Community Treatment Orders for People with Serious Mental Illness: A New Zealand Study

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Summary

New Zealand legislation allows for the involuntary outpatient treatment of people with serious mental illness. This study examines the views of service users, family members and mental health professionals (MHPs) about the impact of this regime. Semi-structured interviews were completed with forty-two service users, twenty-seven family members and ninety MHPs, with recent experience of the regime. Participants were asked to comment on the functions of community treatment (or non-resident) orders, their benefits and restrictions, decisions about their termination and any impact on relationships. Most service users believed the main purpose of the order was to ensure they took medication. They also believed the order provided better access to other treatments, supported accommodation and care from MHPs. Families considered the orders provided relief for them and a supportive structure for their relative's care. MHPs found the orders useful for engaging service users in a continuing therapeutic relationship, and for promoting treatment adherence. In each group, a majority of those interviewed viewed involuntary community treatment in a generally positive light, while acknowledging the restrictions imposed on service users' freedom.

Introduction

The appropriate use of involuntary community mental health care has been under scrutiny in recent British law reform debates. Numerous claims and counter-claims have been made about its likely impact on service users and their families. In Australia and New Zealand, involuntary outpatient regimes similar to those proposed in Britain have been in operation for many years and there is now little controversy about them. This paper presents the results of a recent study of New Zealand's community treatment order (CTO) regime—to indicate the range of perspectives social workers may encounter when working with a well embedded scheme.

Social workers and involuntary mental health care in the UK

British social workers have long played a critical role in the administration of mental health legislation, particularly at the point of crisis intervention and involuntary hospital admission. In particular, they may be required to investigate the social circumstances of the person whose involuntary assessment or treatment is proposed, and they exercise specific statutory powers, as Mental Health Officers in Scotland, and as Approved Social Workers in England and Wales. Social workers may also participate in other aspects of involuntary treatment as members of a multidisciplinary team.

The role of social workers may change under revised mental health legislation in the UK (Dawson, 2005). One change, proposed for both Scotland, and for England and Wales, is the introduction of more extensive powers to treat patients outside hospital. Hitherto, mental health law in these jurisdictions has authorized some control over an involuntary outpatient's place of residence; it has permitted access to service users who are being cared for in the community by others; and it has permitted outpatients under the legislation to be 'taken' and 'conveyed' to a clinic, to be offered treatment. But the recent question has been whether the law should go further, to confer more explicit powers on clinicians to 'enforce medication' in community settings, or to impose other restrictive conditions on those subject to the community regime.

In Scotland, these debates have been resolved by the passage of the 2003 Mental Health (Care and Treatment) (Scotland) Act, which is to come into force in late 2005. This Act permits Compulsory Treatment Orders to be made, for up to six months, that may authorize either inpatient or outpatient care under a special statutory Care Plan. No marked distinction is made in the legislation between hospital and community care, and no prior hospital admission is required for involuntary treatment to proceed. Mental heath officers, who may

be social workers, will continue to play critical gate-keeping and administrative roles within this regime.

In England and Wales, on the other hand, no resolution of the law reform debate is in sight. The government has consistently stated its intention to enact a more enforceable outpatient treatment regime, and a Draft Mental Health Bill, that would include 'non-resident orders' (NROs), and the possibility of involuntary assessment as an outpatient, was referred to a Joint Committee of the UK Parliament for scrutiny in 2004 (Department of Health, 2004).

Widely differing opinions were expressed by the relevant interest groups to that Committee on the merits of the NRO scheme. The BMA was largely supportive, MIND was firmly opposed and many other groups, operating under the umbrella of the Mental Health Alliance, indicated that they might support a more narrowly targeted regime. Overall, there was significant support for a community treatment scheme, provided it extended only to those with a recent history of involuntary hospital admission, and provided it did not lower the threshold for involuntary care. There was also considerable support for a narrower definition of 'mental disorder' in the criteria governing involuntary treatment—one based on listed disorders of mental function, of the kind found in the law of New Zealand and New South Wales (Joint Committee, Volume II, 2005).

In its report, the Joint Committee endorsed the principle of involuntary outpatient treatment, but only if its use was 'explicitly limited to a clearly defined and clinically identifiable group of patients', particularly those who frequently relapse and have previously responded to treatment (Joint Committee, Volume I, 2005, p. 69). In reply, the government rejected such strict limits on the criteria for entry into the scheme. It insisted that NROs should be available following a person's first admission to hospital, and took the position that the detailed criteria for the use of involuntary outpatient treatment could be provided by Regulations (Department of Health, 2005).

