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"Without limit of time" Living as a restricted patient in Scotland: An interpretative phenomenological analysis

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Abstract

Individuals detained within forensic mental health services in Scotland, under Compulsion and Restriction Orders (COROs), have the greatest theoretical constraints on their liberty of any patients within Scotland's mental health system. COROs function to aid patients' recovery but also to prevent harm to the public; unlike civil compulsion where outcomes are measured based solely on recovery. There is a dearth of research exploring patients' perspectives of compulsory treatment and this study is the first to focus solely on the perspectives of those living under COROs. The current study used Interpretative Phenomenological Analysis to analyse interviews with participants about their experiences of living under restriction. Eleven participants were interviewed: six living in the community under conditional discharge and five residing in low secure care. Four superordinate themes were derived from the data: (1) *How did I end up here?* (2) *Impact: Power, Punishment and Protection* (3) *Surviving and Adapting* (4) *Recovery*. The results are reviewed in the context of extant findings; clinical implications and areas of future research are considered.

Keywords

Community treatment orders, Forensic mental health, Conditional release, Involuntary treatment.

Introduction

Compulsory treatment

Compulsory treatment for mental illness, that is legally required medical and/or psychosocial care and treatment, has, since the 1980s, been increasingly delivered in community settings (Churchill, Owen, Hotopf, & Singh, 2007) though in forensic settings long term inpatient commitment continues for some patients. Perception of coercion is found to be high in involuntary patients admitted to both general and forensic psychiatric hospitals with no difference in perception being found between the two in a New Zealand sample (McKenna, Simpson, & Cloverdale, 2003). Meta-synthesis has shown that compulsory inpatient treatment, whether to general or forensic units, is often distressing, however, factors have been identified which appear to ameliorate this effect including a perception of staff as seeking to form compassionate and collaborative relationships and where clear information is delivered (Akther et al., 2019).

Compulsory treatment is extant in most mental health systems within developed countries with community treatment orders (CTOs) being present in more than 75 jurisdictions internationally (Mikellides, Stefani, & Tantele, 2019, Rugkåsa, 2016). CTOs were initially postulated as a way of addressing issues that resulted from deinstitutionalization including care for those who pose risk of harm to others, the increased prevalence of mental illness in homeless and prison populations and the revolving door syndrome (Geller, 2000). However, meta-analysis and systematic review of CTOs in mixed forensic/ adult mental health (AMH) and AMH samples concluded that there was no evidence of benefit for patients, nor was there consistent evidence that CTOs reduce rehospitalisation or length of inpatient admission thus casting uncertainty over their utility and ethics (Barnett et al., 2018; Rugkåsa, 2016). There is however, limited evidence that CTOs may be of some value in administering outpatient treatment, by increasing treatment attendance and providing increased community service provision for AMH cohorts (Barnett et al., 2018). This is a complex area and there is much debate regarding the factors that impact the outcome of CTOs, particularly as they are most often used for patients with psychotic disorders who lack insight, capacity to consent and who by the very nature of their illness are more likely to experience relapse and return to hospital (Mikellides et al., 2019).

Some contend that the principles of modern mental health legislation have engendered a fundamental change in the culture of detention, increasing transparency and applying the decision to greater scrutiny (Scottish Government Social Research [SGSR], 2009). Others posit that compulsory treatment for mental illness is biased, inequitable, paternalistic, and likely to increase the levels of coercion used in psychiatry thereby further reducing the liberty and self-determination of people with mental illness (Lawton-Smith, Dawson, & Burns, 2008). Multiple authors have contended that it may contravene the UN Convention on the Rights of Persons with Disabilities, and needs to be reconsidered given the intended result of community compulsion (i.e. reduced hospitalizations and relapse) is unsupported in over 60 methodologically strong studies (Newton-Howes & Ryan, 2017; Rugkåsa & Burns, 2017; Szmukler, Daw, & Callard, 2014).

Compulsory treatment in forensic mental health

Within forensic mental health (FMH) settings, professionals are tasked with balancing the dual purposes of these detentions, promotion of recovery and public protection. Patients may be detained involuntarily for extensive periods of time, potentially life long. Such prolonged detention poses ethical predicaments not least that individuals often stay longer in these settings than if they had received a prison sentence for their index offence (Völlm, Bartlett, & McDonald, 2016). Only four European countries (Croatia, Italy, Portugal, Spain) limit the length of admission in forensic mental health care (FMHC) to the length of prison sentence an individual without mental disorder

would have served if found guilty of the same offence (Sampson, Edworthy, Völlm, & Bulten, 2016). In a sample of forensic psychiatry experts in 18 European countries, it was noted that some individuals reside in FMHC for most of their lives if not indefinitely (e.g. Latvia, Belgium, Switzerland) (Sampson et al., 2016). This occurs despite continued uncertainty regarding the efficacy of the interventions available (McIntosh, Janes, O'Rourke, & Thomson, 2021) with continued detention reflecting risk management concerns that often offset the best interests of the individual (Völlm et al., 2016). Thus, even when little therapeutic input is available, or treatments have already been undertaken, individuals may remain under the auspices of a restriction order/hospital order for many years (Tomlin, Bartlett, & Völlm, 2018; Völlm et al., 2016). Case law of the European Court of Human Rights states that patients can be detained in psychiatric settings - even if this consists only of a 'therapeutic milieu' - for as long as this treatment is available (Hutchison Reid v the United Kingdom (2003), 37 EHRR 9; MD v Nottinghamshire Healthcare NHS Trust (2010) UKUT 59 (AAC)) (Tomlin et al., 2018; Völlm et al., 2016).

Compulsion Order and Restriction Order

In Scotland, a Compulsion Order may be granted when; an offender has a mental disorder, where medical treatment is available that would likely improve, or prevent deterioration in, symptoms of the disorder, in the absence of which there would be *significant* risk to self or others, and that the making of the order is necessary in respect of the offender. For the purpose of public protection, the Court may in addition grant a Restriction Order (CORO) where an individual poses an ongoing risk of serious harm to others (Scottish Executive, 2005). Restriction orders are "without limit of time" meaning that they could, and in some cases do, last indefinitely. In such cases individuals can only be discharged to the community "conditional discharge" or discharged completely ("absolute discharge") by a Mental Health Tribunal deciding to vary the restriction order from hospital to community-based or revoking the order entirely.

As of October 2021, there were 321 CORO patients in Scotland; 71 in high secure care, 60 in medium secure, 123 in low secure care and 64 conditionally discharged in the community (Dr Ian Dewar, personal communication, November 1, 2021). The population of Scotland, according to mid-2020 estimates was 5,466,000 (National Records of Scotland, n.d.).

The Scottish Government is involved in the monitoring and management of patients subject to CORO. Typically, conditional discharge to the community is contingent on being subject to and complying with several "compulsions" (e.g., their residence, medical treatment, alcohol and drug screening etc) and "restrictions" (e.g., approved travel areas and restricted areas, the activities they can engage in, which private residences they can enter etc). Individuals violating their conditions are subject to hospital recall. Generally, conditional discharge occurs when an individual has demonstrated improvement in their mental state, engagement in psychosocial treatments and made their way through the Scottish forensic estate (high, medium, and low secure care). However, a small number of individuals remain in hospital and do not attain conditional discharge due to ongoing levels of risk and/or acute mental illness.

CORO is among the most restrictive forms of compulsory treatment, with the indefinite nature of the limitations it imposes on individuals' liberty increasing still further the need to investigate patients' perspectives. "Significantly impaired decision-making ability" (SIDMA) criteria which applies to civil compulsion in Scotland, does not apply to the CORO (Mental Welfare Commission for Scotland, 2013). Thus, arguably those under CORO experience an even higher level of coercion than those under civil compulsion due to the retained decision-making abilities they may have while placed and remaining on a CORO. In addition, it differs to civil mental health provisions as outcomes are not only measured in terms of recovery but in preventing and reducing harm to others.

Thus far, research on compulsory treatment has primarily focused on outcomes related to the number and length or readmissions, however, outcomes for compulsory treatment in FMH are likely different given its dual purpose to manage risk of offending. As such, increased frequency or length of admission may not be viewed negatively in FMHC as such measures may have prevented or reduced risk to the public.

Similar procedures are available in other jurisdictions such as the Section 37/41 "Hospital order with restriction" in England, preventive detention in Germany (Steinböck, 2009; Basdekis-

Jozsa, Mokros, Vohs, Briken, & Habermeyer, 2013), and indefinite involuntary treatment in New Zealand (Saya et al., 2019).

The forensic mental health population

The FMH population internationally presents with high levels of psychiatric comorbidity, substance misuse, and childhood adversity/trauma (Garieballa et al., 2006; Ogloff, Talevski, Lemphers, Wood, & Simmons, 2015). A census of all Scottish forensic inpatients found that a psychotic disorder was the foremost primary diagnosis (86.4%) and an equal number (86.4%) were identified as having a history of problematic drug or alcohol use (Karatzias et al., 2019). Prevalence of childhood adversity was also high (79.2%); physical abuse was reported in 40.1% of cases, sexual abuse in 22.8%, and parental drug/alcohol misuse in 25.1% and likely under-represented in the absence of administered measures (Karatzias et al., 2019). Regression analyses demonstrated that higher levels of childhood adversity were significantly associated with problematic use of drugs or alcohol, suicidal and self-injurious behaviour, self-reported abuse of animals, and increased criminal convictions. Nonetheless, trauma informed care and practices are essential to meet the needs of this group (Morrison, Frame, & Larkin, 2003; Muskett, 2014).

A systematic review of international data showed that the manner and extent to which individuals experienced FMHC as restrictive was affected by whether the intention of their care was more custodial or caring (Tomlin et al., 2018). A study exploring perceptions of recovery in FMHC in Scotland revealed that patients; perceived power imbalances between systems and themselves, a sense-making process between the past events and the present, a process of reconfiguring relationships with others, differences in what participants considered recovery to be compared to traditional definitions and wanting to feel safe and to care for others (Stuart, Tansey, & Quayle, 2017). Mezey and colleagues (2010) revealed that those in FMHC in England considered medication, relationships with staff and patients, psychological intervention, and being in a secure setting as all being vital in facilitating recovery. The stigma associated with having a mental illness *and* being an offender was perceived as impeding recovery and most described recovery as reduction in symptoms and feeling subjectively better. Indeed, those in FMHC are subject to a double bind where they are given two roles - the "patient" and "offender" role – and they straddle both systems not fitting either role or system completely. They are noted to be generally ignored within the "psychiatric survivor movement" (Perlin, 2016). Further, individuals may be reluctant to voice their perspective due to learned helplessness while in forensic settings (Winick, 2002). It is possible that experiences of feeling unheard and believing that their voice will make no difference perpetuates this silence (Perlin, 2016).

