**What counts as ‘counter-conduct’? A governmental analysis of resistance in the face of compulsory community care**

Hannah Jobling, Social Policy and Social Work, University of York

**Introduction**

The treatment and control of individuals with severe mental health difficulties in the community has long been positioned as a problem in need of a solution. Community treatment orders (CTOs), enacted under the Mental Health Act (2007) are one recently introduced ‘solution’ in English mental health services. CTOs give mental health professionals the power to impose conditions on how service users live in the community, particularly in regards to medical treatment, and provide a mechanism for hospitalisation and treatment enforcement, called recall, if these conditions are not met or if the service user’s mental health has deteriorated to the extent that they are deemed to be a risk to their own health and safety or that of others. CTOs tend to be aimed at particular groups of service users, especially those who have been described as ‘revolving door’, meaning they regularly stop their medication and experience relapse, leading to continuous movement between hospital and the community. The large majority of individuals placed on CTOs have been given a primary diagnosis of a psychosis-related disorder, and are on anti-psychotic medication (Churchill et al, 2007), which the CTO is intended to ensure they adhere to. Although CTOs are regularly reviewed they can be renewed indefinitely, and so the individuals who are placed on them can be under compulsion in the community for an unlimited period of time.

CTOs have spread persistently across different jurisdictions over the last thirty years, and yet remain a much debated addition to the landscape of community mental health wherever they have been enacted. Modern mental health services, both in the community and in hospital, have always contained elements of compulsion and coercion which can be seen as forming a continuum, from informal persuasion through to formally mandated hospital treatment (Monahan et al, 2001). However, a distinction can be made between the undefined and discretionary use of treatment pressure in the community and the legislatively defined role of CTOs. As Churchill et al (2007, 20, emphasis in original) state, CTOs are qualitatively different from what has gone before in the countries where they have been implemented because they, “enforce community treatment *outside (and independently) of the hospital*, contain specific mechanisms for *enforcement and/or revocation* and are authorised by *statute*”. In this sense, CTOs have expanded the boundaries of legally mandated compulsion in mental health, and in doing so, have galvanised debates on where the balance should be struck between rights or risk, and freedom or coercion for individuals within the mental health system. Therefore, although CTOs are premised on distinctive historical and cultural contingencies, they also bring into sharp focus the longstanding moral balancing acts that frame the treatment (in the broadest sense of the word) of individuals diagnosed with severe mental health difficulties. Opinion on CTOs is strongly divided, with opponents arguing that an extension of compulsion into the community results in an unnecessary and stigmatising focus on risk, a loss of liberty and rights for service users, and the neglect of alternative, less coercive methods of engagement (Brophy and McDermott, 2003; Geller et al, 2006; Pilgrim, 2007). Conversely, supporters of CTOs argue that they help to engage service users who are hard to reach and/or considered a risk, facilitate community-based care, reduce rates and length of compulsory hospitalisation, encourage better treatment, improve clinical outcomes and promote recovery (Lawton-Smith, Dawson and Burns, 2008; Munetz and Frese, 2001; O’Reilly, 2006).

Given the controversial nature of CTOs and the concerns that have been raised about their potentially coercive effects, the experiences of those individuals who are made subject to them seem particularly important to understand. In this chapter the findings of an ethnographic study of CTOs in action are reported on, focusing on how individuals made subject to CTOs perceive the role the CTO has in their lives, and their subsequent responses to its imposition. Empirical work on CTOs has rarely been theorised, and in order to gain a deeper and more nuanced understanding of individual responses to compulsory intervention, Foucault’s notion of governmentality is drawn upon to elucidate the diverse connections between ‘practices of the self’, ‘conduct’ and ‘counter-conduct’ in the face of compulsion.It will be argued that individuals’ conceptions of self in relation to disciplinary policy interventions can lead to complex, ambiguous and perhaps unexpected responses to compulsion, which are not easily categorised into binary forms of compliance and resistance. The chapter begins with an exploration of governmentality and the useful role it can play in making sense of policy interventions, particularly those where compulsion of some form is integral to their function. The intended purposes of CTOs are discussed next, as to understand how individuals respond in varied ways to the CTO, it is important to firstly understand what rationalities they are responding to. This provides context for a series of ‘cases’, which highlight how the personal ‘ends and means’ of those made subject to the CTO coalesce or diverge from the ‘ends and means’ of the CTO.

**Governmentality and subjectification**

Governmentality originates in Foucault’s critique of sovereign power, in which he contested the idea that power is operationalised in a centralised, repressive and hierarchical way. Instead, Foucault contended that “power is everywhere” (Foucault, 1990, 93), being omnipresent and dispersed. As such, power is not ‘possessed’ by a few but is a force that is relational in nature and in constant flux within society; Foucault therefore “challenges the polarisation of such categories as ‘powerful’ and ‘powerless’” (Pease, 2002, 139). Consequently Foucault argued that power does not have to be thought of solely in coercive terms, but can also be productive and indeed necessary – an integral part of how societies work (Gaventa, 2003). Such a conceptualisation of power shifts the focus from an analysis of sovereign power to disciplinary power and how it manifests at a ‘micro-political’ level.

Foucault derived disciplinary power as a particularly modern invention, emanating and evolving from the Enlightenment period: “‘The Enlightenment’, which discovered the liberties, also invented the disciplines” (Foucault, 1977, 222). Disciplinary power is thus reliant on scientific discourses regarding the nature of human thought and behaviour, and associated techniques and strategies of objectification and subjectification, which are not premised on the use of force. In contrast to sovereign power then, disciplinary power is “a modest, suspicious power [which] regards individuals both as objects and as instruments of its exercise” (Foucault 1977, 170). The aforementioned techniques and strategies that underpin disciplinary power consist of various systems of surveillance and categorisation, made possible through the creation of the human sciences and associated expert-based disciplines such as social work, psychiatry, psychology and criminology. In this way a ‘disciplinary society’ is created, where individuals are measured against normalising judgements, and are disciplined, or discipline themselves accordingly.

