

Dilemmas for clinicians in use of Community Treatment Orders

Richard Mullen ^{a,*}, John Dawson ^b, Anita Gibbs ^c

^a *Department of Psychological Medicine, University of Otago, New Zealand*

^b *Faculty of Law, University of Otago, New Zealand*

^c *Department of Social Work and Community Development, University of Otago, New Zealand*

Received 17 April 2006; received in revised form 7 September 2006; accepted 14 September 2006

Abstract

Clinicians who treat patients using Community Treatment Orders (CTOs) face many potential dilemmas in their relations with involuntary outpatients and the exercise of their powers. We compare the dilemmas identified in the literature with those reported by responsible clinicians in New Zealand (NZ). These clinicians experienced a number of well-known dilemmas, such as determining the right moment for a person's discharge from a CTO, but they seemed less troubled by some other difficulties than might be expected, usually because they considered involuntary outpatient treatment the best option for the patient or the best way to manage the risks involved. Further dilemmas were identified by the NZ clinicians that have not been widely discussed, concerning the proper scope of clinical authority over patients under CTOs and the decision to revoke involuntary outpatient status. In conclusion, some suggestions are made as to how clinicians might best manage the dilemmas involved.

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Keywords: Community Treatment Orders; Clinicians; Mental health care

1. Introduction

During a qualitative study of the use of CTOs in southern NZ, we conducted interviews with mental health professionals responsible for the clinical management of 42 patients with recent experience of involuntary outpatient care, including an interview with the patient's psychiatrist in each case. This presented the opportunity to compare these clinicians' views and experiences with the existing literature concerning dilemmas that might be encountered by those working with patients under CTOs (or under outpatient commitment, as it is called in the USA).

A variety of dilemmas might arise for clinicians in the administration of involuntary outpatient care. These can occur at many stages in the process, from initial consideration of a patient's suitability for a CTO, to their final discharge to voluntary care. Elsewhere, we have argued that a number of these dilemmas arise from the fact that different criteria of success may be used to evaluate CTOs (Dawson, Romans, Gibbs, & Ratter, 2003). Clinicians must try to balance different values in the treatment process and try to reconcile the perspectives of different stakeholders, including the patient, family members, health professionals and other providers of community services. There may also be uncertainty

* Corresponding author. Tel.: +64 3 474 7989; fax: +64 3 474 7934.
E-mail address: richard.mullen@stonebow.otago.ac.nz (R. Mullen).

as to the likely impact of the CTO on the patient's condition, a problem underlined by the equivocal evidence concerning the efficacy of CTOs and by considerable variation in individual patients' response.

Further difficulties can arise from the availability and distribution of mental health resources. The publicly-funded community mental health services that are available may not be adequate to provide all outpatients with the treatment they need. In that case, some patients may be placed (or kept) on CTOs to give them priority for care, when they might be prepared to accept treatment on a voluntary basis if greater resources were available.

In addition, considerable discretion is often conferred on clinicians by the open texture of the CTO regime. First, the clinicians' legal powers over involuntary outpatients are often conveyed in permissive rather than mandatory terms. NZ law states, for example, that the responsible clinician 'may' direct the patient's recall to inpatient care if they 'cannot continue to be treated adequately as an outpatient'.¹ This leaves significant discretion in clinicians' hands as to the precise circumstances in which recall to hospital should occur. Second, the criteria for intervention under the legislation are often pitched in vague or general terms. Broad phrases like 'mental disorder', 'serious danger', or 'seriously diminished capacity for self care' are commonly employed.² These terms also leave some discretion in clinicians' hands, when they must be applied to the varied circumstances of individuals. It is therefore possible for widely varying clinical practices to emerge within the framework of a single jurisdiction's laws, both between individual clinicians and between services.

Under most CTO regimes, the clinicians play a critical role in the involuntary outpatient treatment process:

- They decide whether to recommend the patient for a CTO, in preference to some other option, such as continuing hospital care or discharge from all compulsion when leaving the hospital
- They play a critical role in formulating the outpatient treatment plan and exercise significant authority over the patient's medication
- They negotiate with family members and community providers concerning the patient's care
- They complete the documents required by law, such as reports for courts or tribunals reviewing the patient's involuntary status
- They decide whether to revoke outpatient status and return the patient to hospital care, and whether to invoke any related power of entry into private premises, or to call the Police or other officials to assist
- They decide if and when to discharge the patient from the CTO to voluntary care.

In making these decisions, conflicts may arise between the objectives of a mental health service as a whole and those of a responsible clinician, and between different clinicians within a multidisciplinary team.

We present a review of the literature concerning such dilemmas, and relate them to the reported experiences of the NZ clinicians.

2. Literature review

The principal dilemmas identified in the literature can be grouped under the following themes: uncertain efficacy; the uncertain balance of advantage; the impact on therapeutic relationships; the limitations imposed by resource constraints; the dilemma of discharge; and the administrative burdens imposed. The NZ clinicians did not therefore seem to experience substantial dilemmas in this field.

2.1. *Uncertain efficacy*

Beyond the usual uncertainties concerning the efficacy of psychiatric treatment in individual cases, clinicians face further uncertainties concerning the independent efficacy of the CTO regime. The literature is particularly slight concerning the precise characteristics of patients most likely to benefit from involuntary outpatient care. Are those diagnosed with severe affective disorders as likely to benefit as those with schizophrenic disorders, for instance? Such specific questions are not resolved by the research.

The efficacy of CTOs is notoriously difficult to establish through rigorous and ethical methods (Dawson, 2002), so it is not surprising that the results of such studies are often equivocal (Ridgeley, Borum, & Petrla, 2001; Hiday, 2003;

¹ Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), s 29(3); retrievable from www.legislation.govt.nz.

² Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ), s 2: the definition of 'mental disorder'.

