



Research Paper

Control in the community: A qualitative analysis of the experience of persons on conditional discharge in Hong Kong

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ABSTRACT

Mandatory outpatient treatment schemes such as community treatment orders remain controversial despite being commonly used around the world. Given concerns about patient autonomy and civil liberties, such schemes need to be closely scrutinised. Though Hong Kong's mandatory outpatient treatment scheme, the conditional discharge (CD) regime, has a number of significant legal concerns, empirical research on how it operates on the ground remains limited, and data on the subjective experience of relevant stakeholders is limited to healthcare professionals. This two-part cross-sectional study, the first on the service user perspective in Hong Kong, rectifies this gap. Data was collected through a self-reported survey and semi-structured interviews. Results demonstrated that, while similar themes to those in the literature were raised, such as powerlessness, a lack of understanding about the regime and in particular their rights thereunder, concerns about restrictive aspects of the regime and poor attitudes of healthcare professionals, and in some cases positive sentiments about beneficial aspects, the Hong Kong experience differs in the significant extent to which many of these concerns are demonstrated. The insights which this data provides in relation to how the implementation of the CD regime can be improved prior to legal reform is discussed, and suggestions for the way forward are proposed.

1. Introduction

The use of mandatory schemes that require service users in the community to comply with certain conditions or face the threat of involuntary psychiatric admission to a treatment facility, often called community treatment orders (CTO) or mandatory outpatient commitment/treatment, has remained controversial, with stakeholders tending to hold polarised views about whether they should be introduced (O'Reilly, 2004) due to a number of points of contention, including whether CTOs are ethically justifiable (Dale, 2010; Dunn, Canvin, Rugkåsa, Sinclair, & Burns, 2016; Lawton-Smith, Dawson, & Burns, 2008; Munetz, Galon, & Frese III, 2003; Snow & Austin, 2009), whether they are compliant with international human rights commitments such as those under the UN Convention on the Rights of Persons with Disabilities (CRPD) (Newton-Howes & Ryan, 2017) and whether they are

effective (Burns et al., 2013; Rugkåsa, 2016; Steadman et al., 2001).

Despite these controversies, mandatory community treatment schemes have become a common feature of mental health legislation in more than seventy-five jurisdictions around the world (Rugkåsa, 2016). Given this widespread use in spite of concerns about personal freedoms and patient autonomy (Fulop, 1995; Lawton-Smith et al., 2008), it is imperative that the legislative design of such schemes be scrutinised to ensure that any restriction of liberty and autonomy is justifiable and kept to a minimum. On this particular issue, there have been various frameworks put forward to assess CTO regimes across jurisdictions. For example, building upon Dawson's comparative study of CTO regimes in six common law jurisdictions (Dawson, 2006), Jobling proposes a framework for assessing CTO regimes which considers four key elements (Jobling, 2016)¹: (i) whether a capacity clause is included in CTO legislation; (ii) the threshold of risk required to initiate a CTO; (iii)

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¹ While an in-depth analysis of the suitability of Jobling's framework is beyond the scope of this discussion, two points are worthy of mention. The first is that the consideration of capacity clauses in CTO regimes should be undertaken in the context of discussions about Article 12 of the CRPD. In particular, the Committee on the Rights of Persons with Disabilities has stated that mental capacity should not be conflated with legal capacity, and that denying an individual legal capacity on the basis of mental impairment is discriminatory (see United Nations Committee on the Rights of Persons with Disabilities (2014): paras 13 and 15 and McSherry and Wilson (2015) for an overview of the discussion). The second point is that while a lack of provision of care and support is undoubtedly problematic, the presence of reciprocity should not be seen as a way to justify a CTO, if we are to have expectations about proper, individualised care and support for healthcare service users. I am grateful to Peter Bartlett for raising this issue. See also Department of Health (1999) for a discussion of the principle of reciprocity and its potential consequences.

whether a reciprocity clause imposing duties to provide care and support is included in CTO legislation; and (iv) the constraints on professional discretion in the use of CTOs, which includes (1) conditions that have to be met before CTOs can be used, such as the abovementioned capacity provisions, threshold of risk, and additionally, history of hospitalisation and the opportunity to engage voluntarily; and (2) the level of oversight CTOs are subject to, for example in terms of court or tribunal involvement at the point of initiating a CTO or after the CTO has been secured. Using this framework, she concludes that the CTO regime in the UK has a low threshold, and leaves considerable space for professional discretion.