As inferred here, Foucault’s conceptualisation of disciplinary power is entwined with another of his central ideas, that of ‘power/knowledge’. Whilst Foucault did not conflate knowledge and power, he was interested in the complex and inextricable relationship between them, arguing that “power produces knowledge…power and knowledge directly imply each other” (Foucault 1977, 27). The formation of a ‘disciplinary society’ is reliant on particular ‘regimes of truth’ which as dominant discourses constitute normalising judgements and in turn the regulation of conduct, as Foucault (1977, 27) goes on to say:

Knowledge linked to power, not only assumes the authority of 'the truth' but has the power to make itself true. All knowledge, once applied in the real world, has effects, and in that sense at least, 'becomes true.' Knowledge, once used to regulate the conduct of others, entails constraint, regulation and the disciplining of practice.

The question that therefore arises is how discourse - via power/knowledge - constitutes the subject, in particular through the human sciences and the accompanying application of expertise. Accordingly, power is locally dispersed rather than centrally coordinated, using small-scale rather than hegemonic means.

Foucault also posits how subjects might interact with and work at their own constitution through ethical ‘practices of the self’. Foucault’s view of what ‘the self’ might mean is not easily categorised. He rejected humanism and the idea of an unchanging and universal human nature which allows each of us primacy over our selves and in a greater sense, our destinies and our world. However in his development of ‘practices of the self’, which is based on a ‘self-self’ reflexive relationship, Foucault does not take a nihilistic position. His focus is not on defining human nature, but as Hacking (2004, 288) posits, on how people become who they are; the “dynamics of human nature”. This presupposes that a flat, rather than vertical relationship exists between self-government, government by and of others, and government of the state (Dean, 1994, 196). If we accept that particular moral codes have held sway at particular junctures, and in turn interact with how we relate to ourselves and others via ethical practices, then the focus is on how we choose to form ourselves through a variety of means and in relation to a multiplicity of moral codes in the present. What this means is that: “Foucault – most assuredly, not a sociologist – offers us a thoroughly sociological sense of self that does not reduce the self to the social” (Dean, 1994, 216).

In this sense, Foucault is not quite as far removed from an existentialist perspective on the role of agency as has sometimes been supposed (Hacking, 2004). His ‘practices of the self’ refers to four dimensions necessary for ethical self-work: ‘ethical substance’ or the focus for moral conduct; the external stimulus that leads to recognition of moral obligation; ‘ethical work’ or the means by which we attempt change; and the *telos* of such work, the end person that is aspired to (Foucault, 1997). Governmentality thus brings together disciplinary and reflexive power, connecting the processes by which we work on ourselves to broader governance processes by which we might be worked on. Governmentality has subsequently been developed as an analytical framework to illuminate the process of governing across a continuum that stretches beyond sovereign power, to a dispersed disciplinary ‘microphysics of power’, to reflexive power via reformation of identity and regulation of the self.

Specifically, an ‘analytics of government’ is focused on delineating various manifestations of the ‘conduct of conduct’ (Foucault, 2007, 192), which can be defined as “any attempt to shape with some degree of deliberation aspects of our behaviour according to particular sets of norms for a variety of ends” (Dean, 2010, 10). Mckee (2009, 466, emphasis in original) draws out the dual foci of thought and action that an analytics of government explores as:

Both the *discursive field* in which the exercise of power is rationalised – that is the space in which the problem of government is identified and solutions proposed; and the actual *interventionist practices* as manifest in specific programmes and techniques in which both individuals and groups are governed according to these aforementioned rationalities.

Governmentality then is concerned with both how conduct is problematised and how such rationalities are subsequently put to work through technologies which direct and reform conduct. However, the ‘conduct of conduct’ can be understood not only in relation to how others are governed, but as highlighted in ‘practices of the self’, how we govern ourselves. In other words, how “individuals recognise themselves as particular kinds of persons and…work upon and transform themselves in certain ways and towards particular goals” (Hodges, 2002, 457). Individuals make choices in how they integrate influences; logically an individual who can respond positively to external mandates and techniques can also respond negatively. Foucault (2007, 75) terms such responses as ‘counter-conducts’, which he defines as ‘the will not to be governed thusly, like that, by these people, at that price”. ‘Counter-conducts’ therefore are not rejections of government in itself, but an expression of seeking different forms and means of government. Within governmentality, forms of conduct and counter-conduct reflect each other and are interdependent – they both rely on the same processes of rationalities, technologies and reformation. As such, counter-conduct does not translate to resistance in terms of a revolutionary and emancipatory ‘stepping outside’ of pre-existing power structures. Disciplinary power operates at the micro-level and Foucault posited that so did counter-conducts. “Thus there is no grand refusal, only dispersed and shifting points of resistance” (Death, 2010, 239) which draw on ‘subjugated knowledges’ to form alternative ways of thinking and going about governance.

Where governmentality has been empirically applied, such research has been criticised for being overly concerned with the ‘discursive’ aspect of governmentality and a corresponding neglect of the realisation of rationalities in practice (Clarke, 2004; Stenson, 2005; Marston and McDonald, 2006; Parr, 2009). This focus on discourse analysis emphasises a view of the “‘social as a machine’ reforming and constituting everything it comes into contact with” (Hunter, 2003, 331), which does not account for the techniques and technologies of government. That argument can be extended further to suggest that the focal point of governmentality - conduct itself - requires more detailed empirical exposition. The emphasis placed on discourse foregrounds power/knowledge whilst neglecting power/knowledge/ethics and the relationship between conduct, counter-conduct and ‘practices of the self’. Specifically, this would involve study of the complex, unpredictable and contradictory nature of life as it is lived with agency and as embedded in variable social relations and institutions.