Experiences of compulsory treatment

The literature regarding the experience of compulsory treatment in adult mental health (AMH) and forensic samples is growing. Patients tend to experience mixed feelings regarding CTOs. In a Norwegian adult mental health (AMH) sample patients perceived them as both coercive and supportive (Riley, Høyer, & Lorem, 2014). Patients in a mixed AMH and forensic samples from New Zealand noted valuing the CTO in giving them access to services and treatment to which they attributed an improved sense of wellbeing, a sense of security (in therapeutic relationships and structure of the clinical team) and feeling that the restrictions did not tend to disproportionately impede their lives (Gibbs, Dawson, Ansley, & Mullen, 2005).

Perspective of relatives and carers

A study of patients' and carers', recruited through voluntary mental health groups, perspectives of CTOs in England identified five themes: medicalization, playing the game, therapeutic competence and incompetence, amplified control, and forfeiture of credible identity (Gault, 2009). The findings suggest that at the outset individuals are reluctant to comply with intervention but do ultimately accept the need for treatment (whether passively or actively); they also emphasise the importance of communication and the benefit of respectful relationships with professionals. Commonly, research on compulsory treatment in mixed forensic and AMH samples has found that perception of negative experiences is mitigated by supportive therapeutic

relationships with professionals (Gault, 2009; Gibbs et al., 2005; Ridley & Hunter, 2013; Tan, Stewart, Fitzpatrick, & Hope, 2010). An early review of Scottish (forensic and AMH) patient's experiences of the first 2-3years of the MHCT Act found that; patients did not feel involved in decision-making, a lack of community resources, compulsory care and treatment were experienced as intrinsically unwanted, and that treatment tended to be from the biomedical model with little psychosocial treatment offered or available (SGSR, 2009). A later study concluded that patients felt that there was improved opportunity for their perspectives to be heard but that the dominant biomedical model had not been impacted by the MHCT Act (Ridley & Hunter, 2013).

A meta-synthesis reviewing all stakeholders' (service users, relatives, professionals, psychiatrists) experiences of involuntary treatment orders (ITOs) in adult and forensic services produced several common themes (Goulet, Pariseau-Legault, Côté, Klein, & Crocker, 2019). Learning to play the game as an approach, discharge as a substantial quandary for all, finding equilibrium between advocacy and control, the legal process being poorly understood, and a sense of ever-present risk of peril were among some of the main themes generated from the analysis. Questions posed by these findings include whether ITOs promote recovery, whether positive effects of ITOs are related to the intensity of care and treatment and negative effects to its coercive elements, and whether it is ethically justifiable to enforce treatment on those who do not want it when there are not sufficient resources to meet all needs (Geller, Fisher, Grudzinskas, Clayfield, & Lawlor, 2006; Goulet et al., 2019).

The current study

The move, where possible, of compulsory treatment to the community is widespread despite limited evidence of whether this promotes recovery or, for example, whether positive effects are related to the intensity of care and treatment and the negative effects to its coercive elements (Barnett et al., 2018; Rugkåsa, 2016; Goulet et al., 2019). CORO is among the most restrictive forms of compulsory treatment, being "without limit of time" with consequent limitations on individuals' liberty increasing still further the need to investigate patients' perspectives. However, COROs function to aid patients in their recovery but also in preventing harm to the public requiring outcomes to be measured differently to civil compulsion.

The method used here, interpretative phenomenological analysis (IPA), aims to study and encapsulate shared experiences in qualitative data using hermeneutic and phenomenological principles (Smith, Flowers, & Larkin, 2009). The methodology allows for the exploration of new knowledge rather than findings being influenced by predetermined hypotheses, beliefs, and traditional methods such as questionnaires or researcher bias (Smith, 2007). IPA therefore offers the optimum method to capture the experiences of this highly marginalised group who have not previously had a voice within the peer reviewed literature. Due to the exploratory nature of the study and methodology no hypotheses were posited, and themes were derived from the data itself.

Methods

Design

Semi-structured interviews which focused on experiences of living under CORO were electronically recorded, transcribed and analysed using IPA methodology. The key areas explored were: their perception of their life in general, the CORO and what it means to them and the CORO's effect on relationships. Analyses took a "bottom-up" approach; preconceptions were suspended as far as possible whilst acknowledging the bias inherent in all research.

Sample and sample identification

Recruitment took place within two Scottish national health service (NHS) Health boards from within their board-wide FMH services (Forensic Intellectual Disability services were excluded) which include low secure inpatient units and community services. These services typically care for individuals with a primary diagnosis of insight impairing major mental illness (i.e., psychotic or mood disorder), often individuals may have other comorbid diagnoses such as personality

disorder, autism spectrum disorder etc; and so, participants were drawn from this population. Given the small CORO population in Scotland (N= 321), the even lower number of eligible individuals in the individual health boards involved in the study, high identifiability of participants related to index offence etc, and consequent risk of a break in confidentiality meant that permission was not granted to share further demographic details of those who chose to participate. It is of course important to share demographic details but as with all rare populations, constraints were imposed by local ethics preventing this to ensure confidentiality.

Clinicians were asked to identify patients who met eligibility criteria (specifically; were a "CORO" patient, stable current mental state, negligible risk to interviewer, capacity to consent, spoke English) before eligible individuals were invited to take part in the study and provided with a Participant Information Sheet (PIS) by a member of their clinical team (n=17). Those expressing an interest in participating subsequently met with the lead researcher to further review the PIS which explained that participation was voluntary and that they could withdraw at any time. All potential participants reaching this stage consented to participate (n=11). None of the participants were known to the researcher prior to participation.

Data collection

Participants were interviewed using a semi-structured interview schedule comprising open-ended questions which were recorded on an electronic encrypted dictation voice recorder and subsequently transcribed and analysed by the first author. The interview schedule was pilot tested on the first three participants and found to be acceptable for use (i.e. questions were understood by participants) without modification for the remaining interviews and lasted approximately sixty minutes. Interviews took place in NHS buildings without observers. Brief field notes were made after each interview.

Analysis

Data were analysed by the lead author using IPA given its ability to explore shared experience without the imposition of prior knowledge or assumptions. The data were coded and themes identified using a process of initial coding, categorizing and understanding the data with an emphasis on reflexivity and transparency (Elliot et al., 1999). It is recognised that both quantitative and qualitative research is vulnerable to the personal biases of the researchers and this can affect their interpretation of the data (Cresswell, 1998; Cresswell & Miller, 2000; Strauss & Corbin, 1998). Analyses took an inductive approach; the researcher endeavoured as far as possible to suspend predetermined ideas or views in order not to influence the findings by their "natural attitude" (Husserl, 1931, 1967). The researcher recognised the predispositions resulting from their own experiences (see *Epistemological Stance*) while exploring the narratives and phenomena as they naturally developed (Langdridge, 2007). The aim being that the analysis was tempered by reflexivity and remained true to the data.

The analysis undertook the stages noted by Smith and colleagues (2009). This included: reading and re-reading; initial coding; developing emergent themes; looking for connections across emergent themes; replicating these steps for the next transcript and looking for patterns across transcripts. The transcripts were initially coded and analysed using "comment" capabilities in Microsoft Word software. Coding of three interviews was reviewed by a co-author with expertise in IPA.

Respondent validation (Malterud, 2001) consisting of the return of themes to two participants and discussion of these occurred. Both participants agreed with the themes that the lead researcher had derived from their transcripts and reflected further on these.

Ethical considerations

The study was approved by a Scottish NHS Research Ethics Committee. Recordings were deleted following transcription, and transcripts excluded identifiable data.

Epistemological stance

The present research assumed a constructivist method, seeking to clarify the diversity and intricacies of formulations of phenomena. IPA seeks to explore meaning and capture shared features, making it well-positioned for examining the experiences of a small group with a mutual central context (Elliot, Fischer, & Rennie, 1999; Starks & Trinidad, 2007). The researcher here

engaged in IPA's "double hermeneutic", in that the researcher is making sense of the participants' sense making (Smith, 2009).

The conceptualisation of the research questions involves an implicit assumption about what data may reveal (Smith et al., 2009), and this may be linked to the researcher's own experience of compulsory treatment as a mental health professional, in that the researcher may bring an underlying supposition than CORO is in some way significant, or indeed positive or negative, for individuals; including for participants in the current study. It is conceivable that this may have influenced the interview questions or the interview itself, however, the researcher made endeavours to be reflexive in their approach and the interview schedule contained only open-ended questions and prompts about their life in general, CORO, relationships, and the future.

Moreover, the lead researcher was a white, Scottish female, mental health professional (who did not work in Forensic Services at the time of the data collection) and was not known to the participants prior to research interview. The participants were largely males of white Scottish ethnicity, who were detained under the MHCT Act either as inpatient residents in low secure units or conditionally discharged to the community. Thus, the researcher was situated in a plainly different context than participants in many aspects and held a position of relative power as a health professional. This position may have influenced the research process. Prior to meeting participants, the researcher was given no information regarding participants or their history thus reducing the informational power imbalance to some extent. Given the method of IPA, the researchers' sense making of the participants experience has overall dominance. The lead researcher used ongoing discussion and supervision within the research team to aid in remaining reflexive, open and curious in the research process.

Results

Four superordinate themes were generated from the analysis: *(1) How did I end up here? (2) Impact: Power, Punishment and Protection (3) Surviving and Adapting (4) Recovery.* Table 1 exhibits the superordinate and subordinate themes and demonstrates in which transcripts the themes were found.

Table 1

Superordinate and subordinate themes across participant interviews (shaded cells indicate presence of theme)

Pseudonym	Innes	Lewis	Harris	Archie	Bruce	Donald	Magnus	Brodie	Tom	Lennox	Caelan
Conditional Discharge (CD) / Low secure (LS)	LS	LS	LS	LS	LS	CD	CD	CD	CD	CD	CD
How did I end up here?											
Making sense of mental illness and link to offending: "I wasn't in my right mind"	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓
Realising the gravity of CORO	▓					▓	▓		▓	▓	
Impact: Power, punishment and protection											
Always under watch		▓	▓		▓						
Your life's out of your hands		▓		▓	▓						
Found guilty of having a mental illness	▓	▓			▓		▓		▓		
On being a chaperoned adult		▓	▓				▓				
Protection and safety				▓		▓	▓		▓		
Adapting and surviving											
Exercising the power and choices you do have		▓		▓			▓		▓		▓
Passive resistance	▓	▓	▓	▓	▓				▓		
Active acceptance				▓		▓	▓				▓
Avoidance and shifting focus		▓		▓		▓				▓	▓
Recovery											
Reciprocity in relationships					▓		▓				▓
Finding the right medication		▓	▓	▓		▓				▓	
Having a purpose: Psychosocial treatments	▓	▓		▓			▓				▓
Self-disclosure; Navigating new relationships		▓						▓	▓	▓	▓

N.B. To preserve anonymity, the gender of individual participants is not reported specifically, all names have been changed and all participants are referred to as male due to the sample being from a small and identifiable population. Conditionally discharged/ Community: CD. Low secure/ Inpatients: LS.

How did I end up here?