1.1. The conditional discharge regime in Hong Kong

While Hong Kong does not have a CTO regime per se, its conditional discharge (CD) regime, which operates in the civil context and applies to individuals who have been compulsorily admitted to a psychiatric hospital, is a form of mandatory community treatment, and shares the main features of mandatory community treatment regimes. This includes the requirement to comply with conditions, in particular to engage with treatment and maintain contact with services, with recall to hospital in the form of involuntary psychiatric admission as a consequence for non-compliance and deterioration in mental health (Jobling, 2019).

The legal provision regulating CD in Hong Kong is section 42B of the Mental Health Ordinance (Cap 136) (MHO). Pursuant to this section, if a patient (defined as a person suffering or appearing to be suffering from mental disorder) (i) has a medical history of criminal violence or a disposition to commit such violence and (ii) can be safely discharged subject to conditions, the medical superintendent may make an order for their discharge subject to conditions. The conditions are determined at the sole discretion of the medical superintendent,² with the only criterion being that the conditions are reasonable in the circumstances. Once the order has been imposed, its duration is indefinite, with no extension or renewal procedures required. Individuals on CD can be recalled to hospital and compulsorily detained if it appears to the medical superintendent that they have failed to comply with any condition, and if the medical superintendent is of the opinion that this is necessary in the interests of the patient's health and safety or the protection of others. There is no formal mechanism for release or discharge apart from the Mental Health Review Tribunal (MHRT), to which the individual on CD can apply once every 12 months. There is no duty to refer individuals on CD to the MHRT in the same way that there is for compulsory detention and treatment in hospital.

The legal concerns with this regime are immediately apparent. To begin with, it is not entirely clear what the objectives of this provision are. The historical context of the enactment of this provision³ suggests that the objective was primarily protection of the public, a view supported by the fact that the only criteria necessary for the imposition of CD is a history or disposition of violence, and that the individual can be discharged safely. Confusingly, however, the CD regime also contains elements suggesting that it has a medical or therapeutic objective as well, such as the fact that the medical superintendent must consider whether recall is necessary in the interests of the health and safety of the individual (if it is not necessary for the protection of others). Additionally, when considering whether to release the individual from conditional discharge, the MHRT needs to have regard to (i) the likelihood of medical treatment alleviating or preventing a deterioration of the individual's condition; and (ii) the likelihood of the individual, if discharged, being able to care for themselves, to obtain the care they need

² Although in practice this power is delegated to the psychiatrist responsible for the patient.

³ Enactment of this provision was prompted by the Un Chau Estate tragedy of 1982, in which a psychiatric outpatient killed his mother and sister before killing and injuring a number of children in a kindergarten. See further Cheung (2018).

or to guard themselves against serious exploitation (MHO, section 59E (3)). The latter of these considerations in particular demonstrates that there purports to be a medical objective to the CD regime, although this problematically fails to align with the criteria for the CD order in that at the point that the CD order is imposed, there are no therapeutic considerations whatsoever.⁴ While it is entirely possible for a legislative provision or regime to have both therapeutic and public protection objectives, it is argued that these objectives should be internally coherent: it is incoherent to impose paternalistic hurdles for release when no therapeutic assessment was required at the point the CD order was imposed.

I have elsewhere discussed other concerns with the CD regime (Cheung, 2018), such as the fact that (1) even with a public protection objective in mind, the criteria are worded far too broadly; (2) the discretion to impose conditions is much too wide and is thus susceptible to abuse and the unnecessary restriction of the individual's freedoms; and (3) there is a concerning lack of safeguards, in particular in relation to the indefinite duration of the order and lack of regular and effective review mechanisms.