As Marston and McDonald (2006, 7) suggest then, “an analytics of government is particularly relevant to the re-emerging genre of ‘street-level’ policy evaluation…because it focuses attention away from the institutions of government towards the actual practices of government”. Policy interventions which rely on some form of compulsion are especially suited to a governmental approach given their often dual foci on reformation as well as control of the individual. Although Foucault decentred the role of sovereign power, Dean (2010, 8) has argued that governmentality still allows for the elucidation of “sovereign and coercive rationalities and techniques” alongside and in interaction with disciplinary and reflexive forms of power, based on Foucault’s (2000) contrasting notions of the ‘city-citizen’ and the ‘shepherd-flock’. The individual as *citizen* can be defined as operating within a juridico-political structure, on equal footing with other citizens in the exercise of freedom, rights and responsibilities. By its nature, this conception relies on there being a boundary between those who could be classed as citizens (due to their ability to exercise freedom, rights and responsibilities) and those who cannot. Within the ‘shepherd-flock’ concept, the individual can be understood in pastoral terms as “a *living being* who can be *known* in depth, whose *welfare* is to be cared for as an individual and as part of a population, as one *submits* to integration within complex forms of *social solidarity*” (Dean, 2010, 100, emphasis in original). Such an understanding is based on the belief that *all* individuals should be cared for. Notions of pastoral care and citizenship bring between them inherent tensions for the administration of liberal government because they depend on “human beings as both self-governing individuals within a self-governing political community and clients to be administered, governed and normalised with respect to governmental objectives” (Dean, 1994, 209).

This brings us to what Foucault deemed the potential ‘demonic’ possibilities inherent in liberal government, which can arise from the interaction between discourses of citizenship and welfare (Foucault, 1988). It is Dean’s (2010, 156) argument that such tensions, if sharp enough, can lead to the paradox of ‘liberal illiberality’, whereby the subject is managed via ‘dividing practices’ along the axes of responsibilisation and control: “the subject is either divided inside himself or divided from others” (Foucault, 1983, 208). Such divisions often have a strong biopolitical element, which can be seen from extreme manifestations such as forced sterilisation of particular members of a society ‘for their own good’ and for the perceived good of everyone else, through to pervasive ‘whole-population’ messages on self-care and well-being. Certainly, CTOs can be seen as an example of a biopolitical intervention, as they are based on a particular understanding of embodied madness and their foundational function is to ensure the management of such madness via medical means. The intended ‘ends’ of CTOs are discussed in more detail next, as in order to fully make sense of the responses of those made subject to the CTO, it is necessary first to understand to what they are responding.

**The rationalities for CTOs: risk and recovery**

In recent decades, community care for those with severe mental health difficulties has become associated with public fears about insufficiently controlled individuals presenting a risk of harm to the community at large (Stuart, 2003; Pilgrim, 2007). CTOs as a tool for regular monitoring and medication compliance can therefore be posited as a political response to public concerns, most obviously in the North American practice of naming their introduction after the victim of homicide by a mentally disordered individual (for example, Brian’s Law in Ontario, Kendra’s Law in New York and Laura’s Law in Florida). A similar narrative for CTOs was evident in England, beginning in 1998 when the then Secretary of State for Health, Frank Dobson proclaimed that ‘community care has failed’. A spate of much reported homicides committed by individuals in contact with mental health services provided impetus for policy reform, with the Home Office as well as the Department of Health shaping mental health policy based on public safety. The public inquiries that arose from these killings attracted substantial media attention, particularly in relation to their key findings, which drew attention to common service failures and made a range of recommendations, including that legislation should be examined, particularly in regards to compulsory treatment and supervision in the community (Blom-Cooper, Hally and Murphy, 1995; Sheppard, 1997). The Government made it clear early on in the reform process that they believed the existing legislation for community supervision was outdated, and had failed to either benefit service users or to protect the public (Department of Health and Home Office, 2000). As the then Minister for Health Services, Rosie Winterton made clear, the argument for CTOs was closely linked to risk:

There are 1,300 suicides every year and 50 homicides by people who have been in contact with mental health services. We believe that supervised community treatment is vital to helping patient continue to take treatment when they leave hospital and to enable clinicians to take rapid action if relapse is on the horizon (HC Deb, 18th June 2007, Vol. 461, Col. 1193).

However, it would be simplistic to suggest an overriding concern with risk was the sole driver behind policy-making on CTOs. CTOs have also been associated, albeit much less overtly, with a somewhat paternalistic version of the recovery approach in mental health, where it has been surmised they can act to provide a secure foundation for individuals to operate from and to encourage self-efficacy. Dawson (2009, 29) argues that an understanding of CTOs as enabling self-direction and choice is philosophically grounded in the concept of positive liberty (Berlin, 1969) which he defines as “our capacity for self-governance…our ability to set goals and have some chance of meeting them, and to maintain important relationships, without being dominated by internal constraints that prevent this occurring”. The framing of CTOs as a conduit for individual growth and empowerment is most evident in Munetz and Frese’s (2001) assertion that CTOs are reconcilable with the recovery model and indeed, can act as an opportunity for individuals to become ‘well enough’ through long term medication compliance to start the recovery process. In this way, they suggest longer-term outcomes of being on a CTO could include service users sustaining meaningful activity in the community, experiencing better quality of life and holding better relationships with significant others. The result of this thinking is that arguments for individual freedom are constructed as morally hazardous, as it is not enough to simply offer services and medical care which service users are free to reject (Kinderman and Tai, 2008). Munetz, Galon and Frese (2003, 178) go as far as to say that practitioners who do not accept the necessity for compulsory community treatment are negating their “obligation as helper and healer”. Although less prominent as a rationale than risk in policy debates, CTOs were nevertheless defended with recourse to recovery in parliament:

Supervised community treatment…will allow patients, so far as possible, to live normal lives in the community. This will reduce the risk of social exclusion and stigma associated with detention in hospital for long periods of time or with repeated hospital admissions, (Roll and Whittaker, 2007, 21).

