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How patients in New Zealand view community treatment orders

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Abstract

Background: New Zealand operates a well-embedded community treatment order scheme for patients with serious mental disorders. A similar scheme may be enacted for England and Wales.

Aim: To explore the views of patients with recent experience of community treatment orders.

Method: All patients in one region under an order in the last 2 years, not readmitted to hospital for at least 6 months, were included, subject to their capacity and consent. Forty-two patients out of 84 potential participants were interviewed.

Results: The majority of patients were generally supportive of the community treatment order, especially if the alternative was hospital. Many valued the access to services and sense of security obtained, and attributed improvements in their health to treatment under the order. They also experienced reduced choice about medication and restrictions on residence and travel. For a minority this meant they were strongly opposed to the order, but for most the restrictions did not unduly hinder them. The majority of patients viewed the order as a helpful step towards community stability.

Conclusions: The usefulness of community treatment orders is accepted by most patients under them in NZ, as well as by most psychiatrists. Critical factors include the quality of therapeutic relationships and the structure provided for community mental health care.

Keywords: *Mental health, patients, community treatment orders, outpatient commitment*

Introduction

This paper explores the experiences of 42 involuntary outpatients under NZ's community treatment order (CTO) regime. This requires patients to accept psychiatric treatment outside hospital, subject to regular, independent review. The core requirements are to maintain continuing contact with community mental health professionals and to accept medication as prescribed.

A similar regime was recently enacted in Scotland by the Mental Health (Care and Treatment) (Scotland) Act 2003. In England and Wales, involuntary treatment of "non-resident" patients would also be authorized if the Draft Mental Health Bill 2004, now before the UK Parliament, was enacted in its present form (Department of Health, 2004), enhancing the powers available under supervised discharged orders since 1995 (Pinfold, Bindman, Thornicroft, Franklin, & Hatfield, 2001).

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Some advocacy organizations have strongly opposed CTOs in the name of patient autonomy (MIND, 2004). Little comprehensive research into patients' experience of this form of treatment delivery has been published, however. Researchers have given more attention to patients' experience of involuntary hospital care. Contrary to what might be expected, some studies have found that compulsory inpatients subsequently hold generally favourable views of their hospitalization and treatment (Gove & Fain, 1977; Edelsohn & Hiday, 1990; Kaltiala-Heino, 1996), and many will later agree it was required (Spence, Goldney, & Costain, 1988; Conlon, Merskey, Zilli, & Fromhold, 1990; Edelsohn & Hiday, 1990; Kaltiala-Heino, 1996; Gardner et al., 1999).

Qualitative research on patients' views of compulsory outpatient care has now been undertaken in Britain, Australia and New Zealand. In Britain, studies reported that compulsion helped patients maintain contact with health professionals and also that patients felt compelled to accept medication (Atkinson, Garner, Dyer, & Gilmour, 2002; Canvin, Barlett, & Pinfold, 2002; Pinfold et al., 2001). In Australia and New Zealand, patients report both advantages and disadvantages of CTOs. Advantages include the accessibility of mental health professionals, ease of readmission to hospital when desired and the opportunity for discharge from hospital to community care. The disadvantages include reduced liberty, control over medication and restrictions on decision-making capacity (Carne, 1996; Gibbs et al., 2004; Power, 1999).

New Zealand's CTO Regime

A person may be placed under a CTO, under the NZ's Mental Health (Compulsory Assessment and Treatment) Act 1992, if they: (1) have a serious mental disorder (characterized by delusions, or by disorders of mood or perception or volition or cognition); plus (2) they pose a serious danger to the health or safety of themselves or others, or have a seriously diminished capacity for self-care. Adequate outpatient care and social support must also be "available" (sections 2, 27, 28). In addition, the NZ Act precludes a patient's involuntary treatment "by reason only of intellectual disability" (s 4(e)), and those with personality (or "psychopathic") disorders may only be treated under the Act if they present one or more of the specified disorders of mental function listed above. In practice, the scope of the NZ regime is therefore limited to patients with serious mental illness.

Either the responsible clinician can transfer a patient to a CTO from an involuntary inpatient order, or a CTO can be made by a judge, after a hearing, following the patient's compulsory assessment. The order has an initial maximum term of 6 months, although it may be continued following review by a court. At the time of this study, the NZ regime was well-embedded, having operated for nearly 10 years.