No consensus on this matter has therefore been achieved in England and Wales, except on one salient point, on which virtually all the interest groups agree: that 'forced medication' in community settings should not be authorized.

New Zealand's Community Treatment Order regime

New Zealand's mental health legislation permits the involuntary outpatient treatment of people with serious mental illness, under Community Treatment Orders (CTOs). This paper presents an overview of a recent empirical study of this NZ regime. The principal purpose of the study as a whole was to examine the views of service users, family members and mental health professionals on the impact of the CTO regime. The research was initiated to address the lack of qualitative evidence in the literature concerning the advantages and disadvantages of CTOs (O'Reilly, 2001), and because no in-depth study had been conducted of the well embedded and widely used NZ regime (Dawson and Romans, 2001). A randomized controlled trial might be a more rigorous methodology for measuring

CTOs' effectiveness, but that approach poses many ethical and legal dilemmas when applied to a compulsory treatment regime (Dawson, 2002).

New Zealand's 1992 Mental Health (Compulsory Assessment & Treatment) Act authorizes the involuntary community treatment of a person who: (i) suffers from a mental disorder (characterized by delusions, or by disorders of mood or perception or volition or cognition) to such a degree that it (ii) poses a serious danger to the health or safety of that person or others, or they have a seriously diminished capacity for self-care. In addition, involuntary treatment must be 'necessary', adequate outpatient care must be 'available', and the social circumstances of the service user must be 'adequate'. When these criteria are met, the Act requires community treatment to be given preference over hospital care.

A CTO can be made directly by a judge, after a hearing or by a responsible clinician (usually a psychiatrist), who can substitute it for an involuntary inpatient order. The usual conditions of a CTO are that the service user must accept visits from community health professionals, and must attend for and accept treatment, which may include depot (or injectable) medication. The service user's residence may also be specified, and they may be required to abstain from substance misuse, and not to travel beyond certain boundaries. If these conditions are breached, the person can be taken to a clinic for treatment, or returned to hospital care. The police may be involved and reasonable force may be used in that recall process. Nevertheless, there is no explicit power provided to restrain and medicate a person in a community setting, and the statutory Guidelines to the NZ Act expressly state that 'no power to detain the patient for the purposes of treatment' in a residential setting is provided by law (NZ Ministry of Health, 2000).

CTOs are used mainly for service users with a substantial history of previous hospitalization and non-compliance with medication, and for whom the risk of harm to self or others is a significant factor. Demographic data from the region of study show: more men than women are placed on CTOs; Maori are overrepresented compared with their numbers in the population at large; the average age of those under CTOs is around forty years; the main diagnoses of the service users are schizophrenia and affective or schizoaffective psychosis; and many have a history of aggression, self-harm and substance misuse (Dawson and Romans, 2001).

The literature on involuntary community mental health care

Involuntary community treatment remains controversial, with many commentators strongly opposed (O'Reilly, 2004). Some argue it is unethical, because it may permit the involuntary treatment of those who retain their capacity to consent; that it will result in unnecessary coercion, and loss of liberty and rights for service users; and that it is not easily enforced (Allen and Smith, 2001; Pinfold and Bindman, 2001; Moncrieff, 2003). On the other hand, its supporters argue

that involuntary community treatment assists engagement with service users who are particularly needy and hard to reach; that it facilitates outpatient treatment when the voluntary approach does not work; and that it increases compliance with treatment, ultimately leading to greater stability, health improvement and quality of life (Geller, 1990; Torrey and Zdanowicz, 2001; Cornwall and Deeney, 2003; Hiday, 2003).

Most of the empirical research conducted on the operation of community treatment order regimes has proceeded in the USA. The American studies have tended to show that CTOs can be effective in reducing days spent in hospital, incidents of violence and the rates of arrest and victimization of service users, and that CTOs are effective in increasing compliance with medication and outpatient appointments (Gerbasi *et al.*, 2000; Swanson *et al.*, 2000; O'Reilly, 2001; Swartz *et al.*, 2001; Hiday *et al.*, 2002). Nevertheless, much of this apparent effectiveness relies on the provision of a relatively intensive level of mental health services, which may not always be available.

