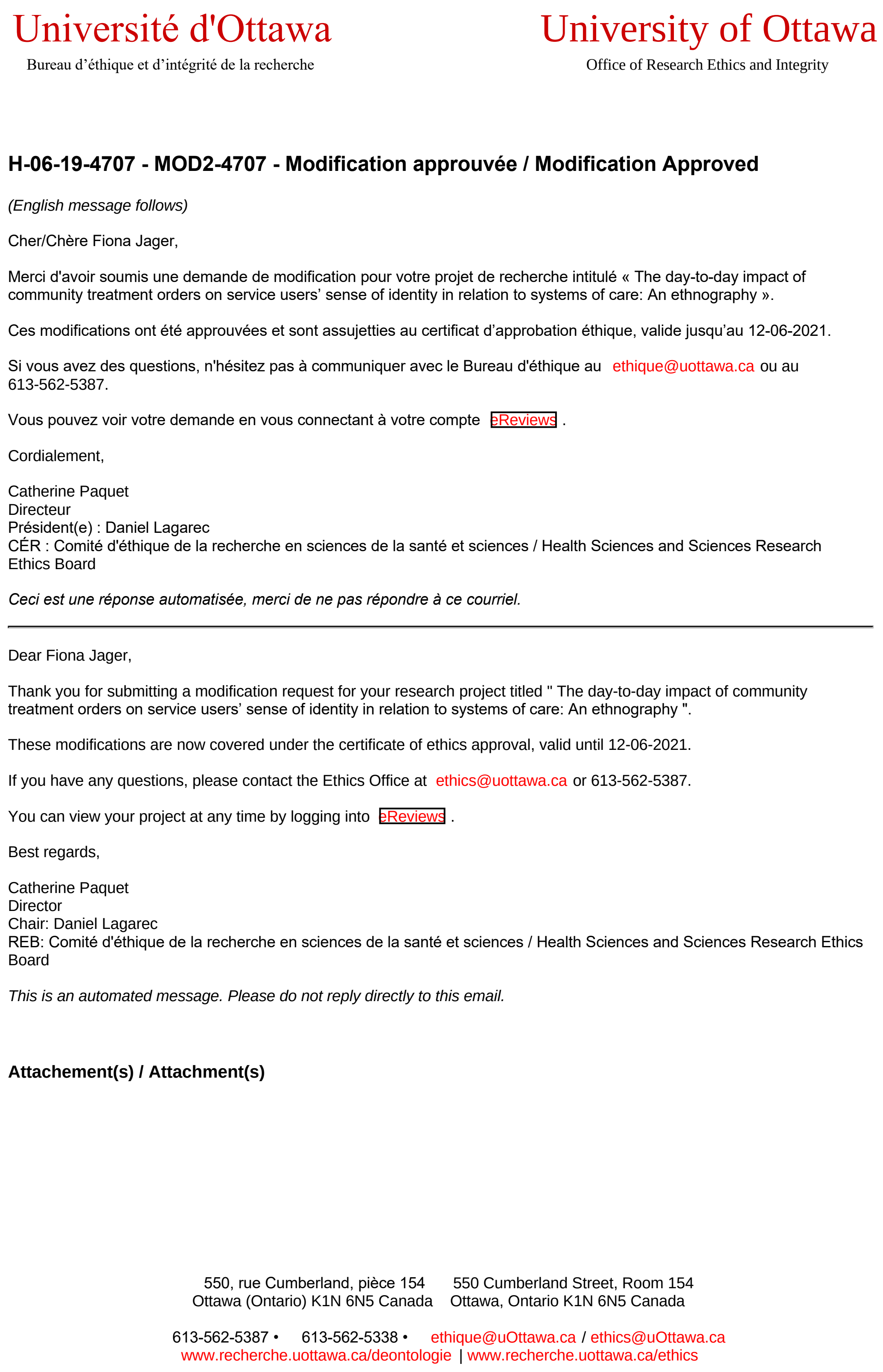
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics



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Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

H-06-19-4707 - MOD2-4707 - Modification approuvée / Modification Approved

(English message follows)

Cher/Chère Fiona Jager,

Merci d'avoir soumis une demande de modification pour votre projet de recherche intitulé « The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ».

Ces modifications ont été approuvées et sont assujetties au certificat d'approbation éthique, valide jusqu'au 12-06-2021.

Si vous avez des questions, n'hésitez pas à communiquer avec le Bureau d'éthique au ethique@uottawa.ca ou au 613-562-5387.

Vous pouvez voir votre demande en vous connectant à votre compte eReviews .

Cordialement,

Catherine Paquet
Directeur
Président(e) : Daniel Lagarec
CÉR : Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board

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Dear Fiona Jager,

Thank you for submitting a modification request for your research project titled " The day-to-day impact of community treatment orders on service users' sense of identity in relation to systems of care: An ethnography ".

These modifications are now covered under the certificate of ethics approval, valid until 12-06-2021.

If you have any questions, please contact the Ethics Office at ethics@uottawa.ca or 613-562-5387.

You can view your project at any time by logging into eReviews .

Best regards,

Catherine Paquet
Director
Chair: Daniel Lagarec
REB: Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board

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