Swartz & Swanson, 2004). Not all the outcome studies have reported positive results, particularly studies of pilot, or newly-established, schemes (Policy Research Associates, 1998; Steadman et al., 2001; Kisely, Xiao, & Preston, 2004). Nevertheless, committees established to review the evidence, by both the American and the Canadian Psychiatric Associations, have recommended the use of CTOs, under certain conditions (Gerbas, Bonnie, & Binder, 2000; O'Reilly et al., 2003). Their use was also strongly supported as an option in the treatment of serious mental illness in a national survey of NZ clinicians (Romans, Dawson, Mullen, & Gibbs, 2004).

The research tends to suggest that well-established schemes provide patients with some priority for care and with more intensive treatment, particularly more contact with outpatient services (Power, 1998; Swartz et al., 2001; Wagner, Swartz, Swanson, & Burns, 2003; O'Brien & Farrell, 2004; Muirhead, Harvey, & Ingram, 2006). The order may help direct resources to patients at an earlier stage in their relapse and may facilitate their readmission, when necessary, to hospital care (Vaughan, McConaghy, Wolf, Myhr, & Black, 2000; Romans et al., 2004; Brophy & Ring, 2004). CTOs may also be associated with a reduced risk of serious violence (Swanson et al., 2000; Hough & O'Brien, 2005).

Many of the mechanisms through which CTOs appear to work are structural and indirect (Swanson et al., 1997; Power, 1998; Romans et al., 2004). They appear to enhance the commitment of service providers to the care of patients who are difficult to engage in treatment, as much as they act directly on the patient. Even regimes that do not permit 'forced medication' may 'persuade the persuadable' (Pinfold, Bindman, Thornicroft, Franklin, & Hatfield, 2001), partly by harnessing the symbolic authority of the law or a judge (Munetz, Grande, Kleist, Peterson, & Vuddagiri, 1997). They appear to work largely through the therapeutic relationships they help maintain. Two major barriers to their successful use appear to be concurrent substance abuse among patients and lack of good supported accommodation (Romans et al., 2004).

Regrettably, the evidence from the outcome studies is likely to remain equivocal, as even if the efficacy of a particular CTO regime could be established (e.g. it was shown to produce greater compliance with outpatient treatment) this would not establish the efficacy of any other jurisdiction's scheme, due to the importance of the local context to implementation. In short, because every scheme is different in legal detail and operation, it is very difficult for clinicians to draw definitive conclusions as to the efficacy, at any moment, of their local scheme (Dawson et al., 2003). This makes it hard for clinicians to determine the appropriate candidates for CTOs: for instance, whether there is any legitimate role for a CTO following a patient's first admission to hospital care (Dawson, 2006). The limitations of the evidence also make it hard to know when the benefits of a CTO are exhausted, with the result that the patient should be discharged.

2.2. *The uncertain balance of advantage*

A related difficulty for clinicians is the uncertain balance of advantage in the use of CTOs in individual cases, when clinical outcomes have to be balanced against other concerns. Research on the views of patients under CTOs shows they tend to experience both benefits and restrictions when under involuntary outpatient care, although not all patients experience the CTO as coercive, particularly when compared with other likely alternatives (Scheid-Cook, 1993; Gibbs, Dawson, Ansley, & Mullen, 2005). A recent survey of patients discharged from hospital in London found about half approved of compulsory mental health care, and only a minority believed compulsion should be limited to inpatient settings (Crawford, Gibbon, Ellis, & Walters, 2004). Other studies have indicated that a majority of patients compulsorily given medications later report it was in their best interests (Lucksted & Coursey, 1995; Greenberg, Moore-Duncan, & Heron, 1996). Nevertheless, some patients clearly experience many negative effects such as reduced autonomy and significant stigma (Gibbs et al., 2005).

Clinicians may favour the use of CTOs to enhance their authority to see and treat patients, and to permit rapid identification of relapse, but they may also be concerned about overuse of coercion and the prospect of continuing the patient's dependence on the mental health system (Romans et al., 2004). They may worry that CTOs will not be used primarily to advance the interests of patients, but to reduce family or public concern about deinstitutionalization, or concerns about the risk of violence, or that they may constitute a form of defensive medical practice (O'Reilly, 2004). The disadvantages of involuntary treatment, in the short-term, may be hard to weigh against the potential long-term benefits.

2.3. *The impact on therapeutic relationships*

Similar concerns often surface when clinicians debate the potential impact of CTOs on the therapeutic alliance (Geller, 1986; McIvor, 1998). The advantages of greater authority to enforce treatment may provide inadequate compensation for

the damage coercion in treatment may inflict on the clinician's relationship with the patient. This dilemma may be especially awkward at the early stages of a person's disorder, when the need for optimum treatment, and the need to establish a useful therapeutic alliance, are both at a maximum. Once an order is in place, any advice given by a clinician may be perceived by the patient as an order or threat (Frese, 1997).

In our survey, NZ clinicians considered the effect of CTOs on therapeutic relationships to depend on the patient's attitudes and illness, on the way professionals approached and explained the reasons for the order, and on the quality of contact between the patient and their family (Romans et al., 2004). Some clinicians considered the order might have a negative impact at first, but it still permitted engagement of the patient, and with time, recovery and development of insight, many patients came to appreciate its use.

Clinicians must periodically justify the need for the CTO in front of the patient, at judicial or tribunal hearings, where they may be required to give explicit opinions on sensitive matters. When giving evidence, clinicians may be required to describe the content of the patient's delusions, their capacity for self-care, threats posed to others, or the concerns of family members. This may require a degree of frankness that may be considered insulting or a breach of trust by the patient, who might understandably be alienated as a result. On the other hand, honesty about such matters might also be considered an aspect of good therapeutic relations, neither party being permitted to ignore the fact that clinicians must sometimes take decisions about the proper use of involuntary care (Du Fresne, 2003). So, both coercion in general and particular features of the CTO process may subvert the therapeutic alliance.

Nevertheless, even attenuated therapeutic relations may be considered preferable to the break-down of contact that may otherwise occur (Power, 1998). The predominant view of the NZ clinicians surveyed was that while coercion can harm relations with patients in the short-term, the advantages of continuing outpatient care usually outweigh this problem, and where greater insight follows treatment, therapeutic relations often improve in the end (Romans et al., 2004).