All participants described how they had tried to make sense of what led them to be placed under CORO. This included attempts to make links between mental illness and offending, often this evoked a sense of sadness, regret, confusion or humour regarding their previous actions. A sizeable minority of participants reflected on being unaware at the time of being placed under CORO of the journey that lay in front of them, the gravity of being under CORO initially and coming to this realisation later. Overall, the findings here reflect that participants' sense of self was altered by coming in to FMHC and for some by being placed on CORO itself.

Making sense of mental illness and its link to offending: "I wasn't in my right mind"

For many, this process of making sense was ongoing and they experienced ambivalence regarding this. Tom discussed holding contrasting paradigms of mental illness and developing insight over time. While grappling with uncertainty whether he experienced mental illness or not, he tried to make sense of where psychological and social factors fitted in with the dominant biomedical model of mental illness:

> *Tom: At the time I never thought I had a mental illness but now I am wondering more about it... in brief I would say that I had been messed about with by people and that would be the reason that I was thinking not 100%. ... That has been inflicted upon me rather than it being some sort of malfunction or illness of the mind.*

Having experienced mental illness and committed an interpersonally threatening act during a period of acute mental ill health some were able to reflect that the risk they posed to others at the beginning on their journey had been fundamental in their move to secure care:

> *Donald: I committed a serious assault and now that I realise why... I was sent to [hospital] cause I was dangerous.*

> *Magnus: Yeah dangerous when I was extremely unwell – I understand that and this is why I have the CORO on me cause when I was unwell I was a danger to myself and the public.*

Recognition of distress, reduced functioning in the context of acute mental ill-health and the point of entry into FMHC being a low point in life was noted frequently in the transcripts:

> *Innes: My head wasn't in the right place, it wasn't... and I wasn't sleeping and I wasn't eating so... I thought I saw Jesus as well so it was y'know... [sighs]*

> *Lewis: ...when I was first detained under a CORO. Things weren't very good at that point at all. I had just tried to kill myself, things were bad for me at that time...*

Magnus reflected on the impact of realising how being mentally unwell and offending were linked, initially caused him to feel disheartened before refocusing this strength of feeling into recovery. He described the sense of negativity in being perceived by others as "dangerous" but how he used this to motivate himself to prove to others that he was "good" and in recovery:

> *Magnus: I was adamant to prove to everybody that I'm not this dangerous person that because I was unwell... I'm in recovery.*

Realising the gravity of CORO

A sizeable minority of participants described not having a clear understanding of the legal processes early on in their journey. Once more familiar with services and realising that the order was "without limit of time" some indicated becoming aware of the gravity of CORO on their lives:

> *Brodie: At the time I didn't realise how serious it [CORO] was. When I got put on it. I thought oh it's just another section I'm no bothered but after I been on it for years that's when I started to realise how serious it was.*

It appeared that some did not understand the basis of their legal status:

> *Bruce: Yeah, they're using the Mental Health Act to detain me. I don't really understand the Mental Health Act.*

While others felt that CORO was explained to them in some capacity, they experienced the explanation as inadequate or inaccessible:

> *Tom: It [CORO] was not [fully explained]. Completely. Definitely not… Well it wasn't really explained to me at the time. I was just told that the government will have input into my care and that will be the only difference.*

A few reflected that their sense of self was disrupted in a negative way when focusing on the gravity of being detained on this order:

> *Caelan: It does actually make you feel quite bad to know that you are criminally detained.*

Impact: Power, punishment and protection

This superordinate theme concerns how participants perceive the impact of living under CORO and how they perceived power to operate within the systems. Many described experiencing systems and staff as exercising power over them in a punitive manner by monitoring, supervising, and taking decisions over their life on their behalf. A majority voiced the double stigma they experienced in systems and society at large in their holding of disempowered dual roles ("offender" and "mentally ill") in society. Conversely, several described experiencing power in the hands of systems and professionals in a positive way; the CORO perceived as protective and allowing them access to services, helpful treatments and beneficial therapeutic relationships.

Always under watch

In the context of being under FMHC where individuals are continually monitored and assessed several discussed the sense of feeling constantly under watch. A small number noted at times internalising this to become their own "self-monitors" and the irritation this caused having to constantly be on self-guard:

> *Brodie: I've got to watch what I say all the time and what I do and my actions and yknow I've been doing that for 16 years now. It's a pain… It's like pressure all the time Vivienne.*

Some described struggling to understand the rationale for being monitored and this constant external observation disrupting their sense of self. They became the "watched" and this caused them to become exasperated with the "watchers":

> *Lennox: I was on 24 hour watch and… I didn't like that… I hated lying in my bed trying to sleep and somebody sitting watching me […] And I mean I couldn't understand why after a certain time why didn't they just go away but no they had to had to keep an eye on me. You're followed everywhere.*

Harris explained how he was supervised in his daily activities and how he took this to mean he was set apart from others. The people who can do what they want and those who cannot; a sense of being "othered":

> *Harris: Well a CORO's a lot is definitely… a lot worse than a normal sorta what would call it informal. You get sorta informal patients where they can do what they want. Where I live there's a corner shop up the road now I can't go by myself, I've got to go with a member of staff.*

A minority described a sense of being "othered" or stigmatised, however, not internalising this message. Lewis remained robust in his assertions that his behaviour was in fact "normal". He

appeared to perceive that his behaviour was pathologized, through a "forensic lens", when in any other life context it may have been interpreted as "normal":

> *Lewis: …what they say is "oh well you don't talk about your mental health much" but that doesn't mean that what you're talking about is superficial just because you're not talking about every little nuance of your mental health or your mental outlook or whatever. My conversations are no more superficial than anybody else's.*

Your life's out of your own hands

Many reflected on the lack of control they had and how others commanded significant power over their lives. They voiced how being in this vulnerable position affected their emotional world and sometimes led to feeling powerless, despondent, and frustrated:

> *Bruce: I really, I've no control.*

> *Caelan: It's just a feeling… Somebody else has got the last say in what I can do yknow.*

> *Lewis: A locum psychiatrist can have so much power over you or how much time you spend in hospital and such like. […] found it a bit depressing the thought that your life's out of your hands. Being out of your own hands so much.*

> *Tom: The patients have no power and the staff have a lot of power over the patients.*

Some described feeling that the only reasonable option in the situation was to trust staff but that was an exposing position to be in, particularly when trusting others was already a core difficulty:

> *Archie: I'm not a very trusting person… that's not my kinda character yknow. Mostly cause I've had it a bit rough in my life yknow so I've always been doing things myself and I've been put in a position where the only real option is to trust the staff is quite yknow worrying sometimes.*

Archie discussed how a seemingly small action could result in major consequences (i.e. recall to hospital, loss of passes, or being moved to higher security). This reflected a sense of being punished and that their recovery was being put back a step:

> *Caelan: It would only take one stupid move and it would all just get washed away and I'd be back in hospital again.*

The delicate tight rope walked day to day, the ever-present sense that something could go wrong at any time (i.e. being recalled to hospital) appeared for some to result in a sense that their life lacked permanency:

> *Lewis: I've had the 6 admissions now and yeah nothing to stop there being a 7th maybe. […] Things are going alright at the moment but yknow doesn't necessarily stay that way.*

> *Caelan: I feel like everything that I've got is just, is just on loan to me… I don't want to go back into hospital.*

Patients face a continual balancing act in that they must adequately and actively divulge their inner psychological world to staff however in doing so they risk saying the "wrong thing". The very challenging task of finding and maintaining the balance makes it difficult for patients to succeed as the "correct path" to succeeding appears to be narrow.

> *Archie: It was a little bit like I was being punished for being honest. If I'd kept my mouth shut things probably would've gone fine, yeah.*

Found guilty of having a mental illness

A majority described a sense of injustice and perceived their detention as a form of punishment for something over which they had little control (severe mental illness). Some discussed feeling they had lost basic rights (e.g. being able to defend themselves, loss of right to a "normal" life) which again spoke to feelings of powerlessness:

> *Bruce: I'm stuck without limit of time. I've never had a trial. If I was found guilty by a jury I'd accept it. Some people if they're put away without limit of time it's at the High Court. It goes on for 3 months. Everyday. Day after day. I never had a trial. I never had a trial.*

> *Innes: Human rights went out the window.*

> *Tom: I don't think I'd ever plead mentally unwell again... because I want the chance to be able to defend myself and I like to have my rights preserved and being on a CORO takes your rights even further away from you than being on a CTO does.*

Many compared their experience to others in the same environment, had different (often more serious offences) but who were under less restrictive orders or conditions:

> *Magnus: When I was charged with the assault and robbery - compared to another patient who [committed a violent assault leading to serious injury[1]] who had more freedoms in [hospital] than I ever had... We were on completely different orders but... the comparison of index offence, there was quite a huge difference. I could see them getting all these freedoms and going out for 3,4,5 hours a day.*

> *Caelen: I met a lot of people who have got discharges who have murdered people. I never murdered anybody but one of the things about this section is that you dinna feel that you have the right to say that. I don't feel you have the right to actually say that "I wanna live" [sighs and laughs]*

Many voiced that they felt the conditions of CORO were not proportionate to their offence. They conveyed they were being doubly penalised for their crime often citing that in the prison system they would have "served" less time. Indicating that CORO may be perceived by some as an order of "punishment" or a "sentence" rather than it's intended role as a form of care and treatment without a punitive element. It appeared that some participants understood the "Restriction" part of the order as a form of punishment, rather than a safeguard:

> *Tom: If I went to prison for the crime, I had committed then I would have spent about a year in prison maximum [...] then I would've been out free and been able to do whatever I wanted. But because I am with the mental health system I got 7 and a half years [in hospital] and a year on from there they're still on at me... so.*

> *Innes: A life sentence. It's felt like that y'know... so I think if I was sent to prison it would have been less and I would have been out.*

Tom appeared to experience the CORO restrictions as being disproportionate to his perception of the level of risk he posed towards others thus leading him to see the system as punitive:

> *Tom: I think it's way over the top. For somebody that's been considered well for the past three years and considered not a danger to himself or others I think I should be given a lot more freedoms than a CORO allows me... it's like if you've got a mental illness you are found guilty of having a mental illness and are locked up for it... And the penalty for that is normally like a year and a half in hospital.*

Lewis drew comparisons between the incongruity of his actions during his index offence (due to mental illness) compared to his identity when well and others who present with consistently anti-social, aggressive attitudes and behaviours. He considers that those who offend without having a major mental illness are treated with greater leniency which was unjust. Lewis appeared to

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[1] Details of offence anonymised in order to preserve anonymity.

understand the rationale for CORO comprehensively however held this in mind simultaneously to his sense of frustration and injustice:

> *Lewis: The guy that maybe I don't know he's just a nasty guy, and beats his wife up every 3 months, or every 6 weeks or something like that or does it every Saturday night the most he's gonna get is 6 months in jail and that's it. When he's out he's out. Whereas I've done 4 and half years locked up for something that's totally out of character for me.*

Many described the negative effect being placed on CORO had on their sense of self and who they now believed society perceived them to be (e.g. unpredictable, less than human, unworthy). Often, they understood society's perception of them as being a "second class citizen", not a "real" person or worth listening to:

