

# Acceptability of compulsory powers in the community: the ethical considerations of mental health service users on Supervised Discharge and Guardianship

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**Objectives:** To explore mental health service users' views of existing and proposed compulsory powers.  
**Design:** A qualitative study employing in-depth interviews. Participants were asked to respond to hypothetical questions regarding the application of compulsory powers under the Mental Health Act 1983 for people other than themselves.  
**Setting:** Community setting in Southeast England.  
**Participants:** Mental health service users subject to Supervised Discharge/Guardianship.  
**Results:** Participants considered that the use of compulsory powers was justified if there were some ultimate benefit, and if there was evidence of mental health problems, dangerousness, or a lack of insight. However, participants rejected intrusions into their autonomy and privacy.  
**Conclusions:** This paper's participants indicated that the proposed CTO may be unacceptable because it would threaten service users' autonomy. Service users' acceptance of proposed changes is conditional and they emphasised the importance of consent; there is no suggestion that consent will be required for the CTO. The findings also have implications for the exploration of mental health service users' views and how they might contribute to policy, service planning, and research.

Government proposals to reform the Mental Health Act (MHA) 1983<sup>1</sup> mean that existing compulsory community supervision orders (Supervised Discharge and Guardianship) could be replaced by Community Treatment Orders (CTOs). The shift towards increased compulsion makes it appropriate to explore service users' views of the acceptability of existing and proposed compulsory powers. Despite the move towards user driven services, service users' voices have largely remained silent throughout the debate, although the organisation Mind reports consultations with mental health service users and their carers.<sup>2</sup> This paper presents service users' responses to hypothetical questions about the current and proposed powers within an ethical framework and discusses the implications of the proposed changes for service user autonomy and involvement in service planning, delivery, and research.

## BACKGROUND

The service users who participated in this study were subject to one of two compulsory orders: Supervised Discharge and Guardianship, both sections of the MHA 1983. Supervised Discharge was intended to strengthen legal powers for engaging service users in the community with aftercare services, especially those who were non-compliant with medication on discharge from hospital. Guardianship is invoked where it is "in the interests of the welfare of the patient or for the protection of other persons".<sup>3</sup> Supervised Discharge should be used if, in the absence of aftercare, "there would be a substantial risk of serious harm to the health or safety of the patient or safety of other people, or of the patient being seriously exploited".<sup>4</sup> Both Guardianship and Supervised Discharge are intended to ensure the receipt of care<sup>5</sup> and can require a service user to reside in a specified place, attend places for treatment and provide access to the clinical team. Supervised Discharge has an additional power to "convey" an individual to a place where they may receive treatment, although in practice this power is perceived to be

ineffective and is rarely used.<sup>6</sup> The proposed CTO would have similar powers, but additionally contain the new and controversial power to specify medical treatment and enforce medication adherence for service users in the community.<sup>7</sup>

Existing descriptions of service users' views of care (reviewed elsewhere<sup>8</sup>) describe service users' wishes for individual future care and/or treatment in the context of crisis cards,<sup>9</sup> advance directives,<sup>10–13</sup> priorities for mental health services,<sup>14, 15</sup> evaluations of quality,<sup>16</sup> and perceptions of an "ideal" service.<sup>17</sup> However, there is no discussion of service users' views about the *principles* of compulsory care in the community nor their views of the use of these powers for people other than themselves. To our knowledge, the use of hypothetical questioning with mental health service users has not been reported elsewhere. Perkins *et al*<sup>18</sup> used hypothetical questions to explore mental health care providers' responses to ethical dilemmas relating to interpersonal aspects of community mental healthcare: the providers showed their sensitivity to ethical dilemmas by giving ethical justifications as part of their responses.