The order requires the patient to accept treatment as directed by their responsible clinician (section 29). In practice, medication is not administered over a patient's objection in a community setting, as that is widely considered unsafe and unethical, but if the patient does not comply with treatment as directed, the legislation authorises their rapid return to a hospital or clinic. The Police are empowered to assist community clinicians in that "recall" process, though in practice that is rarely required.

We have previously reported that a quarter of patients placed under involuntary psychiatric assessment went on to be treated under a CTO in the region studied (Dawson & Romans, 2001).

The usual conditions of a CTO in NZ are that the patient shall:

- permit visits to their residence by members of the community team (often weekly)
- attend outpatient appointments as required (often a monthly psychiatric appointment)
- take medication as prescribed
- remain at a specified kind of residence
- not travel beyond certain geographic boundaries without permission
- avoid substance misuse.

Whether the patient will be returned to inpatient care for breach of those conditions is a matter of discretion for the clinical team. Critical factors in the exercise of that discretion are the relapse profile of the patient, the potential consequences of their relapse, and the likely impact of their recall to hospital. A bed must also be available. The conditions of the CTO and the clear enforcement mechanisms are somewhat more controlling than those provided by the supervised discharge regime in England and Wales (Canvin et al., 2002).

The attitudes of clinicians

A recent national survey of NZ psychiatrists found a high level of endorsement of CTOs (Romans, Dawson, Mullen, & Gibbs, 2004). Most psychiatrists considered them a useful tool in pursuit of core clinical goals for the seriously mentally ill. They were considered to work in a largely structural and indirect fashion, binding into place necessary community services, facilitating contact with the patient, and promoting medication compliance and early identification of relapse. They were considered to support the involvement of families and other agencies in patients' care and to have a significant impact on patients' attitude to their illness.

Compulsion was not seen by respondents as a substitute for adequate service provision. On the contrary, success was seen to depend on the quality and extent of services provided. There was even the perception that compulsion may enhance service provision, with those under CTOs receiving priority for care in poorly resourced systems, whether or not that should be the case.

With regard to the impact on the therapeutic alliance, the predominant view of psychiatrists was that, while compulsion can harm relations with patients in the short term, the advantages of continuing treatment usually outweigh this problem, and when greater insight follows treatment, therapeutic relations will often improve in the end.

Our study: Methods

We targeted for inclusion all patients in the NZ province of Otago who had been under a CTO, without readmission to hospital, for more than 6 months in the previous 2 years. One-hundred-and-three patients met those criteria. Six months' continuous treatment under the order was stipulated to try to ensure that the patients could clearly distinguish their experience of the CTO from their experience of surrounding periods of involuntary inpatient care.

Otago, in the South Island, has 180,000 people (roughly 5% Maori) and a significant rural component. Approval for the study was obtained from the Otago Ethics Committee.

The key workers (or case managers) of those 103 patients were then approached, with an initial request to assess the patient's capacity to participate in the research, in consultation with their psychiatrist, in accordance with the usual capacity criteria those clinicians would employ. Nineteen patients were considered to lack capacity to participate at the outset and were excluded. Of the remaining 84, who were approached personally, 42 agreed to take part and fully completed the process, 34 declined to participate, and in 8 cases the research process was incomplete, due to withdrawal by the patient, their relapse during its course, or breakdown in communication. Hence, the 42 represented a participation rate of 50%. It is unfortunate that the number of participants was not higher but as all had a serious mental disorder, and had recently experienced involuntary treatment, it is not surprising many did not wish to be interviewed or were considered too unwell. It is possible that patients who agreed to participate had benefited more from the CTO, or had more positive attitudes to it, than those who did not. This may affect our results.

Of the 42 patients recruited, 20 had been discharged from the CTO by the time they were interviewed, while 22 remained on it at interview. The interviews were carried out during 2001 and 2002. Patients' key workers and psychiatrists were also interviewed, plus at least one family member if they could be found and they agreed. Permission to conduct all the interviews, and to inspect patients' files, was obtained from patients in advance. Within the sample, 8 patients identified themselves as Maori. A separate analysis of their experiences has been published (Gibbs et al., 2004). We are only reporting on the patient views in this study and further pieces are planned for family and mental health professional views.

The semi-structured interviews with patients drew upon themes highlighted in previous studies of CTOs, and discussion with stakeholder groups. The interviews focused on patient understandings of the CTO regime; why the order was required; its impact on social and clinical relationships; the order's benefits and limitations; compliance with treatment; indicators for discharge; and the impact of the CTO on their health and well-being. Interviews were taped and transcribed. The transcripts were entered onto a NU*DIST database for preliminary coding and analysis. The research team then analysed the interviews using a general inductive approach (Thomas, 2004). This involved deductive reasoning from the themes already developed in the interview schedule, and inductive reasoning from new themes identified from several readings of each transcript.