> *Lewis: It makes you less of a human being in a way.*

> *Tom: I would say that ever since I've been in the mental health system my voice hasn't been heard... I tried to get my message across when I first entered the mental health system and it was like nobody was listening at all. They were just deploying rules down upon me for having a mental illness.*

The repetition of phrase below speaks to the strength of negative feeling Caelan had towards his CORO and the message he perceived it gives society about who he is; undeserving of being considered a "real" person:

> *Caelan: I hate it. I hate the section. I just hate it. It's a weight on me the whole time. Mentally yknow. It's like it's always on the back of my mind yknow like I'm no a real person, I'll never feel like a real person.*

Additionally, Caelan perceived that staff and society saw him as untrustworthy and high-risk thus not permitted to experiment in life as one normally would:

> *Caelan: You never get to the point where people are actually saying "Right, this person actually knows now. Knows his limits now yknow". I've never had a chance to actually explore my limits yknow.*

In contrast, Magnus explained that although he held nominal membership of the CORO group he never internalised the negative "identity" that society may have ascribed him:

> *Magnus: I would've been in a group of [CORO] patients in each hospital... so I came under that identity but I never, I never took that identify on like personally if that makes sense?... I'm not gonna try and let that burden me and get me down and stuff.*

This may in part underly Magnus's experiencing of CORO as protective (see below). For several, the label of mental illness meant that they felt their voice was not heard or taken seriously:

> *Tom: It feels very unfair. It feels like your voice isn't heard. I was always used to my voice being really heard and I could say things and be outgoing and speak to people... before I had the mental illness. Before I was under a CTO. I could speak out and be heard and a lot of the time I'd get what I want.*

On being a chaperoned adult

A majority discussed the restrictions they lived under regarding who they could meet, consort with and which private residences they could enter. For several participants, being a chaperoned adult resulted in feelings of loneliness and difficulties in meeting basic human needs for physical and emotional connection with others. Some experienced this as challenging, restrictive and frustrating:

> *Lewis: So I think I'm allowed to bump into people and speak but I think if I want to go round and see him or her they'd have to send a social worker round... And that's really heavy. That's that that... yknow that impacts, it's gonna impact on your relationships.*

> *Archie: So I don't have the permissions to go to somebody else house which is quite annoying cause that's' been the one time when the CORO has been quite restrictive.*

A minority described the difficulties encountered in developing intimate relationships where their RMO was required to meet any new prospective partner within a short time [this is not the case for every CORO patient and depends on risk]. Lewis reflected that the CORO itself as being a barrier for developing relationships:

> *Lewis: ... before you know it they* [Treating Team] *had made her come in and see them and tell them everything about my offence and what not and that's, that has a fair impact.*

He also mentalised the possible perspective of prospective partners being discouraged in the face of the situation and history of the individual living under CORO:

> *Lewis: they [new partner] would have to be pretty sure I can imagine it must happen lots of times that people are just put off by it. I can totally see why people would be put off by it. The fact that you're on a CORO.*

While others thought it inhibited this process entirely, concluding that having an intimate relationship was unrealistic:

> *Harris: So... I don't even try to think about meeting a girlfriend. Cause what's the point? I can't say "Oh I can't come out tomorrow cause it's not in my planner" [laughs]... They'd be like "what planner? What you on about?"*

> *Brodie: I've got a carer at half 10 in the morning. Yknow and what is she [potential partner] going to do? Sit there with the two of us talking? Can't really do it.*

Tom described the loss of old friendships he believed attributable to the restrictions imposed on where he could travel:

> *Tom: Well I don't get to see my friends when I'm on a CORO so obviously there's no relationship there. Whereas if I was on a CTO I'd just go down and see them... well old friendships are gone because of the CORO.*

Lewis was cognizant that restrictions on intimate relationships were clinically justified for some individuals perhaps contributing to his perception of these as reasonable and founded rather than punitive. He was able to mentalise from the other persons perspective why this would be important:

> *Lewis: So I suppose I can... really see the point that if somebody's got a history of offending it's only fair that a potential victim should find out. So I totally agree with it.*

Protection and safety

An interesting juxtaposition arose in the data where four participants appeared to view CORO as a protective mechanism – "a safety net" – in contrast to those who experienced CORO as punitive. It appeared the former group understood the order differently; viewing it as a channel through which they could access helpful treatments, supportive therapeutic relationships and approaching it with an assumption of trust rather than suspicion. This may be easier for those who had more positive experiences with authorities and caregivers early in life and more difficult for those who had difficult or traumatic experiences of care. This may also be mediated by having a more comprehensive understanding of why they have been placed on CORO. Although this subtheme was endorsed by a minority of participants (4/11), it was felt that the striking contrast between this subtheme and the other felt impacts of the CORO (i.e. punitive, intrusive) meant that this was clearly a subtheme on its own merits.

Magnus and Donald appeared to value the availability of care, reassurance and supportive relationships with staff which aided them in experiencing CORO as protective:

> *Magnus: It's quite a relief to have a care team behind you. It's quite positive and it gives me motivation to… move through and to get on with things and to keep going and to make the right decisions […] I take their advice… it's like having a second check in a way.*

> *Donald: I'm quite happy with the level of care that I receive and the section it doesn't really affect me.*

For Lennox, he experienced the CORO as being in place to protect him (more so than for the protection of other people) which allowed him to experience the CORO as a positive intervention:

> *Lennox: I think it's more about my protection than other peoples' protection.*

For Archie, viewing staff as supportive (rather than punitive) allowed him to trust in the mental health system which was fundamental in his experiencing the CORO as positive and protective:

> *Archie: So I just kinda try and trust in the system will work and the staff will work stuff out… I know that the mental health system is doing it's very best to get me back out the door and on with my life.*

For some, the power of the system in making choices in their life was in fact understood as positive and protective. Lennox reflected how his unintentional breaking of a restriction (meeting a female in private) initially resulted in low mood but that the response of the system in this situation was eventually a positive thing, ensuring that a greater issue was prevented from occurring later:

> *Lennox: I was back at square one… it was a lesson learnt because then I was really clear what I could do and what I couldn't do because the chances are I might have got out and invited somebody round to my house without thinking and it could've been worse.*

Surviving and adapting
Participants described a range of methods and coping styles they developed in to navigate and cope with their situation. Though subthemes were disparate across transcripts (representing subgroups of coping style), these themes all appeared to share similar functions in that they allowed participants to continue living day to day, tolerate challenging emotions and/or restoring a sense of power/agency (however small) in their lives.

Exercising the power and choices you do have
A minority of participants described coping with the lack of control and certainty over their own lives by exercising powers (thereby, taking back some control) they had available to them through legitimate means such as Tribunals and Advance Statements:

> *Lewis: I did that [challenged the status quo]… In that sense that was the mental health act, that was the tribunal system that allowed me to get out [of hospital]… yeah advance statements are just you need to make it when you're in your right mind… in my experience doctors have actually tended to take my advance statement into account.*

Magnus illustrated the satisfaction he felt when he found that's his actions/request had a tangible impact on the system and thus his circumstances:

> *Magnus: I put in a request that I don't want to do planners anymore and they said "yeah okay, no problem" and that came from the Scottish Government as well and I was like "Yesssss!!! Somebody's listening!"*

This may reflect for these participants some sense of power gained through increased understanding of the legislation or system and how to use this. Other participants described how

they may have attempted to seek power from staff or the system in somewhat proscribed ways. Caelan described how he was aware he was likely to be transferred to a higher level of security so he exercised "control" or a "last show of freedom" and absconded from the low secure ward:

> *Caelan: …so I climbed out a window. Went away got drunk, stole [unclear] and came back the next day. Came back and I knew I was going to [higher security hospital]… within about 10 hours I was in [higher security hospital].*

Tom described his attempts to gain a small sense of power control by playing with the flexibility of the rules or verbalising displeasure in order to address the power imbalance he so keenly felt. This could be considered as a form of active resistance:

> *Tom: I would say things to him to wind him up and the staff would be like… "LISTEN to him! He's winding you up!" […] he said "I knew you'd do that" and I said "yeah cause I CAN do that. I CAN do that. There's no rule against me doing that." And he was like "I've got rules" and I was like "whatever mate" and walked off. [laughs]*

Passive resistance

This subgroup appeared to oppose the system (in their minds) while behaviourally complying with it in order to move forward. This may be mediated by assumptions that the system is punitive, they are stigmatised by society for their dual roles and that they have little agency and power over their lives so have little choice other than to comply.

The below excerpt illustrates the significance for Bruce in "conforming" to staff expectations of behaviour to garner their approval so that he might progress. Bruce described concealing anger or behaviour that could be interpreted as "aggressive" by staff in order to keep progressing:

> *Bruce: I never talk back to any of them or get angry at them… Never talk back to staff, never get angry, never make demands of them… Well I just bite my tongue with everybody. I don't talk back or get angry or that I just stay in my room. I'm a model patient I can tell you.*

The excerpt below demonstrates how this subgroup may comply behaviourally with treatment (e.g. take medication) despite beliefs that they did not require this, perhaps reflecting limited insight:

> *Bruce: I take my medication although I've never needed it… It's terrible… It's really, really hard for me.*

Harris described the process of modifying his behaviour so it was "acceptable" to others – from active to passive resistance - as something that took time to develop over many years:

> *Harris: I've learned over the years Vivienne, well how to be a normal person, not to cause bother… there was a doctor she told me "You've been a pain in the arse ever since you come here"… I used to smoke dope and everything on the ward [chuckles] oh it was hellish. Looking back – aye I was crazy.*

Bruce discussed the emotional pain he experienced in perceiving little other choice but to comply and perhaps reflecting on the loss of an alternative life he may have had had he not been in FMHC:

> *Bruce: Twenty odd years later and still I'm here and I am a "model patient". […] Well sometimes you feel like throwing yourself to the walls ay. You've just got to cope with it. You've been given that and you've just got to deal with it but you do feel like throwing yourself at the walls at times.*

Innes described how he gained the acceptance of staff by refraining from "acting out":

> *Innes: Yeah I get on okay with the staff there's been no problems. I don't kick off, I don't shout and scream y'know.*

Lewis described having agreed ostensibly with staff regarding "symptoms" of mental illness whilst holding his own personal formulation of what these experiences were (his faith):

> *Lewis: I can call it a delusion when I'm speaking to the doctors just to make it easier for everybody... I'm well aware that for everybody except me that is part of my mental health problem... I know that the belief that you're [a religious figure], I realise that almost nobody else will accept that.*

Lewis appeared to have decided to "conform" to the system and agree outwardly that his experiences were symptoms of mental illness in order to progress in the system whilst holding his own private view. Tom discussed how he navigated a complex double bind when receiving opposing messages from Multi Agency Public Protection Arrangements (MAPPA), health and legal professionals and complied with "the rules" in order to progress through the system (though personally disagreeing with them):

> *Tom: I talked to a lawyer and he said that I don't have to live by them [rules made by MAPPA] but my doctor says don't trust the lawyer... A few times I've said "I don't have to abide by this" and they're like well technically you don't but... everybody has said that technically I don't but if I don't it's a black mark against me sorta thing and it would ruin an untarnished record.*