We wished to explore service users' views of the acceptability of existing and proposed powers, and did so using hypothetical situations that might occur under the powers of the MHA 1983, the Mental Health (Patients in the Community) Act 1995, and the Mental Health Bill.<sup>1</sup>

## METHOD

This paper is based on responses to the second part of a semi-structured interview conducted with 12 individuals on Supervised Discharge and eight on Guardianship in eight mental health service provider trusts and associated Local Authority Social Service departments in the Southeast of England. The project itself was part of a national study commissioned by the Department of Health in 1997 to

**Abbreviations:** CTO, Community Treatment Order; MHA, Mental Health Act.

investigate the use and efficacy of Supervised Discharge and Guardianship.<sup>19–22</sup> Ten sites out of the 68 trusts and associated social services approached provided current Supervised Discharge and Guardianship cases. The study received management approval in each site and was approved by a multicentre research ethics committee and relevant local research ethics committees. Service users with dementia, learning disability, mental impairment, or severe mental impairment were excluded, and following the application of these initial recruitment criteria we employed convenience sampling. Twenty four service users on Supervised Discharge (out of 52) and 21 on Guardianship (out of 54) were approached through their key worker (a community psychiatric nurse or social worker). Consent was obtained from the consultant psychiatrists responsible for those on Supervised Discharge. Key worker refusals on behalf of service users accounted for 11 out of 25 refusals. The remaining refusals were made directly to the researcher and reflect a rigorous consent procedure that provided a minimum 24 hour cooling off period before the interview.

Participants were mainly white men: one service user was of Asian origin and one of Caribbean/West Indian origin; six were women; all of the service users on Guardianship were white. The majority of participants on Supervised Discharge were male ( $n = 10$ ). Ages ranged from 20 to 74 years. With one exception, all had been in a psychiatric hospital immediately before placement on the order and many had experienced repeated hospitalisation over the years. Two participants were unable to complete this part of the interview.

The sample is not intended to be representative of all mental health service users, those subject to compulsory supervision in the community, nor those subject to Supervised Discharge and Guardianship. One site had much higher numbers of service users subject to Supervised Discharge due to the wide interpretation of the eligibility criteria. However, we recruited our sample from a wide geographical area (Southeast England) and the final sample included a mix of male and female service users of varying ages with a range of psychiatric diagnoses. We therefore captured the diversity of service users subject to these orders and achieved a breadth of views that we feel make the findings in this paper transferable to comparable orders. Data of this kind have not been presented elsewhere, and given the current debates about enforced medication adherence, we consider the reporting of these findings essential to prompt further discussion and research. More importantly, the service user perspective is crucial to this debate especially in light of the proposed changes in legislation that may constrain their freedom in a variety of ways.

In the first part of the interview, participants were asked to describe why they thought mental health professionals had placed them on the order and how their lives were affected. In their responses, participants described past and present events and feelings. These data are discussed elsewhere.<sup>8</sup> The data presented here are derived from participants' responses to seven hypothetical questions (see box) posed in the second part of the interview: hypothetical situations that might occur under Supervised Discharge, Guardianship, or proposed CTO.

Interviews were conducted in service users' homes or in private at their key worker's office. Responses were tape recorded and noted verbatim by hand. The audiotapes allowed the accuracy of the notes to be checked. Qualitative analysis software (ATLAS.ti)<sup>23</sup> was employed to aid the organisation, coding, and retrieval of the data. Data were analysed using the constant comparative method, whereby categories are developed by constantly comparing the data and the content of each category.<sup>24</sup> KC and VP coded a sample

### Hypothetical questions

Do you think it is ever right to:

- make people who live in the community attend places for treatment, education, or training?
- make people go into a psychiatric hospital (even when they don't want to)?
- make people who live in the community let mental health services into their homes?
- tell people they have to live in a certain place (not hospital)?
- make anyone see people from the mental health services when they live at home?
- take people from where they live to places where they can have psychiatric treatment?
- make people have (psychiatric) treatment (in or out of hospital)?

of transcripts to check reliability. KC developed and applied the coding framework with input from VP and AB. Participants' views are represented throughout this paper using verbatim quotations. Where possible and appropriate, "in vivo" codes<sup>25</sup> were given to themes arising from the data—for example, "belief in the system" and "free agent". "In vivo" codes are words or phrases used by participants that capture the content of a theme (or a "category" of data) and are thus adopted as the label (or "code") for that theme, alongside the labels used by the researchers. We considered that the themes arising from the data had resonance with the ethical dilemmas faced by mental health professionals providing compulsory mental healthcare in the community.