2.4. Resource constraints

A further difficulty arises from the prospect that clinicians may find, after placing a person on a CTO, that they have too little time, or too few resources, to provide sufficiently intensive treatment (Appelbaum, 2001). They may be unable to manage the layers of consultation required by law, or be unable to ensure the CTO regime is rigorously enforced when they need to rely on other agencies, like the Police, to perform aspects of the task. In practice, the scope of the mental health services available may be less than satisfactory, particularly in rural areas. This presents clinicians with difficult choices concerning the proper use, in suboptimal conditions, of the CTO regime.

2.5. The dilemma of discharge

Several conundrums may arise when considering the right moment to discharge a patient from a CTO, particularly if their treatment appears to be proceeding well. An important question is whether apparent success in treatment constitutes a reason to discharge the patient from the CTO, or a reason to extend their involuntary care.

By the time discharge is contemplated, sustained treatment may have conferred significant benefits on the patient, including stabilized mental health and improved relationships. These gains might suggest that discharge from the CTO was now warranted, but they are also the very gains that might be lost should the patient withdraw from treatment. Similarly, following treatment under the CTO, the patient may have obtained greater understanding of their condition and have established satisfactory relations with their clinicians. Those changes could be viewed either as an indicator that involuntary treatment was no longer required, or as evidence that the coercive element in treatment had substantially diminished, removing a major drawback to continuation of the CTO. As we expressed the matter in an earlier article this journal, the greater the gains made by the patient on the CTO 'the more successful and the more unnecessary the order seems to be' (Dawson et al., 2003, at 250).

This illustrates the difficulty clinicians face when trying to calculate the overall balance of advantage in the latter stages of the CTO process. This problem may be at its most acute with patients who have undergone a lengthy process of rehabilitation, as with some former forensic patients, who have come under the CTO following reclassification to civil status. Such patients (and perhaps their clinicians) may have the most to lose if their condition deteriorates following withdrawal from treatment after discharge from the CTO, and they may also find the CTO much less coercive than their former forensic status. There may be great reluctance to discharge them to voluntary care, for fear they will lose substantial gains made.

The concern that the liberty of such persons may be unnecessarily infringed, even when they are no longer seriously unwell, has been widely voiced (Bluglass, 1993; O'Reilly, 2004). Nevertheless, one study of the priorities of several stakeholder groups, including those with schizophrenia, still reported that avoiding a CTO was considered less important than avoiding compulsory hospitalisation, avoiding violence, and maintaining good social relationships (Swartz et al., 2003).

2.6. Administrative burden

Finally, it has often been observed that the burden of 'form-filling' and other mechanisms of accountability required to administer CTOs can be a major obstacle to their use (Pinfold, Bindman, Friedli, Beck, & Thornicroft, 1999; Atkinson, Harper Gilmour, & Garner, 2000). The review procedures imposed may be so onerous for clinicians, especially in the event of lengthy or adversarial hearings, that these procedures act as a virtual discharge mechanism for some patients, or discourage appropriate use of the scheme (Dawson, 2005).

In the remainder of this article, we consider the extent to which these dilemmas identified in the literature were confirmed in interviews with responsible clinicians in NZ.

2.7. Methods

The methods we used to interview the NZ clinicians have been fully described elsewhere (Gibbs, Dawson, Forsyth, Mullen, & Te Oranga Tūno Tanga, 2004; Gibbs et al., 2005). The interviews focused on clinicians' views of the use of CTOs in specific cases in which they were recently or currently involved. Further interviews were conducted with patients under CTOs, and with a family member where possible (Gibbs et al., 2005; Mullen, Gibbs, & Dawson, *in press*). In total, 159 in-depth interviews were conducted, concerning the position of 42 patients, all with the patient's consent.

All persons in the province of Otago, in the South Island, who had been under a CTO, without hospital readmission, for more than 6 months during the preceding 2 years were identified for potential inclusion in the study. Otago has a population of approximately 180,000 people and a significant rural component. Its mental health services are mainly located in the city of Dunedin (of 100,000 people), attached to a university teaching hospital. Participating patients, their key worker (or case manager), a family member, and the responsible clinician (a psychiatrist) took part in a semi-structured interview regarding their experience of compulsory outpatient treatment in the specific case. The interviews were recorded and transcribed, then analysed using a general inductive approach (Thomas, 2004).

This paper reports the findings from the interviews with psychiatrists who acted as the responsible clinicians under the statutory scheme,³ concerning their experiences when using CTOs in the cases studied. All names have been changed in this report. The study was funded by the Health Research Council of NZ and approved by the Otago health ethics committee.

3. Results

One hundred and three patients met the inclusion criteria. Nineteen were assessed lacking the capacity to participate at the outset. Of the 84 who were approached, 34 declined to participate, and in a further 8 instances the interviews were incomplete due to patient withdrawal or relapse during the process. The 42 patients who completed the interviews (50% of those considered competent to participate) had an average age of 38 years, and an average time of 14 years since their first contact with mental health services.⁴

Ninety interviews were conducted with the mental health professionals directly involved in these patients' involuntary outpatient treatment: 42 with the psychiatrists who acted as the 'responsible clinicians' under the CTO regime, the remainder with the patients' key workers, most of whom were experienced community psychiatric nurses. It is the 42 interviews with psychiatrists that are the focus of this report.

The results suggest that while the NZ clinicians had experienced only some of the dilemmas identified in the literature, they had, in addition, encountered further potential dilemmas that have not been widely discussed. These concern the proper scope of clinicians' authority to control patients' lives under the CTO, the discretion to revoke outpatient status, and how the CTO can communicate certain messages to the patient, for better and for worse.

³ Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ).

⁴ For more information on the patients included, and more details concerning the NZ CTO regime, see Gibbs et al. (2005).