A separate attempt was made to score the patients' global attitude to 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 put to each patient: "Overall, do you think the advantages of being on the community treatment order outweigh the disadvantages?" The patient'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.

The patients interviewed

The demographic and diagnostic characteristics of the patients interviewed are presented in Table I.

In addition, the 42 patients interviewed had the following clinical characteristics recorded at least once in their notes: co-existing substance abuse, 60%; incident of self-harm, 40%; incident of aggression to others, 86%; experienced delusions, 76%; experienced hallucinations, 77%. Over half (22, 52%) had more than one diagnosis, 4 (9.5%) had one previous hospitalization, 15 (36%) had 2–4 hospitalizations, 15 (36%) had 5–9, and 8 (19%) had 10 or more.

Table I. Demographic and diagnostic profile of participants.

	Discharged $n = 20$ (%)	Active $n = 22$ (%)	Total $n = 42$ (%)
Gender			
Male	15 (75)	17 (77)	32 (76)
Female	5 (25)	5 (23)	10 (24)
Primary diagnosis			
Schizophrenia	10 (50)	13 (59)	23 (55)
Affective psychosis	7 (35)	3 (14)	10 (24)
Schizoaffective	2 (10)	5 (23)	7 (17)
Personality disorder	1 (5)		1 (2)
Other		1 (5)	1 (2)
Ethnicity			
European	16 (80)	15 (68)	31 (74)
Maori	4 (20)	4 (18)	8 (19)
Pacific Islander		2 (9)	2 (5)
Other		1 (5)	1 (2)
Living situation			
Supported housing	7 (35)	7 (32)	14 (33)
Renting a home	6 (30)	6 (27)	12 (29)
Own home	3 (15)	3 (14)	6 (14)
House sharing	3 (15)	1 (5)	4 (10)
With parents		4 (18)	4 (10)
Other	1 (5)	1 (5)	2 (5)
Age (years)			
<20	1		1 (2)
20–29	2	8	10 (24)
30–39	8	6	14 (34)
40–49	3	4	7 (17)
50–59	3	3	6 (14)
60 and over	3	1	4 (10)
Average age (years)	39	37	38
Time since first contact with mental health services (years)			
<5	3	2	5 (12)
5–9	5	7	12 (28)
10–14	2	5	7 (17)
15–19	5	2	7 (17)
20–24	2	4	6 (14)
25 and over	3	2	5 (12)
Average (years)	15.2	13.6	14.4
Forensic background			
Under forensic team	5 (25)	8 (36)	13 (31)
Under criminal justice legislation	3 (15)	5 (23)	8 (19)

There was therefore considerable variation in the personal characteristics and prior mental health careers of those interviewed, but as their average age was 38 years and their average time since first contact with mental health services was 14 years, and nearly a third had previously been under the care of the forensic service, many were clearly long-term users of mental health services.

Results: Key themes in patient interviews

Patients' overall assessment of the CTO

The 42 patients' overall attitude to use of the CTO in their case was assessed as follows:

- wholly favourable: 8 (19%)
- generally favourable but noted disadvantages: 19 (46%)
- equally for and against: 9 (21%)
- generally opposed but noted advantages: 3 (7%)
- totally opposed: 3 (7%).

The majority of patients interviewed specified significant outcomes and improvements from treatment under the order, in terms of quality of life or lifestyle, reduced time spent in hospital, increased stability, and better understanding of their illness. Nevertheless, most were able to articulate clearly both advantages and disadvantages of the order (see below) and some patients were more negative about the order at its commencement than at the end, or after discharge. Ultimately, most patients recognized the order had conferred benefits.

Advantages for patients of CTOs

Some patients said the CTO had "saved their lives", by preventing suicide or serious self-harm. "Safety" and "security" were mentioned many times. Andrew, for example, a 33-year-old Maori man, with a long history of contact with mental health services and homelessness, said the CTO: "Saved my life. It got me off the streets. It helped me communicate with people". Edith, a 60-year-old European with a diagnosis of major depressive disorder, said, "I was pretty much into self-harm and attempting suicide. I don't think I would be here now if I wasn't on it".