Recovery in these terms requires that strong boundaries are put in place in order for individuals to overcome internal constraints, so that they are able to develop the discipline to comply, maintain stability and manage their lives. From this perspective, CTOs can be seen as a typical governmental practice which is aimed at influencing what individuals may become; the limitation of freedom through control in the short term encourages individuals’ capacity for freedom in the longer term.

Returning to the concept of ‘dividing practices’ discussed earlier, CTOs can therefore be characterised as differentiating and categorising ‘low-risk’ individuals who are ‘empowered’ to become responsibilised, autonomous, and self-regulating members of society from ‘high risk’ individuals who require external regulation (Kemshall, 2002). CTOs enable the reformation of individuals and their conduct if possible, but also allow for control and separation of the individual from society and the application of sanctions, should this transformative optimism prove unwarranted. Within this framework, CTOs contain both inclusionary and exclusionary facets so as to both manage risk and bring individuals into the fold of citizenship. The terminology of CTOs reflects these dual objectives. They have a highly contractual flavour, most specifically in the use of the term ‘conditions’ which service users must ‘agree’ and adhere to, or otherwise face the consequence of recall to hospital. Behaviour control in this sense is concerned with risk management in both a concrete and an abstract sense, the latter meaning prudent individuals are expected to make their own way in society whilst complying with complex rules and requirements, or as Rose (2002, 19) puts it in regards to mental health, “’play the game’ of community care”. Citizenship is therefore defined conditionally, and ‘irregular citizens’ (Zedner, 2010) are expected to earn their way to full citizenship through conforming to prescribed expectations. As Zedner (2010, 397) describes, the use of ‘contractual devices’, specific to the individual, subvert “the universalism of the… law and [delegate] considerable quasilegislative powers to the public officials who determine their precise terms”. In this way, CTOs change the state of play in regards to the rights that those who are placed on them hold, as compared to ‘regular citizens’.

There are connections here with a broader narrative which describes an intensification in recent decades of a behaviourist trend in social policy and an associated turn to ‘coercive support’ across a range of welfare domains, aimed at ensuring individual responsibility (Rodger, 2008; Flint, 2009). Both the recovery and risk agendas as played out in mental health policy and specifically in relation to CTOs locate the problem and the solution within the individual, thus individualising social problems. In these terms, it is the individual’s refusal to comply with medication which leads to their riskiness and/or lack of recovery and the underpinning argument for using CTOs has been the ability they would bring to enforce medication compliance. There is little acknowledgement in this explanatory framework of the complex reasons why individuals might be non-compliant with medication, or the societal and institutional factors which mediate risk and pathways to recovery. In the next section, the complexities of individual responses to CTOs are explored via a series of four cases drawn from research findings.

**Conduct and counter-conduct in response to CTOs**

The findings reported here come from an ethnographic study of CTOs, which traced the pathways of 18 CTOs in two English Mental Health Trusts over a period of eight months. Interviews were carried out with 18 individuals who were on a CTO and the professionals who were working with them. Case file analysis and observations of key meetings such as CTO reviews and appeals also took place, and unstructured time was spent within community mental health services in order to examine the day to day use of CTOs. In this way, a picture was formed of CTOs over time, within context and through a variety of methods utilised to capture both meaning and action in their everyday practice[[1]](#footnote-1).

The following cases are drawn from these 18 CTO cases and have been chosen to highlight the various connections that can be made between service users’ conceptions of self as related to the CTO and how they responded to it as an intervention in their life. Service users can be placed along a spectrum from acceptance to resistance of CTOs, and the cases discussed take different points on this continuum. If we revisit Foucault’s (1997) dimensions of ethical self-work, we can see that they relate to: external impetus for change, the means by which we act upon ourselves to bring about such change, and the end person we seek to become through these means. In formulating forms of conduct and counter-conduct, the CTO acts as the external stimulus, and the task here is to delineate how the means and ends service users have conceived for themselves relate to the means and ends – the practices and rationalities - of the CTO.

*Acceptance of CTO means and ends: Nick[[2]](#footnote-2)*

Nick can be described as a service user who whole-heartedly accepted the CTO and who expressed strong respect for the authority of the professionals who worked with him. He had not experienced recall to hospital under the CTO, as he had adhered to its conditions and practitioners saw the role of the CTO in his case being for boundary-setting rather than active intervention. In a superficial sense, he is a CTO ‘success’ story, particularly regarding behaviour change. However, there are interesting nuances that can be drawn out which are not quite as clear-cut, beginning with how the CTO related to the changes he wanted to see in himself. Nick aligned himself with a particular aspect of the CTO agenda, corresponding to how he saw himself and his relationships to others.