3.1. Uncertain efficacy

As the interviews with NZ clinicians concerned specific cases, few comments were made on the likely efficacy of CTOs in general. Nevertheless, the clinicians interviewed commented frequently on matters of clinical uncertainty in the specific cases for which they were responsible, and these uncertainties clearly caused them doubts as to the likely efficacy of the CTO in those cases. Examples were uncertainty about a patient's future treatment needs or regarding the proper diagnosis. Some clinicians also expressed doubts as to the range of conditions for which CTOs were likely to be helpful: whether, for instance, a CTO should be applied to a person with an autistic spectrum disorder.

Uncertainty about the impact of the order was considered a particular problem with patients whose mental illness was associated with substance misuse, as it was widely believed that a CTO could not (and possibly should not) be used to control drug or alcohol use in community settings. One clinician was concerned, for example, that the CTO might be ineffective for a patient whose clinical condition appeared to be the result of prolonged solvent abuse.

Some clinicians also reported disagreement within the multidisciplinary team regarding the continuing efficacy of the CTO or the right moment for discharge.

3.2. The uncertain balance of advantage

The NZ clinicians recognised a wide range of adverse consequences and benefits of involuntary outpatient care. Several observed that although patients sometimes disliked the CTO, for entirely understandable reasons, they seemed to do well on it regardless.

Many clinicians considered coercion in treatment was justified by the positive outcomes achieved. So it was said:
Gary is less anxious. He has developed a comfortable life for himself. He has got a reasonable quality of life.

The biggest change I have seen in Blair is that he is now resigned to taking his treatment and sticking to it because he knows it keeps him well. The fact that we have been able to enforce treatment for a period now has meant that they have had their husband and father at home, living in the family home uninterruptedly, not having to constantly go back and forward and intermittently coming out with all kinds of crazy and embarrassing behaviour which they have had to put up with in the past... In terms of his rehabilitation he is so much more integrated in his family and society than he would otherwise be.

At times Sasha would have felt it as a burden, tedious and tiresome... I think now she would have a completely different view on it... and she is quite relaxed about it continuing.

In other cases, the CTO was seen to contribute little to the patient's care:

I don't know that it makes any difference, because he is actually very compliant. He takes his treatment, he comes to appointments, he is very happy to accept help. I have never needed to use the Act to enforce anything.

It's just simpler to get people back into hospital under compulsion if they are already under the Act.

Some clinicians also identified some clear disadvantages of the order from the patient's point of view:

He would probably see it as harmful because he was having medication he really didn't want to take.

There is always a negative side to the fact that you have this control or coercion over him. We could relate pretty well but there was always a bit of tension around that. I always felt that I was probably seen as the authority figure. But it wasn't like he brought it up each time: "When am I going to get off this order?".

The apparent paradox involved in removing part of a patient's autonomy, with the aim of advancing it later, was mentioned several times.

The negative aspect is that you are taking away some of their autonomy and rights. But at the end of the day the aim is for her to get back that autonomy so she doesn't need to be on a treatment order.

One of the concerns is that you take away his autonomy and whether that has any effect on his ability to take responsibility and autonomy for his health. On the one hand you are saying he hasn't got the ability to do it, when you are actually taking it away from him. There is always the issue with someone with a clear ongoing psychotic illness that we know the illness itself can impair that judgment. So I think we are justified in saying it is OK to take away his autonomy at this point, although we are trying to restore his autonomy in time, as hopefully he develops insight and takes better control of his illness.

Clinicians often appeared to resolve the balance of advantage in their minds by emphasizing the improved mental health of patients who may otherwise go through repeated cycles of relapse and readmission to hospital care. The autonomy of patients trapped in that cycle was often seen as illusory.

The CTO helped us to help her to have some kind of stable living arrangements and a more organised mental life.

What you want is the order to provide a period of stability for them to be able to regain the things they have lost.

Several clinicians referred to the gradual process of recovery of some patients under CTOs, suggesting that resolution of immediate symptoms was only the beginning of a lengthy process of rehabilitation. Issac's psychiatrist said, of someone who had been out of hospital for 6 years:

It has been slow progress. He was quite psychotic, very isolated in his room. Since then he has gradually become more involved in activities. It was a very slow rehabilitation process.

Some other patients' history of disturbed health was said to be in stark contrast to their current stability:

What stopped because he was under the order was the sort of alarming behaviour that had frightened his family and neighbours and everybody else.

I don't think he experiences it as restrictive. It is all the stability he has known in adult life.... Prior to that he was in and out of hospital and in and out of prison and not coping with anything.

One psychiatrist was concerned that the CTO would subvert the credibility of a patient's parenting capacity at a child custody hearing. But few clinicians expressed concern that patients were stigmatized by the order. It was noted that few outsiders would be aware the order was in place, particularly as the Family Court process, through which CTOs are imposed in NZ, is not open to the public.

I think people experience it as an intrusion on their freedom and liberty. I don't think they experience it as stigmatizing. Some people find the illness an intrusion anyway and the treatment is an intrusion and we are an intrusion but all that is true even without the Mental Health Act.

Some clinicians even took the view that the patient might welcome the CTO as a symbol of increasing independence, or they might view discharge from it as a specific goal of therapy:

The CTO is perceived by anyone who has been under an inpatient order as a step forward. When somebody that unwell moves from being an in-patient into the community it is just the normal progression that they go through a time of being on the community order.

I think she saw it as a reasonably therapeutic thing and we were very clear with her that we were working towards her coming off it.

Concern was still expressed that a CTO might make a patient unnecessarily dependent on the mental health service, and less able to cope independently:

Every time you are controlling someone you may be keeping them safe and, assuming they are not a baby, the side effect is that they don't necessarily do that thing for themselves.

Overall, the interviews revealed NZ clinicians had a generally positive view of the CTO scheme. This confirms the results of our earlier survey, sent to all psychiatrists in NZ. Concerns were still expressed that CTOs were used with some patients who would cooperate without them, and that they may foster patients' dependence on the mental health system.