Active acceptance

Another subgroup of patients also described conforming to the system however, in contrast, their compliance appeared active and based on assumptions that CORO offered positive advantages. For example beliefs that: CORO provides access to helpful treatment, that staff have supportive intentions, active engagement is fundamental for recovery, personal goals will still be achieved though this may take longer and/or desire to prove to society that they are "good". Although this subtheme was endorsed by a minority of participants (4/11), it was felt that the prominent distinction between this subtheme and the other approaches to surviving and adapting to the CORO (i.e. avoidance, passive and active resistance) meant that this subtheme was independent and unique in comparison thus meriting inclusion. Archie described beliefs that staff had appropriate knowledge training, and experience to aid his progression:

> *Archie: The doctor's the one who's been trained in dealing with psychosis and symptoms like and I'm just hoping that she manages to get the job done so I can be like "everything's fine - gonna move forward with my life".*

Donald alluded to beliefs that following the rules and actively engaging is the best course of action for his own wellbeing:

> *Donald: I try to follow everything... Myself, personally I've never been restrained. I followed the book if that's the right word to use... I think that's what Dr [name] says: "I wish my patients were all like you!"... Model patient aye!*

Magnus described how he believed being fully invested in his care and treatment had been crucial in his successful progression to conditional discharge:

> *Magnus: Someone had said to me "you know if you really look back Magnus, for being a CORO patient you've flown through the system" and I said "I know but I've really worked hard for it" dyou know what I mean? I committed to everything, I did all the intervention therapies, I participated in everything that I could and I adhered to all the planners and stuff...*

Archie discussed active compliance based on assumptions that his goals would be attained eventually:

> *Archie: I mean the thing with the CORO is if you kinda comply and go with the flow and stuff you still get all the stuff that you're wanting to get like [...] I'll be able to get a new*

> *laptop, a new phone. When I get back to rehab I'll be able to go to the cinema and stuff, with people I've made friends with while I've been in hospital.*

Magnus reflected on his intrinsic motivation to demonstrate to the world that he was fundamentally "good", not "dangerous" and how this helped him to actively engage under CORO:

> *Magnus: I was motivated to prove to people that I was not this dangerous person and was not a risk to the public... it was a motivational factor for me cause I thought "I'm not getting anywhere till I'm better".*

Avoidance and shifting focus

To cope with living in a situation out with their control a minority of participants described shifting their focus instead to things they could control, thereby gaining a sense of agency, or by "sealing over" and engaging in mental avoidance. This coping method may be based for some on (perhaps unconscious) assumptions that confronting the reality of the situation may be too painful. Although this subtheme was discussed by a minority of participants (4/11), it was felt that the uniqueness of this finding in contrast with other modes of surviving and adapting to the CORO in addition to the well researched phenomenon of "sealing over" in this population endorsed its elevation to subtheme in and of itself. Lennox described an avoidant "sealing over" approach towards how he would manage situations with people he knew before he became unwell and committed his index offence:

> *Lennox: It doesn't bother me. No, it doesn't because yknow I think if I was to bump into one or two of them I think they'd want a lot of questions answered and I don't know what their feelings are towards me yknow.*

Bruce, too, described an avoidant coping style in which he used self-isolation to maintain a feeling of safety:

> *Bruce: I'm quite happy 20 hours in my room as long as I get peace... Just shut myself in my room... I've cut ties with everyone... I just wanted a quieter life yknow. If I stayed away from them I'd have a quiet life ay.*

Lewis voiced that staying cognitively in the present helped him to cope with the reality of being detained indefinitely under CORO:

> *Lewis: It's better just to live in the present moment... There's no point in living in the future and always thinking about "I wanna do this when I get out, I'll do that when I get out".*

Similarly, Magnus described focusing on improving himself rather than focusing on the outward situation:

> *Magnus: The up rest and the upheaval with, that was at the State Hospital but I soon forgot about it honestly and thought focus on other things, focus on yourself and I did...*

Lewis described how shifting his focus to his faith aided him in coping with the reality of his situation:

> *Lewis: What I'm really thinking about not just for the future but for the present, by far the most important thing for me is my faith... ehmm I suppose I'm quite unsure about the future, very unsure about the future, there's all sorts of question marks about the future but as long as I've got my faith I'm not scared of anything.*

Recovery

The fourth superordinate theme identified encompassed what participants experienced as valuable in their recovery, what helped them to heal and connect with their lives and others moving forward into the future.

Reciprocity in relationships

Several participants attributed part of their success to approaching interactions in a reciprocal manner. They voiced insight into the fact that reciprocity in interactions provided both parties with positive reinforcement, staff were more likely to build trust in them, and their trust in professionals appeared to mediate this theme being endorsed or not:

> *Archie: They're always really considerate and make things a lot easier being in hospital but I think that's mostly because I've been so accommodating with the staff yknow? You give out and you get back yknow?*

Others discussed how trusting the staff (thereby earning staffs' trust in them) and at times desiring staffs' approval aided them in progressing:

> *Donald: Trust? … If I wanted to ask, put in a request to Dr [name]… she'll say "Okay" but I think I've never gave her problems. Never, never. I've never sprung her a surprise at any of the CPA meetings […] I don't want to let Dr [name] down like.*

> *Magnus: Eventually when I was in the [medium secure unit] yknow I did get a lot of passes but it took a lot of time to build that up. I dunno whether it was just building the trust up with the staff which is understandable because they need to have an element of trust before they can let you out…*

Bruce recognised how his actions impact on staffs' emotional wellbeing and the importance of his own role in contributing to regulating their wellbeing:

> *Bruce: I mean you've got to try and keep them having decent feelings inside instead of getting them angry and that.*

Several spoke of therapeutic bonds being built with particular members of staff and the positive impact this had on them and how they were affected by the loss or temporary absence of these relationships:

> *Donald: I became friendly with a member of staff there… we got on great… he died like… I was upset with that yknow… When Bob [Pseudonym] was alive, god bless him. He would take me down to do ASDAs to do my shopping for the week aye. My keyworker, he was good yknow… It made life easier.*

> *Brodie: Sometimes if I'm in the house on my own in the morning I get a bit lonely a wee bit but sometimes I look forward to my carer coming to my house.*

Finding the right medication

Another aspect of healing frequently discussed by participants was the journey they went on with their doctors to find the right medication(s) at a tolerable dose. They reflected on the disadvantages of being on medication they found difficult to tolerate which at times engendered feelings of powerlessness. Whilst simultaneously identifying the positive experiences (sometimes life-changing) when they found medications that improved their distress and symptoms.

Many participants discussed the challenging physical and emotional impact of medication they struggled to tolerate:

> *Lennox: It was just this one particular one, I think it was quite new on the market. They decided to try it out and as I say it had a terrible effect on me.*

> *Lewis: Some of this stuff really ruins your life… For example, haloperidol it's difficult to explain it's just is a pill and you think it wouldn't make that much difference to you but it makes a huge difference to you. It wiped out my personality altogether, I had no interest, I had no quality of life on that drug.*

Lewis discussed his experience of negotiation with different doctors and moving between a sense of powerlessness and attempts to gain a voice in the dynamic by using advance statements:

> *Lewis: Oh yeah, it depends a lot on the doctor. Some doctors don't much negotiate with you… I've been prescribed diazepam to help with the side effects and really what I wanted was to get off the medication to get on to medication I could deal with […] medication I could tolerate… I mean I've got an advance statement and I've listed some of the meds I don't want to take and some of the meds that I can take.*

A minority reflected on how the power imbalance was only present when patient and doctor disagreed on medication and appeared to fade when tolerable medications were found:

> *Lewis: Well it's easy if you're on meds you can tolerate and difficult if you're on meds you can't tolerate.*

> *Lennox: Well when they get the right ones it's been okay.*

Archie also described a sense of powerlessness being early in his medication journey with his doctor:

> *Archie: So I'm kinda in a state of limbo at the moment. Waiting for my doctors to get me on the right medications. So it can be quite challenging sometimes…*

Many participants discussed the positive experiences they had when finding medications tolerable for them which reduced distressing symptoms or restored functioning such as sleep:

> *Harris: They gave me an injection called modecate… It's really strong… I got it one afternoon and woke up the next day and thought "strange? No voices. No paranoia". It took it away.*

> *Caelan: Was on 525 [mg] of clozapine. On 425 mg now. I'm a lot quicker, less sedated than I was…Oh a lot better. A lot better. Physically especially. I take it [clozapine] every night. It does knock me out. For an hour and a half it feels really nice and then it feels really heavy and then I fall asleep and I forget all about it till I wake up the next day.*

> *Brodie: I got put on clozapine in 2003 and it's helped quite a lot […] as soon as I got put on the clozapine it's made me a lot more weller.*

It may be easier for some to accept the need for lifelong medication if their personal goals (managing their condition) align with that of the staff or service:

> *Magnus: At the end of the day I'll be on medication for the rest of my life. It's about helping me manage the condition.*

Donald described the positive life-changing effects finding right medication had for him. For a number, the positive effects of medication in comparison to a previously poor quality of life worked to encourage compliance:

> *Donald: I had nae quality of life. None whatsoever. No quality of life. Till I went on clozapine and that changed my life… I can't ask for anymore really and that type of CORO doesn't get you better, it's the medication.*

Having a purpose: Psychosocial treatments

Many participants reflected how engaging in occupation whether this be leisure, educational or vocational was a valuable part of their recovery as these activities gave a sense of: purpose, achievement, relaxation and soothing, or a sense of progression in life. For Harris, relaxation and achievement was a positive outcome of his activities as was the positive reinforcement from others around this:

> *Harris: It makes me relax I just sit in the dining room, put my music on and draw away. It's so relaxing and see when you put a picture together and it comes out spot on what a feeling that is!... great sense of achievement... Doctors said it, Charge Nurse has said it so it's a good sign when I'm drawing.*

Caelan's activities appeared to give him a sense of achievement and "ownership" over something. Perhaps serving as an antidote to his aforementioned sense of not being a "real person" (see *Found guilty of having a mental illness*):

> *Caelan: I really liked the essays I must admit. I liked the different subjects. I liked that fact that... I'm good with words and I realised that my writings skills was quite good... I swim once every day... Do a bit of gardening. Cutting a hedge today for my brother. I do his gardening once a week... Aye I like ma garden. I do enjoy it.*

Similarly, Magnus and Archie valued learning new skills and gaining a sense of satisfaction in their activities. Having this sense of purpose appeared to serve a role in maintaining hope for the future:

> *Magnus: I did lots of stuff. I did photography, I went down to the Christmas village. I did loadsa stuff yknow activity-wise it was really productive. I made use of my time.*

> *Archie: And I also do cooking groups with one of the OTs [Occupational Therapists]. The OT takes me to the rehab kitchen, which is the kitchen in the rehab unit and we just make something to eat like broccoli and stilton soup, or a pizza or a turkey burger... So it's stuff that I'm able to do under the CORO and I find those things quite satisfying yknow.*

Often participants identified that their activities took place in the context of relationships with staff which was healing in itself, perhaps aiding in preparing them for what life may be like when they achieve conditional discharge and reintegrate into the community:

> *Archie: Well on a Thursday I've got a 1:1 social group where one of the OTs takes me to the canteen and we get a hot chocolate and a mocha or something and we just kinda sit and chat for a bit. So that's something that I'm able to do under the CORO and that's something that I quite enjoy, it's something that I look forward to every week.*

Donald reflected on the importance of occupation and the sense of loss of purposeful role and positive social contact experienced when it was no longer available to him and fellow patients:

> *Donald: I worked in the laundry down there. But they shut the laundry down in ...[2] and moved it to another hospital yknow... They [patients] need something to do and that was something to do. Me and a few other guys we used to like working there in the laundry.*

Psychological therapy was also recognised as a valuable and acceptable form of intervention by some participants:

> *Magnus: She was a fantastic psychologist. We did some really good work together which helped me so much...*

> *Lewis: Like I've put in my advance statement I'm happy to do any kind of psychology work.*

A minority reflected on lack of psychological intervention in their treatment plan thus far and indicated a longing to explore this:

> *Caelan: Apart from a psychologist or two yknow I've never actually spoken much. There's never been a lot of therapy, talking therapy – it's all been drugs yknow.*

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[2] Identifying word removed.