Some patients said CTOs ensured they got the services needed, and enabled them to return to hospital for short breaks or treatment, as desired. Robert, a 40-year-old, noted: "If you needed a hospital bed you were more likely to get one straight away". He admitted he would not return voluntarily, so the CTO helped make the decision for him. In his view, he had improved over time due to a change in medication. He also had significantly reduced his alcohol intake and stopped smoking. He said of the CTO, "I realized I needed help in some way. It was a good means to an end". Helen, a Maori woman in her 40s, with a diagnosis of schizophrenia, said: "You can get in quick. You don't feel like you are still floating. There are no loopholes. I can get help straight away". Helen likened the CTO to "an umbrella over someone that is mentally ill, and it gives them the opportunity of getting help".

Compared with long-term hospitalization, imprisonment or homelessness, CTOs were considered by virtually all patients to be less restrictive. Typical comments included: "It's more beneficial than an in-patient order"; "It's better to be in the community than in hospital, there's much more freedom".

Dave, in his late 30s, with many prior hospitalizations, said the CTO was a "back-up" in case he became unwell. It was a "step to freedom" because it allowed him to gradually increase his independence from hospital. Anna, in her early 20s, felt the order had got her "well enough to sort of make my own decisions", even though she resented the order initially. She felt it had lessened her self-harming behaviour and increased her quality of life; it enabled her to become more independent before she achieved her eventual discharge.

Despite the low ranking given by psychiatrists in our survey (Romans et al., 2004) to reducing substance abuse, as a reason for using a CTO, perhaps due to doubts about the prospects of success, several patients said the order had that effect, particularly in combination with their placement in a supported accommodation service. James, for instance, a 20-year-old with a history of serious substance misuse, said he reduced his habit while on the order until he considered it no longer caused serious harm. He said the CTO "forced me" into needed treatment.

Disadvantages for patients

The perceived disadvantages of the CTO fell into four broad categories:

- the sense of control by others and loss of freedom
- coerced medication compliance and unpleasant side effects
- restrictions on residence and travel
- the sense of stigma.

Chi, for example, a Maori man in his 30s with bipolar disorder, viewed the CTO as taking away his freedom. He hated the order and when he did not comply he had been returned to hospital and forced to take medication. He said, "I didn't think it helped me. I hated having my freedom taken away from me".

Loretta was a 50-year-old European mother of three living in her own home who had been hospitalized regularly throughout her long contact with mental health services. She placed great emphasis on loss of liberty. She said of the CTO: "I have no choice so therefore I am not just an autonomous individual, I am answerable to people for my mental health".

Many patients felt they had "to do what I am told" by mental health professionals. They had to comply with medication, even if they considered it was harmful, or had unpleasant effects. Jeff, said the side effects reduced his motivation and made him lethargic. This affected his ability to get work because he was so "blobbed out and not capable of working". Helen also complained that the medication "dragged her down. I don't like being numbed and it can make you feel really dopey".

Connor, in his 40s, said the order required fortnightly injections of medication, which impaired his alertness and energy. It stopped him hunting and hiking in the surrounding forests for extended periods. Connor described his psychiatrist as "authoritarian" and the CTO as "like a prison sentence".

Others described restrictions on their place of residence. Fred, Merry and Chi all considered they were deprived of the ability to live alone, or were directed to supported accommodation, as a consequence of the CTO, or failure to comply.

For a number of patients the pain of stigma and others' negative perceptions gave them a negative view of the order. Chi said, "There was a stigma. I suppose that was always in the back of my mind. I was restricted in certain ways". Fred, a man in his 40s, said the CTO lowered his quality of life, and put him in a "category hole", and a "little box".

Neutral comments

There were also a substantial group of patients who considered the CTO made little or no difference to their lives. In many cases, these were long-term CTO patients. Typical comments were: "it makes no difference", "it does me no harm", "I can come and go as I please", "it's just out there in the distance". Gary, in his 30s, noted there were rules he had to follow but it didn't bother him: "I am a psych. patient but I have my freedom.... I still want it [the CTO] and I want to stay on it''. He said the CTO was ''just a piece of paper'' to get him to take his medications, which he did, and felt better for it.

Heather, a Maori female in her 20s, was adamant that the CTO was ''not her life'' but it was ''connected to my life''. It had significance but was not a big influence in her everyday life. She felt it was a means of getting back to hospital, and that ''I knew it was there but it was just sort of in the background''. The CTO was just something that was there and she didn't think about it much. A number of other patients mentioned that they hardly thought about the CTO and that the research described here had provoked them to think about it more than they had in recent months.