Nick expressed extreme anxiety about what he thought he was capable of in relation to harming others, particularly those who he was close to, and the CTO for him performed an important psychological function through imposing control when he did not feel able to exercise self-control. As he said: *being on a CTO if the truth’s known, I know deep down I’ll never ever get to the point where I’ve totally lost control like I’ve done in the past.* Nick’s self-conception was refracted through a ‘risk’ identity and he aligned himself with the risk mandate of CTOs: *I don’t think it’s something for everyone, it’s something that is good for violent, psychotic people like me.* Therefore he accepted one particular ‘end’ of the CTO – risk management – as it related to the kind of individual he wanted to become. As such, Nick was very clear that he did not want to be discharged from the CTO, and talked about it as being necessary for the foreseeable future, for the safety of others as well as his continuing and relative autonomy in the community.

Nick’s compliance to the CTO and insistent dependence on its continuation can however also be seen as a form of resistance to practitioners’ attempts to ‘move people on’ to independence and in this way he was not entirely an exemplar of conduct. For Nick, the idea of the CTO being removed generated similar feelings associated with coercion that study participants who were resentful of the CTO described, such as not having their view respected, anxiety and a lack of control. In Nick’s case, a pattern of uncertainty surfaced in practitioner discussion of how and if to bring about CTO discharge. He had been on the CTO for three years by the time of the fieldwork, and his care coordinator thought it was time to try him without the CTO, but was also aware of the distress such a decision would cause. It is possible to see in this dilemma some of the tensions inherent in the purposes of CTO. Whilst Nick can be positioned as having internalised both CTO means and ends in his appreciation of its boundaries and its risk-oriented rationality, he was also thinking and acting in opposition to a recovery narrative which emphasises the avoidance of engrained dependency. A professed need for dependence can be seen as inimical to an intervention which foregrounds individual autonomy.

*Resistance to CTO means but acceptance of ends: James*

James conversely, had taken on board the messages about responsibilised recovery inculcated in the CTO and expressed in a literal sense the transformation he felt the CTO had brought: *Compared to when I first came on the CTO and now, it’s like two different people…I mean from negative to positive. That’s the difference…I mean my feelings towards people, my actions towards people.* He saw himself very much in relation to the broader mental health system and network of support he received from practitioners, family and friends. In this sense he felt it his ‘duty’ and responsibility to use the CTO to recover and live what he viewed as a productive and independent life. James related this to the contractual nature of the CTO, with him upholding his side of the bargain: *And the CTO, if you’re not compliant to it, you’re wasting people’s time. You’re abusing the system. You’re responsible for yourself. That’s what the CTO is about, isn’t it? So the responsibility for taking your meds, for coming to your appointments, for seeing your doctor, I mean, yes, it’s a huge responsibility.*

Although James was different from Nick in terms of which CTO purpose he related to, it appeared he had also strongly accepted the place of the CTO in his life. Again however, by following James through the CTO it became evident his case was not entirely straightforward. Whilst James accepted the ends of the CTO, he had contested its means and in particular how he had his medication given under its remit, whereby he was placed on an injection for the first time rather than self-administered oral medication. As he says here: *I had a bit of negativity towards my nurse. There wasn’t a bond; there wasn’t a friendship. It was like, ‘no, you’re the nurse and you’re the injection and that hurts, I don’t like it and I’m tired of it’.* It seems that James’ care coordinator’s role in giving him the injection under the CTO created a professionalised distance and conflated her with the painful intervention she administered.

Consequently, in order to reach acceptance of the CTO, James shaped its means in a way which was coherent with his understanding of it. James did not see the CTO as being ‘done’ to him, and he demonstrated considerable agency in making the reality of the CTO fit with his responsibilised conception of it, which revolved around him taking control for his recovery. He did this by making a unilateral decision on how and where he should receive his medication, arranging for the injection to be administered through his GP practice instead of by his care coordinator. Here we can see that an element of the CTO which would be ‘taken for granted’ by practitioners as being inherent to how the CTO worked, was viewed very differently by James as being in opposition to how he saw it. He explained: *I felt that the CTO and my injections were in conflict because I didn’t feel in control of my injections. I was being told you’ve got to have them. It felt like the responsibility had been taken out of my hands. It was in the hands of the nurses and the doctors here and I thought, ‘well, that’s not fair because my CTO says I’ve got to be responsible, I’ve got to be in charge’ and then, when I went up to the medical centre and they started doing it, I settled down a bit better.* For James, his actions allowed him to ‘settle down’ and achieve stability on the CTO. In making this choice, James reduced his treating team’s ability to monitor his medication and consequently created some ‘space’ for himself within compulsion.Through buying into the recovery vision for CTOs, James also rejected and effectively resisted the control-oriented means by which the CTO functioned.

*Resistance to CTO ends but acceptance of means: Simon*

Resistance to CTO ends but acceptance of its means meant in Simon’s case, ‘playing the CTO game’ for his own ends, which did not cohere with the CTO drivers of risk or recovery. This was based on Simon’s ambivalent feelings towards the CTO: on the one hand the CTO was antithetical to his dreams of achieving ‘normality’ and to a life lived without feeling ‘different’; on the other, the functions of the CTO allowed him to carry on using particular support mechanisms. Simon had developed a pattern over the years of seeking admission to a respite facility as a coping strategy, but with the closure of this service and increasingly limited access to beds in acute services, his coping strategy had been disrupted. To this end, Simon regularly attempted (and at least initially succeeded) in triggering recall to hospital under the CTO by refusing his medication and avoiding contact with services. He explained this as a way for him to get admission to hospital, which he saw as a significant safety net: *And so for me it is like most people who have mental health problems, hospital is a safe environment, away from society, away from everything. You don't have to worry about somewhere to stay and whether you are going to get kicked out.*