Self-disclosure; navigating new relationships

A majority of participants discussed how part of the healing process was learning to navigate social interactions with their newfound identities in the context of both restrictions and considerations of whether, and how, to self-disclose.

Participants reflected on difficult situations that arose and having information disclosed about them or having to disclose themselves to some extent whether they wanted to do this or not:

> *Lennox: They start asking questions and this and that and it makes you feel uneasy. So one day I said to my friend "Look would you mind telling them [new friends] what the circumstances are?". So they told them and they said "that's fine" and you could tell by the conversation that things were much easier yeah.*

> *Harris: People used to ask me out... For coffees and visiting and all that and meet them... I couldn't tell them "Well it's not in my planner". They'd be like "what planner? What you on about?"*

Some discussed learning the most appropriate way to self-disclose as a learning process:

> *Lennox: ...You go out with them then you start going on the conversation about being ill and everything and tell them what happened and straight away they put their hands up "oh sorry" but I found out the easiest way... you don't tell them [about offence and illness] on the first time.*

While others, discussed the emotional impact this loss of power and privacy had on them:

> *Lewis: I suppose I didn't feel particularly good about it. Yeah I didn't feel good about it at all.*

> *Magnus: Fortunately enough I had already disclosed to her everything that had happened so I wasn't like hiding anything so that made it easier but it was still like "Oh f*cckkk. Just to be intimate or to be in a proper relationship I need to go through this?" It's quite, quite scary and daunting at times.*

For some, there was a sense of the inevitability about disclosure and agreement that disclosure needed to occur. When participants beliefs about disclosure aligned with professionals this appeared to allow participants to accept this:

> *Magnus: This huge bombshell which has to be dropped there's no, there's no trying to get away from it. Trying to, trying to hide from it you know what I mean. Maybe it's a good thing cause there's no skeletons in the closet and it would be but I like to be honest and upfront especially in relationships and show transparency and I guess when you're living under a CORO that's the way it has to be.*

Magnus considered the impact of being under CORO/FMHC for a number of years as a "pause" in his life which meant that rebuilding social connections, old and new, was required:

> *Magnus: Cause it has quite an impact on your life. Cause the way one of my friends says "Look at it you've had ten years out of your life and you've got to try and rebuild that ten years of relationships. Whether it be with family or friends or girlfriends or stuff like that it's all different."*

Discussion

This study investigated perceptions of the experience of living under CORO in Scotland. IPA revealed that participants naturally attempted to make sense of their journey into FMHC - the links between mental illness and offending – and for a minority the gravity of CORO took some time to be realised (*How did I end up here?*). The impact of CORO was felt in different ways; many experienced the systems as punitive and others took comfort in the safety net CORO provided

(*Impact: Power, punishment, and protection*). Participants reflected on a range of adaptations they developed to the unusual situation they found themselves in; from actively accepting the care and treatment offered, to verbally opposing it but complying with it behaviourally, to finding proscribed and legitimate ways to level the power imbalance, and shifting their focus away from life under CORO, at times engaging in mental avoidance (*Surviving and adapting*). Finally, participants reflected on the different channels of healing (medication, psychosocial treatment, therapeutic relationships, and learning to navigate relationships in healthy ways) and what they found helpful about these (e.g. provided a sense of safety, purpose, self-agency, lessened distress etc.) (*Recovery*).

Though IPA research does not aim to provide generalizable findings, instead seeking to shed light on individual narratives of phenomena (Smith et al., 2009) it is argued that those familiar with an area can evaluate the capacity for findings to be generalized to other similar settings (Polit & Beck, 2010; Thorne et al., 2009). Being cognizant of this, the findings and their clinical implications are discussed below.

The findings of previous research – that patients' attempt to make sense of what has happened to them, feelings that they lived in the shadow of the past regarding the events that brought them into FMHC, and that they have become a different person by virtue of this experience (Stuart et al., 2017) - were strengthened by those found here (*How did I end up here?*). Indeed, participants attempts to make sense of what has happened to them in the current study is mirrored by the coercion literature, where lack of information during the coercion, not understanding why admission is occurring, or knowing what will happen or why is experienced, understandably, as negative (Lorem, Hem, & Molewijk, 2015). The findings of the present study also support those of previous international meta-synthesis of ITOs reinforcing that legal processes are commonly poorly understood (Goulet et al., 2019) (*Realising the gravity of CORO*). This study evidenced that a minority felt that CORO had been inadequately explained and that their understanding of it remained poor for some time after being placed on the order. This may be due to a variety of reasons including impairments in cognitive functioning and attentional processes while acutely unwell. However, the accessibility and understandability of information given to patients regarding their compulsory treatment may be a factor which is amenable to change. Indeed, the readability of statutory letters supplied by FMH services in NHS Scotland has been shown to be poor; between 11.9-57.6% of issued letters were found to be un-readable (Lim & Bennett, 2020).

Participants revealed varied effects of living under CORO from perceptions of punishment, control and coercion to viewing the order as a protective mechanism in their best interests (*Impact: Power, punishment, and protection*). This is in keeping with a meta-synthesis demonstrating that perceptions of involuntary treatment can encompass the contrasting concepts of both protection and abuse; a safety net, a form of punishment, and rehospitalisation as the "Sword of Damocles" (Goulet et al., 2019). In addition, the subtheme identified here - *Your life's out of your own hands* - maps clearly to Stuart and colleagues (2017) theme of *Not having a say in my own life* and to the finding of "having no real options" in mental health care coercion where the sense of being so marginalised dictates that resisting is perceived as futile (Lorem et al., 2015). *Your life's out of your own hands* speaks to the dilemma patients face in that they are compelled to disclose the inner workings if their psyche yet, when they do so, they run the risk of saying the "wrong thing" which may in their eyes set back their recovery/ conditional discharge.

The subtheme - *Found guilty of having a mental illness* - highlighted the perception of a majority patients that those who present with anti-social attitudes and behaviours but do not experience major mental illness (i.e., those who are sentenced to serve time in prison) are treated more leniently than those who experience mental illness out with their own control and offend when acutely unwell. This appears partly due to the perception of restrictions "without limit of time" as unjust in comparison to the time limited sentence of those given prison sentences. The difference may lie in those who view CORO's function as caring as opposed to fulfilling a punitive function which fortifies previous research (Tomlin et al., 2018). This subtheme also perhaps reflects the widely held, if largely inaccurate, public perception of increased dangerousness in those with mental illness (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Hori, Richards, Kawamoto, & Kunugi, 2011; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999;

Pescosolido et al., 1999). This echoes previous findings that their dual role is perceived by patients to impede their recovery (Mezey et al., 2010). This stigma may be even more amplified in those who additionally experience substance use difficulties; a triple stigma (Hartwell, 2004).

The process of epistemic injustice (Fricker, 2007) – unfairness related to knowledge - may be implicated here. One form of this injustice - testimonial injustice – occurs when the integrity of participants testimonies may be demoted by attributions such as emotional dysregulation and cognitive inaccuracy. In addition, another form of this injustice - hermeneutical injustice – occurs when many aspects of patients' experiences of illness are difficult to comprehend and communicate resulting in gaps in collective knowledge. Further, practitioners, services and systems may be advantaged by training, expertise and inherent favouring of particular styles of communicating and demonstrating testimonies (e.g. formal meetings and letters) in ways that ostracize those with illness (Carel & Kidd, 2014). In simple terms, professionals have the knowledge and experience of the law and mental health system that the patient (at least initially) does not. Individuals presenting with mental distress are particularly exposed to epistemic injustices due to entrenched social stigma (attributions of emotional instability and cognitive unreliability) such that their perspectives and interpretations are commonly overlooked or demoted (Newbigging & Ridley, 2018). For example, some feel their voice is not heard or taken seriously by virtue of having a mental illness:

> *Tom: I would say that ever since I've been in the mental health system my voice hasn't been heard... I tried to get my message across when I first entered the mental health system and it was like nobody was listening at all. They were just deploying rules down upon me for having a mental illness.*

In this study, many of those who perceived CORO as coercive did so because of their perception that their voice was not heard or considered reliable because of their status as a person with a severe mental illness. Indeed, this echoes findings in the coercion literature such as not being heard by clinicians (Newton-Howes & Mullen, 2011) and loss of autonomy creating the feeling of not being taken seriously as a person (Lorem et al., 2015). The literature posits that it is unclear whether the negative effects of ITOs relates to their coercive elements (Goulet et al., 2009); this study demonstrates that this may be the case for some.

The third superordinate theme (*Surviving and Adapting*) revealed the ways participants had adapted to their unusual situation. Two forms of compliance were described - *Active acceptance* and *Passive resistance* – which fits with previous findings "*learning to play the game as a strategy*" (Goulet et al., 2019). A sizeable minority of participants appeared to keenly engage with the system and therapeutic options offered. This was perhaps mediated by these participants largely experiencing CORO as protective; for example, three participants (Archie, Donald, and Magnus) all endorsed subthemes *Protection and safety, Active acceptance, Reciprocity in relationships, Finding the right medication, Having a purpose; Psychosocial treatments*. These themes mirrored previous findings in the coercion literature that some individuals "agree and accept" whereby perceiving coercion in mental health care as corresponding with their own best interest and is seen as help and care (Lorem et al., 2015). While another subgroup voiced disagreement with the CORO however complied behaviourally. For example, Lewis, Caelan, Bruce and Tom shared subthemes: *Your life's out of your hands, found guilty of having a mental illness,* and *passive resistance.* As discussed above, this may reflect shared beliefs about the function of CORO/FMHC as punitive and stigmatisation for their dual role.