Further studies have been conducted in Canada (O'Reilly *et al.*, 2000; O'Brien and Farrell, 2004); Australia (Power, 1999; Brophy and Ring, 2004; Kisely *et al.*, 2004); New Zealand (Dawson *et al.*, 2003; Romans *et al.*, 2004) and the UK (Pinfold *et al.*, 2001; Atkinson *et al.*, 2002*a*, 2002*b*; Pinfold *et al.*, 2002). Studies have considered the impact of CTOs on service users, as well as the views of MHPs. In Western Australia, a survey analysis of a newly introduced CTO regime found that it did not reduce rates of readmission to hospital in the first year of its operation (Kisely *et al.*, 2004). Power (1999), on the other hand, in a study of the regime in the Australian state of Victoria, recorded significant therapeutic benefits for patients. Other Australian studies have noted the complexities of consumer experiences with this form of care, including enhanced stigma (Brophy and McDermott, 2003; Brophy and Ring, 2004).

A survey of mental health professionals (MHPs) by Romans *et al.* (2004) in New Zealand showed that MHPs (including psychiatrists, nurses and social workers) believed the CTO regime facilitated contact with service users and the provision of necessary community services, including supported accommodation. Its use was generally seen to enhance therapeutic relationships in the long term, although it was recognized that it could harm relationships in the short term and could be viewed as coercive and stigmatizing by service users. As authors of this study, we concluded that CTOs should be continued in NZ in light of their strong endorsement by experienced clinicians.

In the UK, studies of community care orders and supervised discharge orders found their use had been very limited and that mental health professionals expressed reservations about their utility and 'lack of teeth' (Atkinson *et al.*, 2002*a*, 2002*b*; Pinfold *et al.*, 2002). A small study of community care orders in Scotland by Atkinson *et al.* (2002*b*) found service users knew little about their rights under the legislation and felt obliged to take medication. On the other hand, a study by Pinfold *et al.* (2001) showed that compulsory community treatment helped service users maintain contact with mental health services, reduced their safety concerns and increased their compliance with treatment.

Overall, most studies highlight the continuing doubts about CTOs, in light of the equivocal research results and the ambivalence of service users (Dawson *et al.*, 2003). Many appear to experience the CTO as a less restrictive form of intervention than hospital care or imprisonment, but they also experience coercive effects.

Methods

The study was conducted in Otago—a region in southern New Zealand, with a population of roughly 180,00 people and a significant rural component. The main methods were semi-structured interviews with service users, and their family members and the treating mental health professionals (MHPs)—159 interviews in total. Ethical approval was granted by the local health ethics committee.

All service users in the region who had been on a CTO for more than six months in the previous two years were selected for potential inclusion in the study—103 in all. The key workers (or case managers) of those patients were then approached, with an initial request to assess the patient's capacity to participate in the research, in consultation with their psychiatrist. Nineteen patients were considered to lack capacity to participate at the outset and were excluded. Of the remaining eighty-four, who were approached personally, forty-two agreed to take part and fully completed the process, thirty-four declined to participate, and in eight cases, the research process was incomplete, due to their withdrawal, their relapse during its course or breakdown in communication. The participation rate was therefore 50 per cent of those approached. It is unfortunate that this was not higher but as all participants had been diagnosed with a serious mental disorder and recently been under involuntary treatment, it is not surprising that some were considered too unwell to participate, or did not want to talk to researchers (Gibbs *et al.*, 2005). No information was collected on those who did not participate, as they had not given their permission. So no comparison could be made between those who agreed and those who did not agree to take part.

Of the forty-two service users who took part, twenty (48 per cent) had been discharged from involuntary treatment and twenty-two (52 per cent) were still on a CTO at interview. Table 1 presents demographic and diagnostic data concerning the participants, and further information is provided in Table 1 of Gibbs *et al.* (2005). The average time since participants' first contact with mental health services was fourteen years. Almost a third had some prior involvement with forensic mental health services. Four (9.5 per cent) had one previous hospitalization, fifteen (36 per cent) two to four previous hospitalizations, fifteen (36 per cent) five to nine hospitalizations, and eight (19 per cent) ten or more. As these data indicate, with few exceptions, the participants were therefore long-term users of mental health services.