Simon’s care coordinator was sympathetic to why Simon might do this, as a natural response to the changes and subsequent limitations of services: *I think he doesn’t like the CTO and he would like to be in control of it himself. He’d like to be able to say, ‘I need a break now’, when he's had enough of dealing with living alone, and that's how he was managed previously. But unfortunately we don't have respite care anymore... so the only way he can get respite is by becoming non-compliant, deteriorating and getting into hospital that way, where he feels safe.* Indeed, practitioners generally felt that the recall function of the CTO could provide a much-needed protective ‘short-cut’ to hospital in over-stretched services where admission was often difficult to attain. However at the same time Simon’s actions did not fit with the mandated use of recall which was directed by when practitioners thought it was necessary. Nor did his behaviour adhere to the priorities of inpatient services – self-perceived welfare needs were not viewed as an acceptable reason for acute care and service users were usually quickly discharged if this was deemed the reason for their being admitted. As Simon’s CTO went on, it became increasingly difficult for him to be recalled; in his case notes it was requested that practitioners no longer initiated recall unless absolutely necessary, and in an appeal report it was noted: *His social worker felt that* *the CTO was not necessary since if anything Simon was too demanding of support.* Simon had effectively undermined the use of the CTO by making it difficult for practitioners to decide when *they* thought he ‘needed’ recall and consequently his CTO was eventually discharged.

By subverting the key component of the CTO – recall - Simon had found a way of meeting his self-prescribed needs and retaining some kind of agency. Simon thus used the means of the CTO as a way of maintaining the level of care he felt he required. However, Simon did not align his actions with CTO policy aims as he was opposed to such principles applying to him, and certainly his use did not fit with either of the policy agendas for CTOs. In particular, the recovery narrative for CTOs can be viewed as not only premised on encouraging independence but also on managing levels of service use. This suggests that the development of CTOs for ‘revolving door’ service users such as Simon was also partly resource-driven, particularly within the context of the continuing roll-back of inpatient services and residualisation of state support more generally. In this sense, CTOs can be understood as aimed at maintenance through the enforced delivery of medically-focused ‘bare minimum’ provision. What is interesting is that despite this - in a paradoxical sense - Simon turned the CTO to his advantage by forcing access to resources via the obligations practitioners held under the CTO. In terms of conduct then, Simon acted *within* the remit of the CTO, but in a way which destabilised its agendas, and in a way which eventually rendered the CTO void in his case.

*Resistance to CTO ends and means: Andrew*

At the furthest end of the spectrum were those individuals who rejected both the means of the CTO and what it stood for. Resistance to CTO ends and means meant a complete rejection of the ‘service user role’, and Andrew provides interesting insights into how this might play out. Andrew did not believe the CTO had any place in his life – he resented both the compulsion it placed him under, and the sense that it was aimed at shaping his attitude and behaviour, when he wanted to be ‘left alone’ by services. He believed that the CTO was in place, *just so they [services] can keep an eye on me, so I can’t operate,* and to protect professional interests: *It’s a way of controlling the situation or controlling someone's behaviour, which puts people’s minds at ease and [sarcastically] I think everybody’s minds have got to be at ease.*

Andrew would continue to have occasional meetings with his care coordinator who he had known for some years, but avoided appointments to have his injection where possible and refused to meet his psychiatrist. Because of this, he was an individual who was made to undergo monthly recalls to hospital in order to enforce medication compliance. These ‘recall cycles’ were at the sharp end of compulsion under the CTO. One of the characteristics of CTOs across all countries where they are enacted is that none of them cross the ethical ‘Rubicon’ (Dawson, 2005) of enforced treatment in a community setting – people are always brought back into hospital for enforced medication. The cycling of individuals in and out of hospital on a monthly basis to receive their depot means that the concept of ‘crossing the Rubicon’ loses its potency, as the boundary between community and hospital became porous and enforced treatment in the community happened by proxy.

For those individuals like Andrew whose resistance to the CTO regularly triggered recall, practitioners might think of it as a ‘failed CTO’ because of the problematic ethical questions it raises, and because it bring less stability for individuals in the community, damaging the therapeutic relationship and costing time and resources. An alternative view was if repeat recalls means service users are regularly taking medication and subsequently staying relatively well, then the CTO was working in lowering their risk to others and ensuring they are protected from the worst of relapse. A combination of Andrew’s forensic history and because recall in his case tended to be relatively straightforward, meant that his treating team had decided on balance that his CTO was worth retaining indefinitely even though it had a significant psychological negative effect on him personally. Out of all the cases described thus far, Andrew’s thoughts and actions in relation to the CTO can most typically be seen as ‘counter-conduct’, but his experience is also most redolent of the ‘dividing practices’ of liberal governmental rationalities and technologies. This meant that his attempts at shaping the CTO were also the least effective; his actions meant he was placed very firmly within the parameters of the CTO by practitioners. Agency and resistance are often closely linked in research and theory on the responses of those made subject to coercive policy interventions, and yet in Andrew’s case, the latter significantly limited the former.

**Discussion**

These cases have illustrated the non-dichotomous forms conduct and counter-conduct can take to governmental programmes. Dawson et al (2003, 253) suggest that the CTO has the capacity to “both advance and limit [an individual’s] freedom, in different respects and at different times in their lives”. This complex and fluctuating interaction between compulsion - as characterised by the CTO - and freedom was certainly reflected in participant experiences. The CTO is a compulsory measure, but how much room for manoeuvre participants believed they had within the CTO varied, both individually and in relation to different aspects of the CTO. As noted earlier, conduct and counter-conduct are two sides of the same coin and mutually constitutive – neither involves ‘stepping outside’ of existing power structures, but instead responding to disciplinary power in differential ways, as related to both individual and social means and ends. Removing this ‘either/or’ distinction from discussions of power and resistance means that such responses can be seen in a more variegated sense, which does not look ‘beyond government’ (Rose, 1999, 281) but at how individual action plays out *within* the strategies and techniques of government (Death, 2010). As Death (2010, 236, emphasis in original) comments, forms of conduct “have the potential to reinforce and bolster, as well as *and at the same time as,* undermining and challenging dominant forms of…governance”.