3.3. Impact on therapeutic relationships

Comments in this area were mainly focused on the apparent paradox that good therapeutic relations seemed to be required for a CTO to be effective, although some clinicians noted that the CTO had enabled therapeutic relations to commence or improve. No clinician observed that a CTO could replace a therapeutic relationship. On the contrary, obtaining some degree of collaboration with the patient was considered integral to success. Patients who were absolutely determined to avoid treatment and contact with health professionals were not considered suitable candidates.

The CTO was as much driven by her as us. I don't think it has a lot of teeth, and if someone doesn't want to use it for their own benefit, if you haven't got a therapeutic alliance with them, it's pretty useless.

It's all to do with personal contact and getting his trust and encouragement, rather than compulsion. You can't really force people to rehabilitate.

The therapeutic relationship at the very start is vital and ongoing clear explanations: two way communication.

They have got to have a problem that we can help them with. There has got to be a reasonably available treatment, their living situation has to be adequate, and they have got to recognise the authority of the order. Some people don't and community orders just don't work for them. They leave town or just tell us to piss off. They avoid us. [The ones for whom it works] agree in some way that the Act has validity and that it does work.

In a few cases, a highly authoritarian approach was still considered appropriate:

I said, "Lady, toe the line, or I am going to have to haul you in to hospital".

Under the NZ legislation, a CTO grants extensive powers over the patient's treatment to the clinical team (Dawson, 2005). Nevertheless, many clinicians commented on the practical limits to the exercise of such authority. Several said the CTO had little effect if the patient did not perceive the order to be valid, and it was frequently said the CTO did not lead to clinical teams forcing treatment on unwilling patients. Rather, the main effect was to confer the authority on teams to persist in their efforts to establish and maintain a useful relationship with the patient. Thus:

The CTO is only a piece of paper giving you permission to engage with someone.

We felt legally able to go round and talk to her, whether she wanted us to or not.

It gave us a bit of authority to insist that she come to appointments and that she receive follow up.

The dilemma with CTO is that you still have to develop the therapeutic relationship, and at the end of the day they have got to take the medication.

You need a good therapeutic alliance and a drug that works.

The NZ clinicians therefore considered CTOs could both help and harm therapeutic relationships. Involuntary treatment was seen to be counter-productive in a few cases, often due to the patient's general attitude towards authority, but the structure for care provided was generally viewed in a positive light.

I think it provided a framework, so it did help with compliance with medication and follow up.

There were less relapses and better control of his illness and it indirectly allowed us to monitor him more closely and treat his active symptoms.

It provides a structure for George to know that he is able to accept regular follow-up. That helps with his compliance.

3.4. Administrative burdens and resource constraints

Few clinicians complained strenuously about the burden of administration imposed when using CTOs, or about excessive 'form-filling'. Such comments were frequently heard shortly after CTOs were introduced in NZ, in 1992, but the regime had been in force for nearly a decade when the current study was conducted, and most clinicians had become

familiar with its use. Additional administration is certainly required to fulfill the statutory obligations of psychiatrists in review procedures concerning the patient's status, especially the preparation of short clinical reports for courts and tribunals, and attendance at their proceedings to present clinical opinions. The length of the hearings before these courts and tribunal was not often criticised, although some community nurses, who were also interviewed, said they felt an obligation to prepare the patient for the hearing, transport the patient to it to ensure their attendance, sit through it, and then debrief the patient afterwards. This could 'knock half a day out of your calendar'. One clinician expressed the view that hearings had gradually become more formal and adversarial over time, and were sometimes pedantic, with the lawyers engaged to represent patients becoming more assertive. He considered such hearings could impose considerable stress on the patients involved.

Most clinicians considered the resources available in urban areas of Otago to provide the necessary treatment for patients under CTOs were 'adequate', although fewer services were available in rural areas, especially adequate supported accommodation. The comment was still made that smaller patient caseloads would be preferable when a psychiatrist had several patients under a CTO, in light of the extra time that might be required to establish a collaborative relationship with an involuntary patient. One psychiatrist said he lacked time to discuss the implications of the CTO with the patient when they met.

A formal agreement had been negotiated between the mental health service and the Police concerning their respective roles in returning patients to hospital, and this was the subject of ongoing consultation. It was not said, in those circumstances, that difficulties in relations with the Police were a major obstacle to the use of CTOs.

Nor did clinicians say expressly that patients under CTOs got priority for services over other patients. But many did comment that the order assisted a patient's readmission to hospital, or it ensured the availability of supported accommodation.

We were able to arrange an adequate placement in the community.

Given the risks to him and there still being a relatively recent history of serious aggression to other people, its principal use was as a risk management strategy. It also meant that people like supported accommodation staff were willing to take him because they felt the CTO guaranteed support.

Rather than giving some patients priority over others, these comments suggest the CTO gives patients similar access to services they might not otherwise receive.

3.5. The dilemma of discharge

The weight of clinicians' comments on indicators for discharge from a CTO suggest they were looking, above all, for significant improvement in the patient's clinical condition. These improvements were described in familiar terms, such as attaining greater stability; making critical changes; significantly reduced risk; attaining greater insight; accepting responsibility for treatment; and the disappearance of the initial reasons for involuntary care. In such cases, the balance of advantage was generally seen to have tipped in favour of termination of the CTO. Typical comments were:

I thought she had demonstrated a considerable amount of responsibility and there was absolutely no point in continuing it. She had not made any suicide attempts for quite a long time and she was really cooperative with treatment.

It is something you don't really like to do. So what you are looking for is to restore him to full health, which is obviously insight, judgment, but also having him able to manage his own illness.

If someone is willing to accept treatment on a voluntary basis we should go along with that.

Even if such changes had occurred, there was still the problem that the patient might revert to a prior pattern of illness if they dropped out of care following discharge from the CTO. As was said of one patient with a lengthy forensic history:

There has been some slow progress from right back when he first came out of hospital, and the question is where along the spectrum do you make the choice. I think it is just a matter of time to when he is making a reasonable

adjustment to living independently, where he has got reasonable levels of insight, and he seems to be complying and willing to carry on with the treatment relationships and he does that over a period. I don't think he is quite at that stage yet but a little bit down the track that will be revisited.