All the service users interviewed gave their consent to participation in the research, and gave the researchers permission to check their medical records. They were also asked to nominate a near relative who could participate, and twenty-seven relatives were then interviewed. The service user's keyworker

Table 1 Demographic and diagnostic profile of participants

Total	*n* = 42
Gender	
Male	32 (76 per cent)
Female	10 (24 per cent)
Ethnicity	
European/Pakeha	31 (74 per cent)
Maori	8 (19 per cent)
Pacific Islander	2 (5 per cent)
Other	1 (2 per cent)
Age (years)	
<20	1 (2 per cent)
20–29	10 (24 per cent)
30–39	14 (33 per cent)
40–49	7 (17 per cent)
50–59	6 (14 per cent)
60 and over	4 (10 per cent)
Average age (years)	38
Primary diagnosis	
Schizophrenia	23 (55 per cent)
Affective psychosis	10 (24 per cent)
Schizoaffective	7 (17 per cent)
Personality disorder	1 (2 per cent)
Other	1 (2 per cent)

(a nurse, social worker, occupational therapist or other health professional) and their responsible clinician (a psychiatrist) were also interviewed—a total of ninety interviews with MHPs.

A semi-structured interview schedule was used and the interviews were taped and transcribed. They lasted between thirty minutes and 1.5 hours. The schedule asked respondents about their experiences of CTOs, any impact on the service user's health, relationships and quality of life, their perceptions as to why the CTO was used, as well as the factors they thought had led (or would lead) to discharge from the order. In addition, MHPs were asked if there were resource implications in the use of CTOs.

The content of the interviews was then analysed using a General Inductive Approach (Thomas, 2004). This uses a mix of deductive and inductive reasoning. So the interviews were analysed both under the original themes used in the interview schedule, and new themes were developed from several readings of the transcripts. By this means, a detailed coding schedule was developed, with each transcript being coded independently by at least two members of the research team. Coded extracts from the transcripts were then entered onto NUDIST software for further computer-assisted qualitative data analysis.

A separate attempt was made to score the service users' global attitude to the use of the CTO in their case. To this end, two researchers independently reviewed each interview transcript as a whole, then negotiated solutions if they disagreed. Particular weight was placed on the final question asked: 'Overall, do you think the advantages of being on the community treatment order outweigh

the disadvantages?' The service user's overall attitude to the order was then rated as: wholly favourable, generally favourable but noted disadvantages, equally for and against, generally opposed but noted advantages, totally opposed.

Results
Impact of the CTO on service users

Service users viewed the impact of community treatment orders in both positive and negative terms. Many considered the CTO provided a security net for them when they became unwell, describing it as 'part of my personal risk management plan', or viewing its purpose as 'a protection', or 'to keep me safe'. Some said the CTO had saved their life, through preventing suicide, or had prevented self-harm, or had prevented their imprisonment due to inflicting violence on others. For example, one young woman with schizophrenia and depression, and many years of serious self-harm, said the CTO 'kept me alive; I don't know if I would still be here'.

Specific benefits mentioned by service users were:

- improved access to mental health services, including ready access to hospital for respite care or further treatment (although for some, this was a negative feature);
- greater freedom than provided by hospital care or imprisonment;
- a feeling of security that help would be available if required;
- the security provided for their family members;
- guaranteed continuation of a welfare benefit on the ground of disability.

Service users also said that being on a CTO meant they had to do certain things, like 'take your meds', 'see the nurse', 'turn up to your appointments', or perhaps face a speedy return to hospital and enforced medication. The majority of service users said they complied with such expectations but recorded their annoyance at a system that 'gives drugs instead of support'. Most had a number of support mechanisms in place—either the assistance of MHPs or family and friends—but these were not generally viewed as related to the CTO.

They still noted specific improvements: in relations with their family, reduced substance misuse, reduced attempts at self-harm, increased understanding of themselves and their illness, and small improvements in feelings of well-being and self-respect. Typical comments included: 'it settled me down', 'it kept me alive', 'it's about recovery, responsibility and rehabilitation', 'I have my freedom', 'it changed things to a point where I was 90 per cent sure of myself'.

The overall attitude of the forty-two service users to their CTO was assessed as follows: wholly favourable, eight (19 per cent); generally favourable but noted disadvantages, nineteen (46 per cent); equally for and against, nine (21 per cent); generally opposed but noted advantages, three (7 per cent); totally opposed: three (7 per cent).