With CTOs, it is possible to see where conduct and counter-conduct contain continuity and movement between them: with Nick who although accepting of the risk agenda for CTOs and compliant in every sense to the CTO, highlights the challenges practitioners might face when individuals resist the lifting of compulsion; James, whose personal ‘ends’ aligned with the recovery-oriented aim of the CTO even if he resented and reformed the means of the CTO in itself; Simon who although opposed to the CTO in principle took the means of the CTO to achieve his own ends of support; and with Andrew, who became further entwined in systems of conduct the more he attempted to resist the CTO. It is also possible to see the significance that needs to be placed on personhood when considering the effects policy interventions have on individuals. As Sayer (2005, 51) explains, interpreting this normative dimension of everyday life is necessary to avoid a representation of “bloodless figures who seemingly drift through life, behaving in ways which bear the marks of their social position and relations of wider discourses, disciplining themselves only because it is required of them, but as if nothing mattered to them”. These cases illustrate the potent psychological responses service users could have to the CTO as premised on the way it keyed into their sense of identity and reflected their sense of self and self in relation to others as an articulation of being and belonging in society. ‘Thin’ theorisations of change through policy programmes framed as ‘carrots, sticks and sermons’ (Bemelmans-Videc, Rist and Vedung, 1998) do not account for the individual they are imposed on – their history, hopes and self-conceptions, or the reflexive work such factors instigate. A governmental analysis of how service users think and act in response to disciplinary and coercive forms of power has implications for why CTOs follow particular pathways. The CTO cannot be understood as transformative in and of itself, but instead as acting in conjunction with ethical ‘self-work’. Consequently, simplistic policy theories about the responses of ‘target’ groups to intervention cannot predicate what programme outcomes will be. It seems that both the multifaceted motivations and challenges service users bring to CTOs, coupled with the complex ways they interact with CTOs, mean such expectations are not always fulfilled. In this way the process of subjectification via governmental means is complicated by how people are ‘made up’ from below via communicative action and the application of lay normativity as well as from above via discourse (Hacking, 2004, Sayer, 2005).

Indeed, the responses of service users to CTOs highlight the ‘inconvenient facts’ about discontinuities between explicit governmental rationalities and their strategic effects (Dean, 2010). Foucault argued that programmes of government include the seeds of their failure, which inevitably leads to on-going strategies and mutations in forms of government, and we can see how that plays out with the evolution of CTOs. As Lemke (2000, 9) suggests, struggles and compromise are integral to governmental programmes, “actively contributing to...‘fissures’ and ‘incoherencies’ inside them”. Specifically, the cases of Nick and James exemplify that the dual risk management and responsibilised version of recovery for which CTOs are intended to work, carry tensions which are not easily reconciled. Further, the cases of Nick and Simon in particular bring to the surface a further ‘ground-level’ rationality which is missing from the dual risk/recovery narrative for CTOs - that of dependency and associated care - which does not align easily with “contemporary practices of government…which have come to rely on the governed themselves” (Dean, 2010, 82). It is difficult to separate out the responsibilised individual from the networks of support which sustain them and within which they are entwined (Trnka and Trundle, 2014). Flint (2009) suggests that the public positioning of policy programmes aimed at behavioural change as premised on coercion can hide the provision of enhanced support such programmes may provide to the individuals made subject to them, particularly when more universal provision is becoming increasingly restricted. The responses of individuals in the face of CTO means and ends demonstrates that they do not necessarily perceive the CTO in terms of their own “power and powerlessness, consent and constraint, subjectivity and subjection” (Dean, 2010, 84). An analysis of conduct and counter-conduct thus also moves the debate on CTOs beyond the opposing positions that are prevalent in discussions of their use.

**References**

Bemelmans-Videc, M., Rist, R. and Vedung, E., (1998), *Carrots, Sticks and Sermons: Policy Instruments and their Evaluation,* New Jersey: Transaction Publishers.

Berlin, I. (1969) *Four Essays on Liberty*. Oxford: Oxford University Press.

Blom-Cooper, L., Hally, H. and Murphy, E. (1995), *The Falling Shadow: One Patient’s Mental Health Care 1978-1993.* London: Gerald Duckworth & Co Ltd.

Brophy, L. and McDermott, F. (2003). What's driving involuntary treatment in the community? The social, policy, legal and ethical context*. Australasian Psychiatry*, 11 84–88.

Churchill, R, Owen, G, Singh, S & Hotopf, M, (2007*), International Experiences of Using Community Treatment Orders,* London: Institute of Psychiatry, Kings College London.

Clarke, J. (2004). *Changing Welfare, Changing States: New Directions in Social Policy*. London: Sage.

Dawson, J. (2009). Concepts of liberty in mental health law. *Otago Law Review*, 12(1), 23-36.

Dawson. J., Romans. S., Gibbs. A., and Ratter. N. (2003). Ambivalence about community treatment orders. *International Journal of Law and Psychiatry,* 26, 243–255.

Dean, M. (1994), *Critical and effective histories: Foucault’s methods and historical sociology,* London: Routledge.

Dean, M. (2010) *Governmentality: Power and Rule in Modern Society*. (2nd Edition) London: Sage.

Death, C. (2010). Counter-conducts: a Foucauldian analytics of protest. *Social Movement Studies*, 9(3), 235-251.

Department of Health and the Home Office (2000), *Reforming the Mental Health Act* (Cm 5016).

Flint, J. (2009), Governing marginalised populations: The role of coercion, support and agency, *European Journal of Homelessness*, 3, 247-260.