Impact on relationships

The few patients who felt the CTO made a difference to close family relationships considered it reassured their relatives and enhanced their sense of safety and security. Anna said, ''My family felt safe''. Sasha said her parents viewed the CTO ''as a protection for me; it was less stressful on them to have to be concerned for me''. Connor said the order had brought him ''back into society as a normal Dad''. It also lifted the burden of monitoring his condition from his wife, improving their relationship.

CTOs appeared to have a greater impact on patients' relationships with mental health professionals. Many patients viewed those professionals as controlling and wielding considerable power. ''They dictate the rules and you have to abide by them'', said Jeff. Psychiatrists were usually viewed more negatively than other health professionals. Fred noted how afraid of his psychiatrist he was, ''I haven't got that much to say to the doctor each time . . . I am just a bit scared of what I should say to him'', lest it be taken the wrong way. Nevertheless, many patients said the CTO made no difference to their therapeutic relationships. They felt able to access health professionals' advice and found them helpful. Their keyworkers (usually experienced community nurses) were viewed most positively, perhaps because they had more time to spend with patients during regular visits to their residence. Chi's keyworker was viewed as ''fantastic'' because she helped him get off medications: ''without her help I would be on the injection right now. She is someone I can really open up to''. Heather said her key worker ''has just got more positive input. He has got the skills that he can teach me. Psychiatrists, in the past, they haven't really taught me anything. All I do is tell them my problems, they write it down, and then bye bye, oh, here are some drugs''.

Generally, CTOs were not seen by patients to damage therapeutic relationships even when health professionals were quite directive in their conduct.

The dilemma of discharge

Discharge from a CTO was viewed by patients as an important indicator of ''success''. It meant they were getting better and could be free of some constraints the order imposed. The CTO was often viewed as a ''stepping stone'' to full independence.

Some patients felt they had to achieve a great deal to be discharged. Sasha, for example, said, ''a CTO imposes rules; to get off it you have to show you are capable of being adult about medication and not being suicidal''. Others felt they would never get off the order. Connor said, ''if it's not broken then why fix it''. He felt he would never be discharged because he had been so stable under compulsory treatment. Sasha commented that she did not know what was expected of her by health professionals to achieve discharge. She asked, ''what level of wellness do they want the patient to be before they can come off?''. Fred, who had a previous history of sexual offending, was unsure as to why he was still on the order, although it was obvious from his case notes and the comments of his psychiatrist that he was considered high risk in terms of re-offending, and the order was required to continue his medication and ensure regular monitoring. Fred said, "I don't understand why I am still on it. Why do I have to stay on it for so long?" He had been on the order for 2.5 years.

Factors that patients considered favoured their discharge from the order were: a considerable period of stability outside hospital; compliance with medication; keeping appointments; gaining knowledge and awareness of the impact of their illness on themselves and others; taking responsibility for their health and self-care; doing what clinicians expected of them; achieving goals in relationships, work or study; and reducing self-harm. Dave said the CTO "changed things to a point where I was 99% sure of myself". He felt he had been discharged because he had worked hard while on the order, had showed some insight and made good progress.

Some patients were very clear, however, that they did not want to be discharged. Heather noted, "I am quite thankful I am on the order because I know I am not quite strong enough to look after myself completely". Without it she would have felt like "a boat in the middle of the ocean without an oar". She had seen improvements in her situation, but needed more time to attain stability and confidence. Sasha, a young woman with a history of suicide attempts, was reluctant about the CTO when first on it but came to value its impact, particularly reduced self-harm. Over time, some patients had become, in effect, volunteers for compulsion. They accepted the constraints the order imposed, acknowledged it was necessary in times of crisis, and valued the sense of safety it gave.

Other patients, however, were extremely pleased to be discharged. They said they were involved to varying degrees in planning and consultation about the discharge. Some felt they had been fully involved; others felt they had merely been informed discharge would happen or that it was almost a "non event". There were also comments that appointments with health professionals tailed off slightly once discharge occurred.

Overall, discharge was the aim of most patients but a small group wished the order to continue. There was a general view that discharge was not easy to obtain, with patients having to prove that significant changes had occurred. Staying on the CTO was not necessarily considered a failure, however, because periods of stability while outside hospital, on the order, could also be considered a success. Anna said that discharge was a positive experience for her and she had "got her life back". She felt she had been discharged "because the CTO wasn't necessary anymore, I was fine, I was taking my meds, I wasn't self-harming".