On the other hand, many service users who were generally favourable about the CTO also identified negative aspects of their experience. Typical phrases used were: 'I have to do what they say', 'under control, supervision and surveillance', 'restricted, ordered, pressured'. Many were clear that the order limited their freedom with regard to choice of treatment, travel, residence and decision-making capacity. One person asserted that he was restricted to travelling within a 50 km radius of his house; this meant he could not visit his father, with whom he had a good relationship, because he lived 55 km away. Other service users said they were told to live at a specified address, or they risked return to hospital. Most seemed prepared to 'put-up' with these negative features, nevertheless, if they felt they were getting better and avoiding hospital. A number linked the negative side effects of medication and an enduring sense of stigma to their involuntary treatment: 'a CTO puts me down', 'a CTO's got handcuffs on it', 'I'm 20 stone because of medication', 'it makes you feel as though you are not normal'.

Many service users who were still under the CTO at their interview wished to be discharged from the order, and the majority of those already discharged were pleased with their voluntary status. A significant group were quite happy to remain on the order, however. They were either not bothered by its presence, or they did not feel well enough to 'go it alone'. One Maori female in her twenties said: 'I am quite thankful I am on the order because I am not strong enough to look after myself completely.' These 'volunteers for compulsion', as we describe them elsewhere (Dawson *et al.*, 2003; Gibbs *et al.*, 2005), viewed the CTO as 'necessary', 'a back-up' or 'an insurance policy', to assist them gain access to resources, especially respite in hospital should they become unwell.

To achieve discharge from the order, service users considered a number of substantial changes would have to be made, e.g. remaining well and out of hospital for over a year. They would also have to persuade their doctors to discharge them. For some, this felt like an impossible task: 'It imposes rules. To get off it you have to show you are capable of being adult about medication and not being suicidal,' said one female service user. A number were confused as to why they remained on a CTO, as they were complying with treatment and 'doing what was expected'; they felt they were not given proper reasons for their continued compulsion.

The factors which seemed most likely to help service users successfully negotiate the terms of their CTO, or be discharged from the order, included: sustained compliance with treatment; acknowledging that the benefits of treatment outweighed its disadvantages, or that it acted as a safety mechanism or insurance policy; accepting support from MHPs, family members, or a supported accommodation service; increased self-care; and taking responsibility for their own treatment. One young man described how the CTO brought him stability: '. . . it sort of requires you to go, "hey, wait a minute I am under some sort of restriction" [but] you have got to will yourself to understand that it is a time for recovery [and] it gave me a responsibility, to seek my injection and take my medication and go and see the doctor.' He said the CTO became 'part of my life' for a while

before eventual discharge. Overall, he praised the order for being a means to a good end, and providing 'a guarantee that I wasn't going back to hospital'.

Many service users seemed to consider that the CTO allowed them to live two lives. In one, they were mentally ill people with few decision-making powers; in the other, they were 'free people', able to choose their friends and daily routines. The contribution made by the order to these latter freedoms, which were not found in hospital, meant they were better able to accept the restrictions it imposed. One service user put it this way: 'He [the psychiatrist] tells me where I can live and where I can't live, he is the one that is in charge of me [but] not in charge of my whole life. I still go to the pubs, he can't stop me from going to the pubs to see my mates.'

Views of family members

The twenty-seven family members interviewed were very involved in the care of their relative. Often, they supported and supervised and accommodated them, took them to appointments and gave out medication. They generally viewed the CTO as a very significant aspect of their relative's care. They said it gave them 'hope for recovery' of their relative, that it provided 'relief', 'security' and 'support' for them, and, in some cases, that it 'saved' their relative's life. The sister of Jeff said, for instance, that the CTO meant that he could live in the community for longer periods and it gave the family a sense of relief (Gibbs *et al.*, 2004).

Relatives also viewed the order as providing strengthened support for their unwell relative, because extra services and resources were offered. Gary's mother said that the CTO 'keeps him safe because they keep an eye on him'. Without it, she was not sure he would be well looked after. When their relatives were discharged from the CTO, some family members noted support from MHPs dropped off and hospital care became harder to access. For example, one mother of a male service user said: 'When he was on the order we would phone up and get access about him straight away. Now he is not, we don't know. I don't think anyone actually knows what is going on with Andrew at times.'