Foucault, M. (1977). *Discipline and Punish: the Birth of the Prison*. New York, NY: Pantheon.

Foucault, M. (1983), ‘The subject and power’, in H. Dreyfus and P. Rabinow (Eds), *Michel Foucault: Beyond Reason and Hermeneutics* (2nd Edition), Chicago: The University of Chicago Press.

Foucault, M. (1988), *Politics, Philosophy, Culture,* L. Kritzmann (Ed), New York : Routledge.

Foucault, M. (1990), *The History of Sexuality. Volume 1: An* Introduction. London: Vintage.

Foucault, M. (1997), ‘The ethics of the concern of the self as a practice of freedom’, in P. Rabinow (ed) *The Essential Works of Michel Foucault, vol. 1: Ethics: Subjectivity and Truth*, New York: The New Press.

Foucualt, M. (2000), ‘Omnes et singulatum: towards a critique of political reason, in J. Faubion (ed), *Power,* New York: The New Press.

Foucault, M. (2007), *Security, Territory, Population*. London: Palgrave.

Gaventa, J. (2003), *Power after Lukes: An overview of theories of power since Lukes and their application to development.* [unpublished briefing paper].

Geller J, Fisher W, Grudzinskas A, Clayfield J and Lawlor T (2006). ‘Involuntary outpatient treatment as “deinstitutionalised coercion”: the net-widening concerns’. *International Journal of Law and Psychiatry*, 29 (6), 551–62.

Hacking, I. (2004). Between Michel Foucault and Erving Goffman: between discourse in the abstract and face-to-face interaction. *Economy and Society*, 33(3), 277-302.

HM Government (2007) *The Mental Health Act 2007.*

Hodges, I. (2002). Moving beyond words: therapeutic discourse and ethical problematization. *Discourse Studies*, 4, 455-479.

HC Deb, 18th June 2007, Vol. 461, Col. 1193.

Hunter, S. (2003). A critical analysis of approaches to the concept of social identity in social policy. *Critical Social Policy*, 23(3), 322-344.

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

Kemshall, H. (2002). *Risk, Social Policy and Welfare*. Maidenhead: Open University Press.

Kinderman, P. and Tai, S. (2008). Psychological models of mental disorder, human rights, and compulsory mental health care in the community. *International Journal of Law And Psychiatry*, 31(6), 479-486.

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

Lemke, T. (2000), Foucault, governmentality and critique, Paper presented at the *Rethinking Marxism Conference,* University of Amhurst (MA), September 21-24 2000.

Marston, G., and McDonald, C. (Eds.). (2006). *Analysing Social Policy: A Governmental Approach*. Cheltenham: Edward Elgar Publishing.

McKee, K. (2009). Post-Foucauldian governmentality: What does it offer critical social policy analysis?. *Critical Social Policy*, 29(3), 465-486.

Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., Roth, L., Grisso, T., and Banks, S. (2001). *Rethinking Risk Assessment: The Macarthur Study of Mental Disorder and Violence.* New York: Oxford University Press.

Munetz, M. R. and Frese, F.J. (2001). Getting ready for recovery: Reconciling mandatory treatment with the recovery vision. *Psychiatric Rehabilitation Journal*, 25(1), 35-42.

Munetz, M. R., Galon, P.A., and Frese, F.J. (2003). The ethics of mandatory community treatment. *Journal of the American* *Academy of Psychiatry and the Law*, 31(2), 173-183.

O’Reilly, R. L. (2006). Community Treatment Orders: This Emperor is Fully Dressed!. *Canadian Journal of Psychiatry*, *51*(11), 691.

Parr, S. (2009). Confronting the reality of anti-social behaviour. *Theoretical Criminology*, *13*(3), 363-381.

Pease, B. (2002), Rethinking Empowerment: A Postmodern Reappraisal for Emancipatory Practice, *British Journal of Social Work*, 32, 135-147.

Pilgrim, D. (2007). New ‘mental health’ legislation for England and Wales: some aspects of consensus and conflict. *Journal of Social Policy*, 36(01), 79-95.

Rodger, J.J. (2008), *Criminalising Social Policy: Anti-Social Behaviour and Welfare in a De-Civilised Society*, Devon: Willan Publishing.

Roll, J and Whittaker, M. *The Mental Health Bill [HL],* House of Commons Library Research Paper 07/33, 30 March 2007.

Rose, N. (1999). *Powers of Freedom: Reframing Political Thought.* Cambridge: Cambridge University Press.

Rose, N. (2002)*.* ‘Society, madness and control’, in A Buchanan (ed), *The Care of the Mentally Disordered Offender in the Community,* Oxford: Oxford University Press, 3-25.

Sayer, A. (2005), *The Moral Significance of Class,* Cambridge: Cambridge University Press.

Sheppard, D. (1997), *Mental Health Inquiries Published During 1997.* Institute of Mental Health Law.

Stenson, K. (2005). Sovereignty, biopolitics and the local government of crime in Britain. *Theoretical Criminology*, 9(3), 265-287.

Stuart, H. (2003). Violence and mental illness: an overview. *World Psychiatry*, *2*(2), 121.

Trnka, S. and Trundle, C. (2014), Competing responsibilities: Moving beyond neoliberal responsibilisation, *Anthropological Forum: A Journal of Social Anthropology and Comparative Sociology,* 24 (2), 136-153.

Zedner, L. (2010). Security, the State, and the Citizen: The Changing Architecture of Crime Control. *New Criminal Law Review*, 13, 379–403.

1. For more detailed information on methodology, see Jobling (2014). [↑](#footnote-ref-1)
2. All participants have been given pseudonyms. [↑](#footnote-ref-2)