Discussion and conclusions

Our central finding is that NZ's CTO regime was viewed in a generally positive light by most patients with recent experience of it who were interviewed. Most patients could articulate clearly both the benefits and drawbacks of the order, but, contrary to our expectations, only a minority of those interviewed strongly opposed its use in their case. It seems it would be easy to over-rate the degree of opposition to CTOs likely to be found among patients with recent experience of a well-embedded regime.

This is a small study, however, of a particular regime in one part of NZ. The manner in which CTOs operate clearly depends on the resourcing and practices of local community mental health teams. Even within Otago there is variation in the services available between rural and urban areas.

The fact that only 42 patients in the original target group were interviewed is another limitation. Due to the requirements of capacity and consent, it was inevitable that a proportion of patients with recent experience of involuntary treatment would not take part. This introduces the chance of bias, as it is likely that patients who benefited more from treatment under the CTO, or had a more favourable attitude to it, were enrolled.

Nevertheless, only 6 of the 42 patients interviewed were generally opposed to use of the order in their case. It would therefore require a high degree of opposition among the 34 patients who refused to take part to reverse the finding that most patients held generally favourable views.

Some patients interviewed strongly opposed coerced community care, however, particularly control over their medication and the timing of discharge from the order. Others were ambivalent, even if they considered the benefits predominated overall (Dawson, Romans, Gibbs, & Ratter, 2003). As Connor said, "it's good but there's handcuffs on it".

Much discussion in the patient interviews revolved around the themes of autonomy and dependence, freedom and control, power and powerlessness, medication and its side effects, and the desire of patients to achieve stability, meaningful relationships and a better quality of life. The same themes have been identified in other qualitative studies of compulsory outpatients' experience (e.g., Canvin et al., 2002; Scheid-Cook, 1993).

Many patients expressed their dislike of restrictions placed on them. Yet, the same patients would express their need for structure, discipline and stability, which they acknowledged could only be supplied by the CTO. Many praised the availability of resources, and their access to hospital and care from professionals, which they considered was more readily available at critical times. For them, the CTO facilitated intervention when they experienced a "crisis", and so provided an "insurance policy" or a "safety net".

Viewing this material as a whole, we consider patients held generally favourable opinions of this CTO regime because:

- they assessed their experience under the order against their prior patient careers, especially in light of negative experiences in institutions
- they considered community treatment allowed them more freedom and control over their lives than hospital care
- they appreciated the sense of security provided and enhanced access to services in poorly resourced systems
- they valued the ongoing support of mental health professionals and accommodation providers
- they often viewed the order as a transitional step from a chaotic to a more stable life.

For some patients who remain firmly opposed to the CTO, its use may be so antagonizing as to be counter-productive in their case. Assertive community treatment can still be attempted with such patients (Petrila, Ridgely, & Borum, 2003; Stein & Diamond, 2000), and they may be more amenable to it when compulsion is removed, but there is no guarantee that such voluntary approaches will reach patients who persistently refuse medication and remain seriously unwell. When such persons pose serious risks to themselves or others, the CTO seems likely to remain the tool of choice for clinicians in NZ (Romans et al., 2004).

Mental health professionals can still seek to enhance patients' sense of participation in decisions about their treatment, even about matters over which authority has been transferred by law to the clinical team. They may try to increase progressively, during the order, the range of decisions over which patients can exert control. Helping patients identify areas where they retain some control may also help reduce their sense of loss.

A number of patients saw their lives divided into parts: into a mental health life, where restrictions were in place, and a non-mental health life, where they had more control. They were able to dilute the negative experience of compulsion by viewing the order as limited in its impact to discrete parts of their lives, leaving other parts untouched. It is important to recognize that serious mental disorder affects many parts of patients' lives, but we should understand that in distinguishing aspects of their identity in this way some involuntary patients find hope and choice. Empowering patients to identify areas within their control may enhance their overall experience of mental health services, even if they remain under a CTO (Rapp, Shera, & Kisthart, 1993): being in charge of the care of children, for instance, or maintaining their homes, or participating in recreational or educational activities.

Community treatment orders are flexible instruments. There is room for considerable discretion to be exercised within them by clinicians and for continuing negotiation with the patient. The orders may impose immediate restrictions, but they may also enhance a person's autonomy in the longer term. The experiences of the 42 patients interviewed in this study show compulsory community care represents both a restriction on personal liberty and an opportunity for improved health and social functioning. It is usually assessed by patients in a longitudinal manner, against the backdrop of their prior psychiatric career.

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