Many relatives believed the order meant the burden of care for their sick relative was shared with MHPs. However, family members were not always informed of their relative's progress, and they were not often told when their relative was to be discharged off the order, or about other important clinical decisions. Some were told literally at the moment of discharge, having no time to prepare themselves for a significant change. One mother said that she had to take the initiative to discover her son's progress on the CTO: 'I have to get in touch with them most of the time. I would like them to keep me informed or updated.'

The great majority of family members supported use of the CTO for their relative. Overall, they felt it provided extra security and enhanced quality of life for the whole family.

Views of mental health professionals

MHPs viewed CTOs as a helpful way of engaging and treating service users who had a history of non-compliance, although a minority viewed CTOs as unnecessary, intrusive and ineffective. They also viewed the order as an 'insurance policy' that gave them some power to monitor service users' mental health and behaviour. This was especially important for those deemed at risk of self-harm or causing harm to others. In our sample, thirty-eight of the forty-two service users had such risks identified. MHPs also felt that use of the order brought greater stability to service users' lives, thereby increasing the chance they would comply with treatment, gain insight, access additional services and attain improvements in other areas of their lives. One psychiatrist put it like this: '. . . the CTO helped us to help her have some kind of stable living arrangement and a more organised mental life.' Another mental health professional noted how the 'CTO broke the cycle of continued hospital admissions and relapses', thus enabling the service user to take stock of his situation and choose to avoid further hospitalizations.

The MHPs felt there were adequate resources to provide treatment for everyone under a CTO for whom they cared, but provision in rural communities was lacking, especially supported accommodation. In our survey of MHPs, lack of adequate supported accommodation was also rated as the most significant factor undermining the effectiveness of involuntary outpatient care (Romans *et al*., 2004). In our interviews, MHPs again frequently mentioned that better access to hostels, staffed houses, supported flats and culturally appropriate accommodation would give service users the stability they needed to improve in other areas of their lives. In Otago, however, most supported accommodation is city based and rural areas do not have sufficient provision.

Psychiatrists often stated, with regret, that they had too little time to spend with service users, due to high caseloads. One said he would like to make home visits, to see how his patient was doing in the home environment, but that he only had time to see patients at his office. Family members echoed this concern in their interviews, noting how little communication or feedback they received from psychiatrists. Service users also said they felt nurses and social workers had more time for them than psychiatrists.

The MHPs stressed the difficulty of knowing the best time to discharge a person from a CTO, when it seemed to be a fairly successful intervention. Some psychiatrists said they were hesitant to authorize discharge if they felt the service user would then deteriorate quickly. Others were more willing to take risks. In the survey of MHPs mentioned earlier (Romans *et al*., 2004), the following were considered the most important indicators for discharge from a CTO: clinical improvement, compliance with treatment, development of insight, and reduced risk to others or self. These priorities match the comments made in interviews.

MHPs considered CTOs were very useful in permitting them to maintain contact with service users, to monitor their condition and to increase their compliance with treatment. Most also acknowledged the coercive aspects of

these orders, and some even admitted using the threat of return to hospital for non-compliance. But few felt the coercive aspects of these orders outweighed the overall gains for service users. CTOs were seen as a stepping-stone from hospital to community stability for the service user, with the goal of improving their mental and social well-being in the long term. CTOs were not viewed solely as a means to reduce risk. On the contrary, risk reduction was usually seen as a secondary objective of good clinical care. If risk reduction had been the primary objective, it is likely that a number of those in our sample would not have been discharged from the order when they were.

Discussion and conclusions

Under revised mental health legislation in the UK, social workers are likely to be more involved in the provision of involuntary community care. This study has revealed that complex and overlapping views are held by key stakeholders about the use of CTOs. The majority of service users, family members and MHPs appear to be generally supportive of the current NZ CTO regime. Only a minority would seem to prefer a mental health system that operates without them (Romans *et al.*, 2004). Many service users dislike aspects of CTOs, but they prefer them to alternatives they have experienced, especially involuntary hospitalization or imprisonment. Some service users even declare themselves to be 'volunteers for compulsion', expressing dislike of the order, but wanting it to remain in place. They consider they are under a 'contract' to co-operate with MHPs, who are, in turn, obliged to assist in their care.