A fourth subgroup advocated coping in the form of shifting attention and avoidance away from the reality of CORO. The literature on this form of avoidant coping - "sealing over" – is well established (McGlashan, Levy, & Carpenter, 1975). Such coping styles are correlated with negative early experiences in childhood, and an insecure adult attachment style which is itself associated with less engagement with services (Tait, Birchwood, & Trower, 2004). Given the current knowledge on attachment, it is fitting that those who experience CORO as more punitive/custodial (e.g. those who endorse subthemes *Your life's out of your hands* and *Found guilty of having a mental illness*) also largely tended to endorse the subtheme *Avoidance and shifting focus*.

For the subgroup who endorsed CORO as protective and actively accepted the order this appeared to occur when participants own goals aligned with those of staff/services for them, resulting in engagement and a sense of ownership or agency over it. Again, this reflects previous findings (Canvin, Bartlett, & Pinfold, 2002; Goulet et al., 2019; Jobling, 2014). Thus, this study reinforces that individuals should be supported to have pro-social agency over their life where possible in line with the principles of the good lives model (Barnao, Ward, & Robertson, 2016; Ward, Mann, & Gannon, 2007).

The final superordinate theme concerned the modes of healing participants found beneficial (*Recovery*). This included the use of medication, psychosocial activities, reciprocity in relationships with professionals, and the process of reconnecting in the outside social world and learning to self-disclose in appropriate ways. The relational themes found here fit with previously demonstrated themes such as *trying to fit back in, relationships are more difficult now* (Stuart et al., 2017), *characteristics of a good relationship in a coercive context* (Goulet et al., 2019), *relationships with staff and patients being important in bringing about recovery* (Mezey at al., 2010), and in *agreeing and accepting* where it is easier to "take advice" from a trusted professional, particularly in situations involving coercion (Lorem et al., 2015). The subthemes found here *Having a purpose: Psychosocial treatments* and *Finding the right medication* echoes those found in previous research regarding medication and psychological work being important in supporting recovery (Mezey et al., 2010). Previous international meta-synthesis highlighted that it remained unknown whether the positive effects of ITOs are related to the intensity of care and treatment (Goulet et al., 2019). This study provides preliminary evidence that individuals value and perceive CORO as protective if care and treatment is experienced as helpful, purposeful, reciprocal and if goals are shared.

Discussion of mental health staff involvement in patients' personal relationships was noted by most participants who had been conditional discharged (*On being a chaperoned adult* and *Self-disclosure; Navigating new relationships)*. It is important that this involvement is balanced and based on individual risk management needs in order to allow patients to benefit from the protective effect good quality relationships have on reducing offending in this population (Laub, Nagin, & Sampson, 1998; Laub & Sampson, 2001). Indeed, deficits in emotional intimacy with others is shown to be a strong risk factor for sexual offending (Mann, Hanson, & Thornton, 2010). The protective influence of these relationships cannot be underestimated given the common perception of dehumanisation in the coercion in mental health care literature, whereby individuals primarily feel dehumanised through loss of normal human interaction and isolation (Newton-Howes & Mullen, 2011).

When comparing the community and inpatient subgroups, it was notable that four subthemes (*Protection and safety* community:3/6 vs inpatient:1/5, *Reciprocity in relationships* community:4/6 vs inpatient: 2/5*, Self-disclosure; Navigating new relationships* community:4/6 vs inpatients: 2/5*, On being a chaperoned adult* community:5/6 vs inpatients:3/5) were more present in the community group than inpatients. The strong presence of *Reciprocity in relationships* and *Protection and safety* in the community subgroup may reflect the perceptive of CORO as a safety net and the trust and reciprocity between patients and treating teams which has perhaps paved the way for conditional discharge to occur. In contrast, the stronger presence of *Passive resistance* (inpatients: 4/5 vs community: 2/6) in the inpatient subgroup may indicate this coping strategy is used more commonly by those in inpatient care compared to those who have progressed to the community. Potentially those who do not use this coping strategy in inpatient care progress more quickly on to conditional discharge or perhaps once living in the community on conditional discharge there becomes less need to passively resist the system due to increased freedoms? The stronger presence of *Self-disclosure; Navigating new relationships* and *On being a chaperoned adult* in the community subgroup may reveal they have more experience of their treating team being involved in their relationships than those in inpatient care.

Clinical Implications

A practical recommendation stemming from the findings of this study may be the importance of providing clear information regarding MHCT Act status in an accessible format with discussions repeated at appropriate intervals to ensure ample opportunity for understanding and informed decision making given the fluctuating nature of capacity in severe mental illness. Restrictions and compulsions should be worded in a way which is clear to both patients and health professionals in order to avoid uncertainty as far as possible. This echoes findings from meta-synthesis that where clear information is delivered this ameliorates the negative effects of coercive treatment (Akther et al., 2019).

Given that the vast majority of participants endorsed the superordinate theme *How did I end up here?* it is pertinent that clinicians ensure patients have ample opportunity to understand their own journey on to CORO (inclusive of their mental health and pathway to offending) and are well supported in this important task. Psychologists can play a key role in this through methods such as psychological and risk formulation; patient involvement in risk assessment and formulation may be of benefit (Ray & Simpson, 2019).

Several participants communicated their discomfort with frequent observation and monitoring in the subthemes *On being a chaperoned adult* and *Always under watch*. Given the high levels of childhood adversity and trauma in his population there is potential for frequent monitoring (e.g., continuous observation on wards) to inadvertently perpetuate paranoia; as such it is important to use a trauma informed approach in the engagement and monitoring of patients.

The epistemic injustice which may be at play in this complex context may be reduced by encouraging the voices of those in FHMC, in patient advocacy and in the recovery movement in which they have previously been unheard (Mezey et al., 2010; Perlin, 2016).

The subtheme *Self-disclosure; Navigating new relationships* speaks to a psychological and social need for some patients to be supported in learning skills to establish and maintain healthy relationships in addition to how best to disclose sensitive personal information. Thus, appropriate psychosocial intervention may be of benefit. Given the protective effect good quality relationships have on reducing offending in this population (Laub, Nagin, & Sampson, 1998; Laub & Sampson, 2001) risk management of relationships should be balanced to allow patients to benefit from the potential risk mitigating impact of such relationships.

Other jurisdictions utilise similar procedures which operate without limit of time – such as the Section 37/41 orders in England, preventive detention in Germany (Steinböck, 2009; Basdekis-Jozsa et al., 2013), indefinite involuntary treatment in New Zealand (Saya et al., 2019) – it is possible that the issues and implications discussed above may be similarly relevant to these contexts.

Limitations

Six individuals were offered the opportunity to take part in this study and declined; they may have provided a different perspective which we were unable to explore or shared a common view that led them to decline. As the sample contained those on conditional discharge in the community and those living as inpatients, the sample was not fully homogenous however this allowed for between group comparison that would not otherwise have been possible. In this area of research, issues of anonymity are fundamental, thus identifying details were removed which limited contextual information that may have aided the reader in their understanding of the results.

There is no definitive sample size appropriate for IPA methodology (Smith et al., 2009; Smith & Osborn, 2015). However, a sample size of between 4-10 interviews is advised for robust studies (Smith et al., 2009) ensuring its idiographic nature is retained as large samples may obstruct/hinder successful analysis which requires time, reflection and dialogue. Eleven participants were interviewed from the national CORO population of approximately 321 individuals, this study sampled approximately 3.4% of the entire CORO population within Scotland. Some subthemes (namely, "Protection and Safety", "Active Acceptance" and "Avoidance and Shifting Focus") were only endorsed by four of the eleven participants. It has been advised that in samples of eight or more in IPA research that extracts from at least three participants for each theme is present in addition to a measure of prevalence of themes (see Table 1) (Smith, 2011) which is present in the current study. Rationale as described in the results section delineates why these were considered thematic, however, this could be considered a limitation of the study.

Respondent validation of results (Malterud, 2001) occurred individually with two participants. Both participants agreed with the themes that the lead researcher had derived from their transcripts. Preferably, all participants would have been offered and engaged with the respondent validation process. In addition, participants involved in the respondent validation may have felt compelled to agree with the professional researcher's, who held a position of power, analysis of their narrative. Indeed, although qualitative research allows for unheard accounts to be revealed, the analysis is done by professional researchers meaning a "them and us" discrepancy persists (Barnao, Robertson, & Ward, 2010).

Future research

Future research should explore patients' understanding, or lack thereof, of their legal status, the implications of this and how best to increase understanding when their mental state allows. Investigation of the experiences of those under COs and CTOs in Scotland may delineate any differences in the impact and needs of these populations compared to those under CORO. The admissions of those in FMHC tend to be significantly longer warranting additional examination, particularly as there exists greater potential to develop longer relationships with staff and peers which may in fact serve a protective function. Patients' perspectives on the use of CORO to manage risk would be useful. Future research may benefit from focus on measuring risk indicators and patients' perspective of the management of risk.

Conclusion

Uniquely, individuals living under compulsion and restriction orders do so "without limit of time". In seeking to understand their experiences this study derived four superordinate themes; How did I end up here? Impact: Power, Punishment and Protection; Surviving and Adapting and Recovery that were echoed by previous findings (Goulet et al., 2019; Mezey et al., 2010; Stuart et al., 2017).

Though these described the challenges encountered by people living under CORO (e.g., difficulties understanding legal processes, the stigma of having dual roles) they also highlighted the adaptive ways individuals adjust in order to progress through a complex system, and the methods which aid them in recovery (e.g. medication, psychosocial interventions, reciprocity in relationships with staff and learning how best to self-disclose). In doing so, they provide valuable insight into a novel area in a population whose experiences are often unheard (Mezey et al., 2010). Clinical implications and areas for future research and are discussed in light of the study's findings.

It is our hope that these findings will allow service providers to better appreciate the complex position those under CORO find themselves, and the ways they can be supported to progress in their recovery.

Acknowledgements

References

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open*, 5(3).

Barnao, M., Robertson, P., & Ward, T. (2010). Good Lives Model Applied to a Forensic Population. Psychiatry, Psychology and Law, 17(2), 202–217.

Barnao, M., Ward, T., & Robertson, P. (2016). The good lives model: a new paradigm for forensic mental health. *Psychiatry, Psychology and Law*, 23(2), 288-301.

Barnett, P., Matthews, H., Lloyd-Evans, B., Mackay, E., Pilling, S., & Johnson, S. (2018). Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis. *The Lancet Psychiatry*, 5(12), 1013-1022.

Basdekis-Jozsa, R., Mokros, A., Vohs, K., Briken, P., & Habermeyer, E. (2013). Preventive detention in Germany: an overview and empirical data from two federal states. *Behavioral Sciences & the Law*, 31(3), 344-358.

Canvin, K., Bartlett, A., & Pinfold, V. (2002). A 'bittersweet pill to swallow': learning from mental health service users' responses to compulsory community care in England. *Health & social care in the community*, 10(5), 361-369.

Carel, H., & Kidd, I. J. (2014). Epistemic injustice in healthcare: a philosophical analysis. *Medicine, Health Care and Philosophy*, 17(4), 529-540.