Before examining the views and values of the participants, we must address an important aspect of their responses. Some participants repeatedly referred to their own experience rather than speaking hypothetically when responding to the questions: "I don't know the answers to these questions at all. I get a headache trying to think about it. They're not relevant to me. What do I know about people? I never think about them. It's not myself they're thinking about, it's people in general." (Paul)

One explanation for this might be the different line of questioning employed: in the first part of the interview, participants were asked to reveal their personal experiences and feelings; in contrast, the second part of the interview invited comments on hypothetical situations. The second part of the interview also focused on sensitive issues, including enforced hospitalisation and medication, and many of the participants had personally experienced these "hypothetical" situations. Although it is possible that their direct, subjective experience made it difficult for these participants to make generalisations, refer to abstract principles, or talk objectively about these situations, we do not believe that these were inappropriate and emotional responses that revealed an inability to separate personal feelings from general principles. Instead, we consider the inclusion of their personal experiences in their responses to be an attempt to apply their experiential knowledge to the scenarios. In this way, their personal accounts corroborate their views and values in the same way that the providers in Perkins *et al's*<sup>18</sup> study indicated personal experiences of the ethical dilemmas they were presented with. Arguably, these participants have the requisite expertise to comment on the acceptability of compulsory powers, and their views are more, not less, valuable as a result.

## SERVICE USERS' VIEWS AND VALUES

Participants' views regarding the acceptability of the compulsory powers are grouped according to two broad themes: ethical considerations linked to participants' "belief in the system" (encompassing paternalism and beneficence) and ethical considerations related to the idea of being a "free agent" (including autonomy in the community).

### Belief in the system

All of the participants expressed their "belief in the system". This reflected their voluntary acceptance of and praise for mental health services' intervention. It is worth noting that service users are required by law to consent to being placed on Supervised Discharge/Guardianship, and that these orders will terminate if service users fail to comply with them.

### Beneficence

Some participants viewed mental health services' interventions and the use of compulsory powers as justified because of the potential benefits they provide. For example, when asked whether it was "ever right to make people who live in the community attend places for treatment, education or training" participants identified benefits such as employment prospects, "a better future" (Harry), staying well, keeping occupied, and having "something to get up for" (Ruth). Similarly, being visited at home by mental health professionals was thought to provide support to enable independent living in the community: "you're not just dumped out in the community to get on with it" (Chris) and social contact: "sometimes they find it difficult to get out ... It's better for somebody to visit and give an external perspective on outside things" (Ash). The presence of benefits was sometimes invoked as a condition of participants' acceptance of a power. For example, the acceptability of people being told they have to live in a certain place would depend on "the place and person" and evidence of a "valid reason" (Gavin), such as safety: "you should be able to choose where to live, unless it's somewhere really bad, with drug addicts" (Harry).

Participants also thought that the use of compulsory powers was justified if people had mental health problems, as in relation to the use of the power to convey someone to a place where they may receive treatment: "It depends, if someone needs it, then yeah. Some people need medication. If someone is getting mad delusions and needs calming down it's only helping them." (Gavin)

This was despite the fact that half of the participants either disagreed with their diagnosis or considered that their mental health problems were in the past. For example, Sam stated "I don't class *myself* as mentally ill," but found it acceptable for people to be made to attend places for treatment, education, or training "because if they're ill they need help."