The experience of service users suggests that some negotiate the CTO regime by demarcating their lives into parts: a mentally unwell part, where they have little choice about their fate, and the rest of their life, where they have more freedom to choose. To them, the CTO therefore represents both freedom and lack of freedom, help and hindrance, restriction and liberty. The CTO appears to 'save lives' but can be like a 'rope', where service users are 'held back and kept under rule'. Nevertheless, the majority of service users interviewed in this study supported the use of the order in their case, and were able to articulate improvements in mental health, quality of life, accommodation, misuse of substances, relationships and reduced hospital stays. These findings, while qualitative, concur with other studies of effectiveness (Ridgely *et al.*, 2001; Hiday, 2003; Petrila *et al.*, 2003).

Families too recognize the constraints imposed by CTOs, but they favour them for their security benefits and the access to extra resources for their relative they provide. There has been little discussion in the literature of family views of involuntary community treatment. Families in our study wanted better communication with MHPs, to share the burden of care with them, and to be informed about treatment options after their relative's discharge from the order. Improving support to family members and providing better information about the progress of the service user would enable families to feel more valued and a more integral part of the treatment regime (Rapp *et al.*, 1993; Jones, 2004).

MHPs generally favour the availability of CTOs because they assist with engagement, supervision and compliance, but they struggle with decisions about the optimal time for the order to end. Other studies have shown that consumers find it difficult to obtain discharge from a CTO (McDonnell and Bartholomew, 1997; Power, 1999). This research shows psychiatrists also struggle to determine what will count as success in this form of care (Dawson *et al.*, 2003). Clearer criteria to govern discharge might assist psychiatrists with such decisions, although they may also reduce necessary elements of discretion. MHPs could be more explicit with service users about the process of discharge from CTOs and what they need to achieve. Otherwise, service users may feel they are pursuing an impossible dream. On the other hand, the use of a CTO may permit service users, who have considerable difficulties and a long history of contact with mental health services, to be discharged safely to the community if the right support and resources can be matched to their needs (Gibbs *et al.*, 2004).

Implications for social work

From this discussion, it can be seen that social workers involved in the administration of CTOs are likely to play a number of different roles:

- advising service users and their families on the use of CTOs and their implications;
- monitoring and supervising the care and social circumstances of service users under CTOs;
- assuming the role of case manager or key worker in some cases;
- providing a social work perspective to discussions within a multidisciplinary team;
- providing reports or evidence to tribunals concerning the social circumstances of service users under CTOs, within the review process;
- considering, and perhaps activating in some cases, the recall to hospital process.

For these purposes, social workers must be knowledgeable both about their specific powers and responsibilities under new legislation and about the research literature on CTOs, of both a qualitative and quantitative kind. This research literature, including this and similar studies conducted by Scheid-Cook (1993) and Brophy and Ring (2004), identify both negative and positive aspects of involuntary community care. It is clear from these studies that not all service users oppose such treatment; some feel they need the CTO to provide them with a sense of stability in their lives. Some service users view such treatment as oppressive and stigmatizing, but they may also experience benefits simultaneously, leading them to reach a positive view of the order's usefulness overall.

Social workers could advise service users about the potential usefulness of CTOs and may help them evaluate the benefits and disadvantages of staying in the community, especially if compared to an undesired hospital stay. In practice, service users may gain an enhanced service if subject to compulsion in the community, whether or not that ought to be the case (Dawson *et al.*, 2003). Coercion is not necessarily incompatible with good therapeutic outcomes in all cases (Gibbs, 1999). Nevertheless, for a minority of service users, the experience may be considered so coercive and intrusive as to be counter-productive, and social workers should bring such cases to the attention of the clinical team.

Another important message from the research is that families and carers continue to ask for more contact with MHPs and more information about the progress and treatment of their unwell relatives. Even where consultation is advocated in policy or legislation, this does mean in practice that MHPs will make more than token efforts to keep the family or other carers involved. Families and carers often play a pivotal role in assisting MHPs with the care of people with a serious mental illness, and clearer procedures, which allow for increased information sharing at all stages of examination, assessment and treatment, could be implemented. Not all family members contribute positively to service users' lives, but social workers have both an opportunity and a responsibility to convey to relatives and carers the message that they can be part of the helping solution in many cases, when families have too often been viewed as part of the problem (Muhlbauer, 2002; Jones, 2004).

In conclusion, CTOs in New Zealand appear to operate more flexibly in practice, and with a higher degree of acceptability among service users than might initially be thought. It is clear from this study that CTOs both produced benefits and imposed limitations on service users and their families, but they were still viewed by the majority of those interviewed in a generally positive light.

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