Clearly some clinicians would accept higher levels of risk than others, and their views seemed conditioned partly by their prior experiences: that is, whether they believed they had ‘made mistakes’ when discharging patients from CTOs in the past. It was not only the current patient’s condition, therefore, that influenced their discharge decisions. One senior clinician observed:

I am sure there is quite wide variation among my colleagues about when people come off and how long they should stay on. I think guidelines would be helpful to provide some sort of consistency.

The degree of harm caused by the patient to others, and the time elapsed since, were clearly relevant factors, along with the ‘relapse profile’ of the patient.

The CTO means we are able to exert a bit more control to manage the risk of his sexual offending. It is like an insurance policy.

The CTO was predominantly about trying to get her back into hospital rapidly ... because of the seriousness of her suicide attempts.... She could become quite unwell very quickly and unpredictably.

The attitude of other stakeholders to the patient’s discharge could also be influential. The degree of ‘reassurance’ the CTO conferred on the patient’s family was considered important, for instance.

[His wife] likes to have it in case things do go wrong because it's like an insurance policy for her. She knows that if things aren't working out then she has got some leverage.

In addition, the patient’s own attitude to their discharge was considered relevant. In particular, discharge might be delayed if the patient saw no disadvantage in the order, or they saw it as a guarantee of continuing access to care.

There was particular reluctance to discharge patients with a substantial forensic history, particularly where they had made substantial gains under the CTO.

Nothing has to change with Mac. We really have to bite the bullet and take him off. All we have to do is carefully weigh up what gains we have. We are going to sit down in the next six months and think seriously: ‘should we take him off?’, and we are likely to think, ‘let's not upset the apple cart’, and leave him on.

Concern was expressed that some discharge decisions had been unnecessarily delayed, or that insufficient consultation occurred with the patient or their family about this decision:

Some times we probably don't act quickly enough to take people off, or to discuss clearly enough with people why they are on.

An experienced nurse voiced the concern that one patient’s discharge from a CTO was delayed because he was black.

A wide range of factors therefore seems to influence discharge decisions, particularly the history and progress of the patient’s illness, the impact of their conduct on other people, and the particular clinician’s views concerning acceptable levels of risk.

3.6. *The proper scope of clinical authority*

A further dilemma articulated by the NZ clinicians concerns whether intervention under the CTO should be limited to the medical management of a narrowly defined mental disorder, or whether it can be used legitimately to control wider aspects of a person’s behaviour or social circumstances that strongly influence their mental health. Some clinicians were concerned that the powers conferred by a CTO were used to monitor drug and alcohol use, for instance, or to ensure continued access to supported accommodation, when this no longer seemed justified in light of the patient’s current mental state but such factors were relevant determinants of patient’s mental health. Should the clinician try to control not only the patient’s psychiatric treatment (narrowly conceived), but also other aspects of their behaviour and circumstances that might precipitate their relapse?

The NZ statute does not expressly empower judges or clinicians to order the patient to reside at a specified address, but it does authorize the patient's recall to hospital if the conditions for their outpatient treatment are no longer adequate. So accommodation requirements can be effectively imposed by clinicians as a condition of continuing outpatient care. In such cases, the CTO is used to 'lock in' a supportive structure intended to prevent a deterioration in the patient's mental health, but the concern was voiced that clinicians were not consistent in their approach to the exercise of such powers.

Broad forms of authority were clearly exercised in some cases.

When we put them under a CTO we are really regulating and policing their drug intake. We check their drug screen and the minute it is spotted we take them back because they are not complying.

I wanted it for very specific purposes apart from the psychiatric stuff. I wanted it for contraceptive purposes, so we could even look at the extension of her illness, which was her having this tendency to go out and get pregnant, which caused her difficulties when she had to give her children away or have them adopted out.

In the latter case, the clinician took the view that the patient's sexual conduct was a feature of her illness and that its consequences severely affected her mental health. But he was uncertain whether contraception was a legitimate form of treatment to impose, particularly when only 'treatment for mental disorder' is authorized by the Act.

Other clinicians questioned whether the powers conferred by a CTO should be used mainly to benefit a patient's family, or to benefit the providers or other residents of supported accommodation, rather than for the direct benefit of the patient to whom the clinician's principal duty was owed.

In each of these situations, the clinicians seemed to be concerned, therefore, that they might stray beyond their core clinical functions, or that they might breach their primary ethical obligation to the patient, in their efforts to influence the wider determinants of the patient's mental health.

3.7. The discretion to revoke outpatient status

Not all the powers conferred by a CTO regime must be exercised, of course, even if the legal criteria for their use are met. We particularly questioned clinicians about the circumstances in which they would invoke their power to recall a patient to hospital. Their responses showed they possessed broad authority in this field:

Even without seeing him I can, with the flick of a pen, get him back into hospital. That is helpful, necessary for him, and it enables his mother to get a good night's sleep.

The power of the order is such that we could bring her back to hospital, so we did, and she was horrified and furious. But these days she turns up, and we say, 'You need to come and see me', and she does.

I once had to do the whole performance, recalling him to hospital, and giving it to him in hospital, and sending him out again. Then he was compliant, once he realised we intended to insist on it.

We certainly made it clear that we would not tolerate him getting unwell again.

The clinicians were adamant, however, that recall to hospital was not always an immediate consequence of non-compliance with treatment:

He would not have been returned to hospital if he had not taken his medication for one night. That wasn't the way it was working. I had a good relationship with him. It was ongoing, as far as education and discussion were concerned.

I don't pressure them, saying, 'I am going to ring the Police, going to take you to hospital now'. I have never done that. I work alongside him, you know.