In making a distinction between themselves and other people with mental health problems, participants dismissed their own negative experiences of the compulsory powers and deemed them acceptable for people who they perceived as *really* having mental health problems or being dangerous. Similarly, while they described compulsory hospitalisation as "unpleasant", "frightening", "a horror story" (Sam), and "a nightmare ... an awful experience" (Harry), the same participants found it acceptable for other people to be hospitalised against their will, "even if they've done nothing wrong" (Larry). This was justified on the grounds of safety "they're dangerous to themselves and the public" (Sam), and "even if it stops one bad thing happening it's worth it" (Larry).

Safety and protection were the focus of responses to the question whether it is "ever right to make anyone see people from the mental health services when they live at home".

Participants viewed visits by mental health professionals as a form of protection from relapse, hospitalisation, and suicide:

"If you're out in the community and no-one wanted to be bothered with you, you'd probably become unwell again." (Chris)

"It keeps people out of hospital." (Ruth)

"Because you can't see that you're ill and that you need help and stop you from killing yourself." (Harry)

Larry deemed providing access to mental health services acceptable on the basis of a family member notifying services of illness: "I'm a great believer in the system. You should be able to enter just from a family member saying this person is ill. [They] should be able to get access, even if it's your own house."

### Paternalism

A lack of insight was used to justify all of the compulsory powers, for example where people "don't realise that they're unwell" or "might not seek help but they might need it" (Harry), but was not cited as a precondition of intervention. An individual's perceived incapacity to make decisions in their own interests led to a great deal of unconditional support for forced psychiatric treatment: "People can become unwell and lose aspects of what's real and unreal, it's not like healing an arm or leg, mental health issues" (Ash). Consequently, participants concluded that mental health services intervention was acceptable: "It shouldn't be allowed to take them against their will, but some people need to be shown the light" (Larry). *All* of the compulsory powers, including forced treatment, being taken for treatment and hospitalisation were described as acceptable on the grounds of evidence of mental health problems: "I should say if the person is unwell and either their psychiatrist or key worker would advise them to go into hospital. I do think it would be a good idea, even if they didn't want to and other people thought it would be best" (Chris). Paradoxically, these participants had themselves rejected the label of mental health problems.

These participants' views reflect a paternalistic attitude towards other mental health service users. Their allusions to benefits, needs, safety, and protection from harm resonate with the objectives of Guardianship which refer to the patient's "welfare" and Supervised Discharge which aims to prevent serious exploitation and "serious harm" to the patient's health or safety.<sup>25</sup>

### Free agent

Participants' references to the principles of autonomy and consent can be found in their descriptions of being a "free agent".

### Autonomy in the community

All of the participants at the time of the interview were subject to either Supervised Discharge or Guardianship and so were required to live in a certain place in accordance with the requirements of the order. The majority of these participants were living in residential care or a group home. Very few were living in their own home. Most participants saw comparatively few benefits from being told where to live. Whereas receiving treatment in the community or being admitted to hospital were also experiences common to all of the participants, they were able to associate these powers with a "need" generated by evidence of mental health problems. They were unable to do so in relation to being told where to live.

The participants made reference to the idea that they were "free" in the community, as opposed to detained in hospital. Accordingly, being told where to live was found to be unacceptable, even in the event of mental health problems:



"If a person's got a home they want to live in it" (Tony). It was suggested that people should be offered "choice and negotiation" (Ash) in where they should live. Participants also made reference to privacy. They disagreed with the prospect of mental health professionals entering their homes on the basis of the private quality of one's home: "I think people's homes are just for them to live in, [home is] not the right sort of place [for professionals to visit]" (Cathy). Legislation that permits mental health professionals access to service users homes was seen as "a fundamental principle of freedom that's being breached" (William) and as "taking human rights away" (Sam) because of the potential restriction on "freedom of movement" (Sam).