Churchill, R., Owen, G., Hotopf, M., & Singh, S. (2007). *International experiences of using community treatment orders.* London: Department of Health and Institute of Psychiatry, King's College London.

Creswell, J. W. (1998). *Qualitative inquiry and research design*. Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124-130.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry*, 177(1), 4-7.

Dawson, J., & Mullen, R. (2008). Insight and use of community treatment orders. *Journal of Mental Health*, 17(3), 269-280.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving Guidelines for Publication of Qualitative Research Studies in Psychology and Related Fields. *British Journal of Clinical Psychology*, 38, 215-229.

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.

Garieballa, S. S., Schauer, M., Neuner, F., Saleptsi, E., Kluttig, T., Elbert, T., ... & Rockstroh, B. S. (2006). Traumatic events, PTSD, and psychiatric comorbidity in forensic patients–assessed by questionnaires and diagnostic interview. *Clinical Practice and Epidemiology in Mental Health*, 2(1), 7.

Gault, I. (2009). Service-user and carer perspectives on compliance and compulsory treatment in community mental health services. *Health & Social Care in the Community*, 17(5), 504-513.

Geller, J. L. (2000). At the margins of human rights and psychiatric care in North America. *Acta Psychiatrica Scandinavica*, 101(399), 87-92.

Geller, J. L., Fisher, W. H., Grudzinskas Jr, A. J., Clayfield, J. C., & Lawlor, T. (2006). Involuntary outpatient treatment as "deinstitutionalized coercion": The net-widening concerns. *International Journal of Law and Psychiatry*, 29(6), 551-562.

Gibbs, A., Dawson, J., Ansley, C., & Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, *14*(4), 357-368.

Goulet, M. H., Pariseau-Legault, P., Côté, C., Klein, A., & Crocker, A. G. (2020). Multiple stakeholders' perspectives of involuntary treatment orders: a meta-synthesis of the qualitative evidence toward an exploratory model. *International Journal of Forensic Mental Health*, *19*(1), 18-32.

Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review, 15*(1), 84-99.

Hori, H., Richards, M., Kawamoto, Y., & Kunugi, H. (2011). Attitudes toward schizophrenia in the general population, psychiatric staff, physicians, and psychiatrists: a web-based survey in Japan. *Psychiatry Research*, *186*(2-3), 183-189.

Husserl, E. ([1931] 1967) *Cartesian meditations* [trans. D. Cairns]. Nijhoff

Jobling, H. (2014). Using ethnography to explore causality in mental health policy and practice. *Qualitative Social Work: Research and Practice*, *13*(1), 49–68.

Karatzias, T., Shevlin, M., Pitcairn, J., Thomson, L., Mahoney, A., & Hyland, P. (2019). Childhood adversity and psychosis in detained inpatients from medium to high secured units: results from the Scottish census survey. *Child Abuse & Neglect*, *96*, 104094.

Langdridge, D. (2007) *Phenomenological psychology: Theory, research and method.* Pearson Education.

Laub, J. H., Nagin, D. S., & Sampson, R. J. (1998). Trajectories of change in criminal offending: Good marriages and the desistance process. *American Sociological Review*, 225-238.

Laub, J. H., & Sampson, R. J. (2001). Understanding desistance from crime. *Crime and Justice*, *28*, 1-69.

Lawton-Smith, S., Dawson, J., & Burns, T. (2008). Community treatment orders are not a good thing. *The British Journal of Psychiatry*, *193*(2), 96-100.

Lim, Y. T., & Bennett, D. M. (2020). Readability of statutory letters issued by Forensic Services in NHS Scotland. *Medicine, Science and the Law*, *60*(2), 93-101.

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American Journal of Public Health*, *89*(9), 1328-1333.

Lorem, G. F., Hem, M. H., & Molewijk, B. (2015). Good coercion: Patients' moral evaluation of coercion in mental health care. *International journal of mental health nursing*, *24*(3), 231-240.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. The Lancet, 358(9280), 483–488.

Mann, R. E., Hanson, R. K., & Thornton, D. (2010). Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment*, 22, 191-217.

McGlashan, T.H., Levy, S.T., & Carpenter, W.T. (1975). Integration and sealing over: Clinically distinct recovery styles from schizophrenia. *Archives of General Psychiatry*, *32*, 1269-1272.

McIntosh, L. G., Janes, S., O'Rourke, S., & Thomson, L. D. (2021). Effectiveness of psychological and psychosocial interventions for forensic mental health inpatients: A meta-analysis. *Aggression and Violent Behavior*, 101551.

McKenna, B., Simpson, A., & Cloverdale, J. H. (2003). Patients' perceptions of coercion on admission to forensic psychiatric hospital: a comparison study. *International Journal of Law and Psychiatry*, 355-372.

Mental Welfare Commission (2011). *Consent to treatment: A guide for mental health practitioners.* https://www.mwcscot.org.uk/media/51774/Consent%20to%20Treatment.pdf

Mental Welfare Commission for Scotland. (2013, July). *Early revocation of compulsion orders*. Retrieved 23 November 2021, from https://www.mwcscot.org.uk/sites/default/files/2019-06/co_revocations_.pdf

Mezey, G. C., Kavuma, M., Turton, P., Demetriou, A., & Wright, C. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, *21*(5), 683-696.

Mikellides, G., Stefani, A., & Tantele, M. (2019). Community treatment orders: international perspective. *BJPsych International*, *16*(4), 83-86.

Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology*, *42*(4), 331-353.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, *23*(1), 51-59.

National Records of Scotland. (n.d). *Population of Scotland.* Retrieved December 22, 2021, from https://www.nrscotland.gov.uk/statistics-and-data/statistics/scotlands-facts/population-of-scotland

Newbigging, K., & Ridley, J. (2018). Epistemic struggles: The role of advocacy in promoting epistemic justice and rights in mental health. *Social Science & Medicine*, *219*, 36-44.

Newton-Howes, G., & Ryan, C. J. (2017). The use of community treatment orders in competent patients is not justified. *The British Journal of Psychiatry*, *210*(5), 311-312.

Ng, L., Friedman, S. H., & Diesfeld, K. (2016). Checking and Balancing New Zealand's Mental Health Review Tribunal: Perspectives of Forensic Patients. *Psychiatry, Psychology and Law*, *23*(1), 135-147.

Ogloff, J. R., Talevski, D., Lemphers, A., Wood, M., & Simmons, M. (2015). Co-occurring mental illness, substance use disorders, and antisocial personality disorder among clients of forensic mental health services. *Psychiatric Rehabilitation Journal*, *38*(1), 16.

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry*, *167*(11), 1321-1330.

Perlin, M. L. (2016). International human rights and institutional forensic psychiatry: The core issues. In B. Völlm & N. Nedopil (Eds.), *The use of coercive measures in forensic psychiatric care: Legal, ethical and practical challenges*, (pp.9-30). Springer International Publishing

Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, *47*(11), 1451–1458.

Ray, I., & Simpson, A. I. (2019). Shared risk formulation in forensic psychiatry. The *Journal of the American Academy of Psychiatry and the Law*, *47*(1), 22-28.

Ridley, J., & Hunter, S. (2013). Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care &Treatment) (Scotland) Act 2003. *Health & Social Care in the Community*, *21*(5), 509-518.

Riley, H., Høyer, G., & Lorem, G. F. (2014). 'When coercion moves into your home'–a qualitative study of patient experiences with outpatient commitment in Norway. *Health & Social Care in the Community*, *22*(5), 506-514.

Rugkåsa, J. (2016). Effectiveness of community treatment orders: the international evidence. *The Canadian Journal of Psychiatry*, *61*(1), 15-24.

Rugkåsa, J., & Burns, T. (2017). Community treatment orders: are they useful?. *BJPsych Advances*, *23*(4), 222-230.

Sampson, S., Edworthy, R., Völlm, B., & Bulten, E. (2016). Long-term forensic mental health services: an exploratory comparison of 18 European countries. *International Journal of Forensic Mental Health*, *15*(4), 333-351.

Saya, A., Brugnoli, C., Piazzi, G., Liberato, D., Di Ciaccia, G., Niolu, C., & Siracusano, A. (2019). Criteria, procedures, and future prospects of involuntary treatment in psychiatry around the world: a narrative review. *Frontiers in Psychiatry*, *10*, 271.

Scottish Executive (2005). *Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice. Volume 3 Compulsory Powers in Relation to Mentally Disordered Offenders.* https://www.gov.scot/publications/mental-health-care-treatment-scotland-act-2003-code-practice-volume-3-compulsory-powers-relation-mentally-disordered-offenders/pages/9/

Scottish Executive. (2001). *Report on the review of the Mental Health (Scotland) Act 1984.* https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf

Scottish Government Social Research. (2009). *Evaluation of early experiences of the Mental Health (Care & Treatment) (Scotland) Act 2003: A cohort study.* Edinburgh, UK: Queens Printers of Scotland.

Smith, J.A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, *2*, 3-11.

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

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, research.* Sage.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis. Smith, J. A. (Ed.). (2015). *Qualitative psychology: A practical guide to research methods*. Sage.

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372-1380.

Steinböck, H. R. (2009) New developments in preventive detention in Germany. *Current Opinion in Psychiatry*, *22*, 488–491.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research* (2nd ed.). Thousand Sage.

Stuart, S. R., Tansey, L., & Quayle, E. (2017). What are the barriers to recovery perceived by people discharged from a medium-secure forensic mental health unit? An interpretative phenomenological analysis. *Journal of Theoretical & Philosophical Criminology*, *9*(1), 1-31.

Szmukler, G., Daw, R., & Callard, F. (2014). Mental health law and the UN Convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry*, *37*(3), 245-252.

Tait, L., Birchwood, M., & Trower, P. (2004). Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies. *The British Journal of Psychiatry*, *185*(5), 410-415.

Tan, J. O., Stewart, A., Fitzpatrick, R., & Hope, T. (2010). Attitudes of patients with anorexia nervosa to compulsory treatment and coercion. *International Journal of Law and Psychiatry*, *33*(1), 13-19.

Thorne, S., Armstrong, E. A., Harris, S. R., Hislop, T. G., Kim-Sing, C., Oglov, V., ... & Stajduhar, K. I. (2009). Patient real-time and 12-month retrospective perceptions of difficult communications in the cancer diagnostic period. *Qualitative Health Research*, *19*(10), 1383-1394.

Tomlin, J., Bartlett, P., & Völlm, B. (2018). Experiences of restrictiveness in forensic psychiatric care: Systematic review and concept analysis. *International Journal of Law and Psychiatry*, *57*, 31-41.

Völlm, B., Bartlett, P., & McDonald, R. (2016). Ethical issues of long-term forensic psychiatric care. *Ethics, Medicine and Public Health*, *2*(1), 36-44.

Ward, T., Mann, R. E., & Gannon, T. A. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior*, *12*(1), 87-107.

Winick, B. (2002). Therapeutic jurisprudence and the treatment of people with mental illness in Eastern Europe: Construing international human rights law. *New York Law School Journal of International & Comparative Law, 21*, 537–572.