The patient's compliance with treatment and their current mental condition were said to be major factors in the recall decision. The reasons a patient had not complied with treatment would also be considered, including legitimate objections to side-effects of medication. Swift recall was said to be more likely when the patient was known to have a rapid relapse profile, and where their relapse had serious consequences in the past. The stage

reached in their process of recovery, and their understanding of their illness, were emphasised. A further element was the degree of oversight that could be exercised by family members or others in the early stages of a relapse, along with any threats that might be posed to vulnerable people, such as children. There was also the question of the availability of a hospital bed.

There was a widespread view that recall to hospital was only necessary in a few cases, but a few patients had to be recalled numerous times. This pattern was confirmed by our study of the 42 patients' files. Recall to hospital was a relatively rare event. This group of patients as a whole had experienced 0.44 recalls to hospital for each year spent under involuntary outpatient care, or an average of 2.3 years involuntary treatment for each recall to hospital. Eighteen patients (43%) had never had their involuntary outpatient status revoked, while 9 (22%) accounted for 58% of all exercises of the recall power.

So, use of the recall power did not seem to cause major concerns for clinicians in practice, but some doubts were still raised about its proper use. In particular, how long should clinicians wait before recalling a CTO patient to hospital who is known to be relapsing; may a CTO patient be recalled at an earlier stage in their relapse than a voluntary patient; and should such a recalled patient be allocated a scarce hospital bed in preference to its current occupant? Some clinicians considered the recall power should be more actively used:

Sometimes these orders are wasted because we don't use the power they give us.

Others were concerned about the long-term impact of recall on relations with the patient:

If you come on too strongly you can destroy the relationship. We have to wait for them to learn from their experience and what it means to stop medication.

Some clinicians seemed defensive in their recall practices, appearing concerned at the potential for liability to be imposed in legal proceedings, or at possible media exposure, should a tragedy occur, following failure to recall a relapsing patient. Several commented that clear published guidelines on the use of all the powers conferred by a CTO could bring greater consistency to such discretionary decisions.

While the recall power was forcefully used by some clinicians, therefore, some doubts concerning its proper use remained.

3.8. *The CTO as a form of communication with the patient*

A final issue identified by clinicians concerned the capacity of the CTO to communicate certain messages to the patient. Psychiatrists responding to our earlier survey had attributed considerable importance to the fact that putting a person on a CTO could 'signal to the patient that they have a major mental illness' (Romans et al., 2004). Similar comments were made in these interviews: that the CTO could communicate to the patient the severity of their condition, its effects on others, and the fact that others cared for them and would intervene. This function of the CTO was viewed positively by clinicians. It was often summarised in the notion that a CTO could 'bring home to the patient the seriousness of their situation', or could promote greater understanding of their condition.

He got clearer about the need for compliance with medication. He got better motivated on the need to stay away from alcohol and drugs. He got better at monitoring his own capacity to tolerate stress.

Some other messages that might be communicated to the patient, by certain decisions concerning the use of the CTO, were viewed in less positive terms. One concern was that placing a patient on a CTO could bolster their belief that they did not need to take responsibility for their own care. One patient, for instance, was said to have taken the following message from the CTO:

You have put me on an order because I need lots of people to look after me.

Another dilemma concerned messages that might be sent to the patient by their discharge from involuntary outpatient care. This might send a counter-productive message, subverting that patient's subsequent care.

His mental health can change abruptly. I worry that without the CTO he would take that as a signal that he was well and didn't need his medication.

So both helpful and unhelpful signals may be sent to the patient by various decisions in the use of CTOs.

4. Discussion

4.1. Limitations

This study has several limitations. First, the interviews were limited to clinicians in one region of NZ, who were questioned about the use of CTOs in specific cases for which they were responsible. It might be expected, in that context, that clinicians would say positive things about the CTO regime. Furthermore, dilemmas encountered by these clinicians in other cases may not have been discussed. In addition, this report covers only the use of community compulsion. Other potential dilemmas may be more salient in inpatient settings, where the environment may underscore the involuntary character of treatment, and where the relationship between clinician and patient, in the more acute situation, may be more coercive.

Secondly, only half the patients who met our inclusion criteria and were considered competent to participate agreed to take part in this research and permitted us to speak to their psychiatrist. It is possible that those who declined to participate, and whose clinicians were not interviewed, had less positive experiences of the CTO. Their clinicians might therefore have experienced greater difficulties in the treatment process, of which we were not informed.

Our earlier reports indicate that the patients who were interviewed felt free to describe their experiences to the CTO in both negative and positive terms (Gibbs et al., 2005), but those not interviewed might still have been more strongly opposed to treatment under the CTO. So this kind of selection bias may have influenced our results.

This problem was unavoidable, as it would not be ethical to interview clinicians about specific cases without the patient's consent, but it is possible that more positive comments were obtained from the clinicians whose patients gave consent. Nevertheless, our national survey of psychiatrists, conducted at around the same time, confirmed that NZ psychiatrists overwhelmingly preferred to work within a mental health system that included a CTO regime (Romans et al., 2004).

Furthermore, a substantial number of psychiatrists were interviewed in this study, in some depth, and they worked in services attached to a university teaching hospital. It is unlikely that they would, as a group, exhibit maverick attitudes or practices, and they were working with a well-embedded CTO regime.

4.2. The views of NZ clinicians compared with the previous literature

The interviews indicate that Otago clinicians commonly encounter some of the dilemmas discussed in the prior literature, but not others. In particular, they struggle to determine the right moment for discharge from compulsion. Even when the proper decision seems clear at the time, the optimum outcome is not assured, and some decisions may later seem wrong.

Despite these uncertainties, the NZ clinicians seem less troubled by such dilemmas than might be expected. In most cases, they seem to reach a firm conclusion that the benefits of the CTO outweigh the costs of coercion, mainly because they consider involuntary treatment a better option for the patient than other likely alternatives, and because they believe patients benefit from greater stability in their health, particularly in their capacity to maintain an independent living situation and important personal relationships. As our earlier survey revealed, most NZ psychiatrists appear to see CTOs 'as a useful tool in pursuit of core clinical goals' (Romans et al., 2004, at 840). They take a fairly long-term view of the contribution involuntary outpatient treatment can make to a patient's health and they tend to be somewhat sceptical about the scope of the autonomy that can be exercised by a person with a serious mental disorder who is repeatedly admitted to inpatient care. On the other hand, it was also said that CTOs could not be used effectively with some patients who were 'completely uncooperative', or that the regime 'lacked teeth'. Nevertheless, some clinicians clearly made active use of their powers, recalling a small number of patients repeatedly to hospital.