These responses highlight a conflict that has emerged since the introduction of compulsory supervision in the community, that of being a mental health service user subject to compulsory powers yet living "freely" in the community. This incongruity was observed by one participant about the use of group and residential homes: "if allowed to be a free agent outside hospital, no point in living in a place for the mentally ill" (Larry). The same feeling was expressed about whether it is ever right to make people attend for treatment, education, or training, "not if for the rest of the week you've been doing what you want" (Larry).

### Consent

All of the participants demanded the provision of consent or having "your own choice" (Jason) as a prerequisite to the exercise of the powers described in the hypothetical questions. Consent was prominent in participants' responses to the controversial "power to convey" people from where they live to places where they can have psychiatric treatment: "You can't force them" (John), and hospitalisation: "No, they don't have to go if they don't want to" (Cathy); "Psychiatrists aren't always right. If somebody doesn't want to go to hospital but is forced against his will, there'd better be a solid enough explanation for it" (Terry).

Although participants identified benefits from mental health services knowing their whereabouts, the acceptability of this was conditional on not being compelled: "It's right that Social Services should know where you are and be able to contact you, but forcing you to live in a certain place is not on" (Ruth). Similarly, agreement with the power to make service users see people was conditional on that service user giving consent: "you can't make somebody see somebody, but if you explain it's keeping them out of hospital they would be more willing" (Ruth). Reservations about the power to make people attend for treatment, education, or training were based on the issue of consent: "It's up to them, you can't force anyone" (John). Thus, participants questioned whether interventions were of any value if an individual did not consent: "I don't know if it's worth it if they don't want to" (Larry).

### DISCUSSION

Unlike the mental health professionals in Perkins *et al's* study,<sup>18</sup> the mental health service users who responded to these hypothetical questions did not explicitly state that the situations described in the questions were ethical or unethical. However, as in Perkins *et al's* study, their responses had clear resonance with the ongoing ethical dilemmas experienced by mental health professionals, and so demonstrate a similar sensitivity to the ethical issues involved. To summarise: the participants considered that the use of compulsory powers was justified if there were some ultimate benefit (such as safety or protection), and if there was evidence of mental health problems, dangerousness (whether to self or others), or a lack of insight. On the other hand, the participants rejected intrusions into their autonomy (for

example, to choose where to live) and privacy (that is, at home), and conveyed that consent should be a prerequisite to the exercise of all compulsory powers.

Similarly, Magnusson and Lützén<sup>26</sup> found that "home" held significant symbolic meaning for community psychiatric nurses in Sweden and that they were uncomfortable with compromising this aspect of privacy of mental health service users. However, Watts and Priebe<sup>27</sup> found that service users perceive "proximal" interventions (affecting the body, for example medication) as more coercive than "distal" interventions (affecting the social environment, for example housing) and recognised the value of distal interventions more easily than proximal interventions. Our participants appeared less concerned with these factors, perhaps because when they shifted from describing their perceptions of their *own* care (in the first part of the interview) to views about the acceptability of care *in general*, they employed general principles of acceptability—that is, whether the intervention was beneficial, or interfered with autonomy.

Some participants (for example, Harry and Sam) specifically acknowledged dangerousness to self and others when considering the appropriateness of compulsory mental health services intervention. Participants alluded to the "dangerousness", "best interests", and "treatability" tests, in addition to the tests for capacity and competency.<sup>28–29</sup> Their reasoning also takes into account the objectives of mental health legislation including principles of care and control, self determination, the protection of fundamental rights and freedoms, and the minimisation of harm and risk.<sup>28</sup> Indeed, their considerations were similar to those of psychiatrists making decisions about psychiatric commitment at a Swedish psychiatric unit: severity of psychiatric symptoms, suicidal ideas, and dangerousness.<sup>30</sup>