In some jurisdictions, many other forms of leverage are frequently applied to individuals with mental disorder to improve their treatment adherence, including control of money, access to housing, and criminal sanctions (Monahan et al., 2005). Comparing the position of a patient on a CTO with one of complete autonomy may therefore be an oversimplification. A comparative liberty analysis may be more appropriate, under which the position of a patient on a CTO is compared with other likely alternatives, including involuntary hospitalisation and the possibility of further imprisonment or forensic care.

Most NZ psychiatrists clearly consider that a CTO can help establish the necessary framework or structure for a patient's care, that the order can influence the patient's attitude to their illness, and enhance their engagement with services over the long-term. These clinicians also seem to use their powers in flexible and pragmatic ways, so that the boundaries between voluntary and involuntary treatment are frequently blurred, even with patients under the CTO scheme.

The well-known dilemma of discharge seems to be experienced most acutely with patients who may have the most to lose from further relapse in their condition (such as former forensic patients), and with patients having a severe or rapid relapse profile. Here the CTO is seen to be particularly helpful in authorising closer monitoring of the patient's condition, earlier intervention, and more rapid recall to inpatient care.

On the other hand, several dilemmas for clinicians in the use of CTOs that have been discussed in the literature were not often raised in our interviews. These include the burden of administration and the potential for abuse, or over-use, of involuntary treatment powers. That administrative burden was not often raised contrasts with consultants' experience of supervised discharge orders in England, where this has been considered a substantial problem (Pinfold et al., 1999). One would not expect clinicians to express many concerns about the inappropriate use of CTOs, however, when discussing cases for which they were responsible. A notable exception was the case in which it was suggested by a nurse that the patient was left too long on an order because of his ethnicity, a concern that has often been raised before (Bluglass, 1993; MIND, 1999).

Although the potential for CTOs to stigmatise patients has often been discussed, this was not a major concern of NZ clinicians. They may be indifferent to, or ignorant of, this concern. Alternatively, they may suppose that the CTO, as a private event, is less stigmatising than many other disadvantages confronting people with serious mental disorders. For example, it is widely reported that stigmatisation of psychiatric patients has much to do with others' perceptions of their dangerousness (Thornton & Wahl, 1996). Interventions that appear to reduce dangerousness, or other evidence of mental disorder, may therefore serve to reduce stigma.

The NZ clinicians varied in their views concerning the scope of the treatment powers a CTO conveyed. Nevertheless, the precise scope of their powers remains unclear and controversial at the margins, as the contraception example shows. The reasonable concern for the welfare and rights of individuals who were incarcerated in large psychiatric institutions in the past may not fit the era of community psychiatry, and coercion in the community may be more intrusive in theory than in practice. Nevertheless, there remains the danger, identified by the NZ clinicians, that the extensive powers conferred by CTOs may permit clinicians to reach beyond their core clinical role, to impose an excessive degree of control over a person's lifestyle and environment, in the attempt to influence all matters that seem to determine their mental condition. Perhaps this is the most pressing dilemma of all.

5. Recommendations for clinicians

We therefore offer the following recommendations for clinicians.

CTOs should not be used in a rigid or inflexible manner, but should be tailored to individual circumstances and need. Much will depend on the history, relapse profile and social circumstances of the individual patient. It is therefore acceptable for varied practices to be followed with CTOs and rigid service guidelines for their use should be treated with some scepticism. CTOs might be more rigorously enforced with former forensic patients, for instance, and with patients who have a severe relapse profile or who are responsible for the care of children.

The extensive powers conferred by CTOs should be used with great discretion. Not every power that can be used should be used, and the consent of the patient, to all interventions, should be obtained first whenever possible. Heavy-handed use of the powers conferred may be counter-productive and may prevent the patient from taking responsibility for their own care.

While it may seem problematic, from an ethical point of view, to use CTOs in a manner that appears to provide more assistance to family members, or other third parties, than the patient, this problem may be mitigated to some extent when those other parties provide important assistance to the patient. That assistance may be vital to the patient's survival outside hospital, and might not be available if the CTO were not in place. In such cases, support for third parties, via the CTO, can fairly be viewed as indirect support for the patient.

With regard to the power to control the patient's accommodation, as an aspect of their treatment under the CTO, it may often be sufficient to specify the kind of accommodation required, or the level of support that should be available, the patient being left free to move between different residences of that kind.

Establishing a good therapeutic relationship with the patient within a reasonable time may be an essential condition for the successful use of a CTO. If no useful clinical relationship can be established, or the patient does not recognise the order as valid in any way, they should probably be discharged sooner, rather than later, to voluntary care.

Finally, the resolution of the dilemma of discharge may lie in the active use of both the power of discharge and the power to reinstitute commitment proceedings. The finality of discharge from a CTO should not be over-estimated. In many cases, the commitment process can be set in motion again, if required. There may be a tendency for clinicians to believe that the threshold for maintaining a person on a CTO is lower than required to initiate the process from the start: that actual danger to self or others is always required, for instance, for the latter to proceed. But that belief may not be fully reflected in the law, as many civil commitment statutes rely on roughly the same legal criteria for entry into and exit from the scheme. Formulating an active strategy for reinstating the commitment process may therefore assist patients to be discharged more readily from the CTO scheme.

Acknowledgements

Thanks to all those interviewed, the Health Research Council of NZ, the NZ Law Foundation, Sarah Romans, Te Oranga Tōnu Tanga (the Māori Mental Health Team of the Otago District Health Board), Chris Ansley, Nikki Ratter and Hine Forsyth.

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