The psychiatrist's role has been described as subject to the conflicting demands of reducing hospital beds and listening to patients, while identifying and detaining dangerous patients.<sup>31</sup> International research has shown that the public associate mental health problems with dangerousness and find compulsory admission acceptable on this basis,<sup>32–35</sup> and that the public perceive people with mental health problems to pose a threat to others and to be at risk of self harm.<sup>34</sup> Consideration of public protection has been argued to have resulted in the increased use of coercion in the form of MHA compulsory admissions and orders,<sup>35–36</sup> and in the development of new coercive mental health legislation (outpatient committal in Canada and involuntary inpatient treatment in New York State) following acts of violence by individuals with mental health problems.<sup>37</sup> However, the perceived risk to the public from people with mental health problems is disproportionate to the evidence of "dangerousness".<sup>38</sup>

Recently, there has been a marked increase in service user involvement in service planning, delivery, and research,<sup>39</sup> and the government has acknowledged service users' expertise in relation to their own condition and treatment.<sup>40</sup> In North America similar emphasis on consumer involvement has been contrasted with the proposed introduction of the CTO, lobbying of family members for paternalistic care, and coercive models of treatment such as assertive community treatment.<sup>37</sup> There is a clear paradox between the depiction of mental health service users as dangerous (and the ensuing exertion of increased control over those living in the community) and the rhetoric about service user involvement in service planning, delivery, and research.

Community mental healthcare creates several ethical dilemmas, requiring the principles of coercion, consent, beneficence, paternalism, commitment, and autonomy to be balanced.<sup>27–41–42</sup> In other words, providers must aim to

maximise the effectiveness of medical care with the minimal intrusion on autonomy.<sup>43</sup> The participants' responses draw attention to the importance of this balance and the conflict between their autonomy in the community and being subject to compulsory powers. The requirement for balance is key to the debate about the introduction of CTOs, which hinges on whether the CTO is more or less restrictive than involuntary hospitalisation.<sup>37</sup> This deserves some exploration. The "free agent" theme in particular raises questions about the nature and contemporary meaning of the "institution" and "deinstitutionalisation" for mental health service users. Historically psychiatric institutions have been defined as bricks and mortar, and by place.<sup>44-46</sup> More recently, it has been argued that this is not necessarily the case,<sup>47</sup> and that institutions frame experience, limit and constrain challenges to institutional authority, and provide the user of the institution with a sense of its legitimacy.<sup>48</sup> Such competing notions of the "institution" challenge the concepts of autonomy and deinstitutionalisation.

The service users in this study had experienced the psychiatric institution both as buildings and as a web of people, ideas, and practical/potential power: they live, work, and socialise in the community as "free agents" yet remain subject to rules and restrictions as if contained within an institutional building. The requirements of compulsory mental healthcare in the community contradict what it means to be autonomous,<sup>41</sup> leading Watts and Priebe to ask, "Are the restrictions of the asylum being transported to the community without the statutory controls?"<sup>27</sup> Although the requirements to which these service users are subject vary in their intrusiveness, they structure their lives in a similar, though lesser way than hospital. Compulsory supervision in the community extends restrictive legal powers over service users, widens the net of compulsion, and supports the concept and reality of the psychiatric institution without physical boundaries. While this enables service users to consider themselves to be "free agents" it does perpetuate the dilemma of how to define the limits of powers to which such "free agents" can be subject. Moreover, the proposed introduction of the CTO begs the question whether any limits will be set at all.

## CONCLUSIONS

### The introduction of the CTO

The views presented in this paper indicate that the acceptability of compulsory powers depends on whether they respect privacy and autonomy. Yet the proposed CTO would effectively threaten service users' autonomy. As such, it represents an assault on any traditional notion of deinstitutionalisation. However, the participants did acknowledge that mental health problems might lead people to lose sight of their needs, in which case intervention is justified. Whether service users would accept the proposed changes, then, seems to hinge on evidence of mental health problems and potential benefit, but most importantly, the participants in this study emphasised that consent was a fundamental prerequisite to the exercise of all powers. There is no suggestion that consent will be required for the CTO. The legal status of service users in the community subject to the proposed CTO will closely resemble that of hospital patients (with regard to enforced medication adherence) and this will serve to exacerbate the ethical dilemmas described. Accordingly, it is unlikely that these service users would welcome the CTO even in relation to other people. It is arguable that their views denote "good" ethical practice and the provision of "good" services, whereas the proposals included in the Mental Health Bill are considered to not contribute to the provision of good services.<sup>2</sup>

### The participants and the implications of their responses for future involvement and research

In light of our findings, accessing and utilising service users' views and experiences may require some caution. The participants' justifications for interventions on the grounds of mental health problems and their references to dangerousness should be considered in the context that they might be more likely to identify the risks associated with illness. Ryan<sup>34</sup> showed that hospital workers perceived the risk of "threat" and "vulnerability" in people with mental health problems to be greater than other mental health professionals, because their contact with people with mental health problems is mainly at times of acute illness, increased vulnerability, and decreased competence to make decisions. The participants in this study would also be familiar with the worse aspects of illness, and some perceived *other people* as more ill than themselves.

It is also likely that the views of this particular group of service users were influenced by the nature of the compulsory orders they are on. We have described elsewhere the way in which service users adapt their response to compulsory orders in order to maximise their benefits from the "system" and how this may coexist with a "dependency" on mental health services and intervention.<sup>8</sup> Compulsory supervision in the community relies heavily on the consent and cooperation of the service user and their perception of their own needs. These participants (subject to Supervised Discharge and Guardianship) have consented to a degree of compulsion, and their views may reflect this,<sup>20</sup> especially their expressions of "belief in the system". Whether this amounts to genuine consent is questionable, especially if they have been faced with a choice between hospital and community. Eastman has called this "reality coercion".<sup>49</sup> We propose that researchers and policy makers exercise caution when considering service users' assertions that mental health services interventions are desirable and necessary. Their apparent support could stem from their dependence on services, and could be used inappropriately to justify the use and/or extension of compulsory powers.

It is a weakness of this study (and others that recruit individuals with mental health problems via mental health services) that service users who are resistant to compulsion and refuse to cooperate with mental health services are not included in the sample. It is arguable that their inclusion would impact on research findings. Paradoxically, it is precisely the views of these hard-to-reach individuals that should be considered in service planning. Nevertheless, we feel that the views and values we have presented in this paper are valid, not least because they are grounded in the experiences of the participants, or what might be called their "expertise".

This paper is based on interviews with a subset of mental health service users: we do not assume that their views are representative of all mental health service users. We have attempted to use these data as a vehicle for exploring the appropriateness of using hypothetical questions with this group, and the implications of their views for the current debate about the future of mental health services. Qualitative research seeks to achieve the transferability of findings: if the numbers of people on these kinds of community orders grows and forms a larger proportion of users than is currently the case, the relevance and potential transferability of these findings will be enhanced.

We consider that further investigation of the issues raised in this paper would be valuable. Worthwhile comparisons could be made with the responses of mental health service users who are not subject to compulsory supervision in the community (that is, a wider sample of mental health service users), and with a sample of people without mental health

problems (that is, the public). This would shed light on whether the views of service users are affected by the level of compulsion they experience, and would provide an opportunity to explore (and compare) what influences public and mental health service users' views of mental health services and legislation. Further understanding of whether these kinds of orders affect service users' views about the acceptability of compulsory mental healthcare is important because such a finding could have implications for service user consultation and involvement.

So, what is to be gained from this exploration of mental health service users' responses to hypothetical questioning? Our findings indicate that mental health service users are capable of responding to hypothetical questions and will use their experiential knowledge to support their reasoning. We have shown how our findings have implications for the exploration of mental health service users' views and the way in which mental health service users might contribute to policy, service planning, and research. Finally, this paper attempts to contribute to the field of ethics by applying ethical principles to community mental healthcare from the perspective of the mental health service user, as opposed to the professional.

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