Returning to Jobling's framework for assessing mandatory community treatment schemes, though Hong Kong's CD regime requires a high threshold of risk to initiate the order,⁵ the legislation does not include a capacity clause or reciprocity clause,⁶ and of greatest concern, there is minimal constraint on professional discretion in the use of the order, both in relation to the conditions that have to be met before the order is used and the level of oversight that these orders are subject to. In relation to the former, there is no need for any previous history of hospitalisation, and no requirement to provide the individual an opportunity to engage voluntarily. In relation to oversight, there is no court or tribunal involvement when the CD order is initiated, and the MHRT is only involved if the individual makes an application on their own accord.^{7,8} Additionally, the medical superintendent is given a very wide discretion in relation to a number of key matters, including whether the individual should be conditionally discharged, the setting of conditions with which the individual needs to comply, and whether the individual should be recalled to hospital and compulsorily detained. As such, it is clear that the mandatory community treatment regime in Hong Kong leaves significantly more space for professional discretion, which Jobling argues is problematic because this creates an 'intrinsic ambiguity to legal boundaries, making it difficult to challenge what can be flexible interpretation of criteria' (Jobling, 2019, p. 96). Additionally,

⁴ The CTO in the UK, for example, considers, among other criteria, whether the individual is suffering from mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment, and whether it is necessary for their health or safety or for the protection of other persons that they should receive such treatment (*Mental Health Act 1983 as amended*, sections 17A(5)(a) and (b)).

⁵ This is likely attributable to the fact that the CD regime was designed with public protection in mind, as its historical context indicates.

⁶ Although being placed on a CD order does come with a number of additional services under Hospital Authority guidelines, including visits from a community psychiatric nurse and social worker (but see n 1 above regarding reciprocity clauses).

⁷ As will be discussed further below, due to the lack of information provision, many individuals on CD are unaware of their rights to apply to the MHRT and therefore fail to do so.

⁸ Even where applications are made to the MHRT, the statistics the author obtained from the MHRT via an Access to Information request dated 9 June 2020 suggest that the prospects of success are extremely low. Between July 2017 to Jan 2020, only 1 out of 43 first applications for unconditional discharge from CD were successful, i.e. a success rate of 2.3%. Adding the number of second applications, 9 (all of which were unsuccessful), the success rate becomes a mere 1.9%.

the lack of a capacity criterion coupled with significant professional discretion will likely result in a strongly paternalistic approach being adopted.⁹

In considering the design of a mandatory community treatment scheme, however, it is important that we not only examine the relevant legal provisions, but also how the scheme is implemented on the ground. Empirical research on the implementation of the CD regime in Hong Kong remains limited. There are no current and updated figures on the number of individuals on CD in Hong Kong. In its 2017 Mental Health Review Report, the Review Committee on Mental Health, a committee set up by the government, released figures for (i) the number of individuals who were released on CD and (ii) the number of individuals on CD who had been recalled for the years 2011 to 2015 (Review Committee on Mental Health, 2017, p. 199).¹⁰ The number of individuals released on CD ranged from 131 to 162, and the number of individuals recalled ranged from 16 to 35. Data was also provided in relation to how long individuals who were on CD in 2015 ($n = 361$) had been on CD, with 23.5% having been on CD for 1 year or less, 31.6% for 1–3 years, 41.8% for 3–10 years, and 3% ($n = 11$) having been on CD for more than 10 years (Review Committee on Mental Health, 2017, p. 199). There is also no data on the efficacy of CD. Wong and Chung's retrospective case notes review examines the characteristics and short-term outcomes of conditionally discharged individuals in Hong Kong (Wong & Chung, 2006), but provides no information about efficacy due to the lack of comparison with a non-CD control group with matched clinical characteristics.

In relation to the subjective experiences of relevant stakeholders, the only study thus far that has explored this is Chiu's empirical work on the perspective of psychiatrists involved in the CD regime (Chiu, 2019). Particularly worthy of note is the confusion and/or disagreement about how the law should be applied among the interviewees across various aspects of the CD regime. For example, there was a sense that there was a very wide discretion and thus an 'absence of clear boundaries' in relation to what kinds of conditions practitioners could impose on individuals, which in turn led to conditions being imposed that were 'weird', 'difficult to monitor', and in some cases, not directed at the individual's medical condition or disposition to violence (Chiu, 2019, p. 74). In addition, there was a sense of confusion about when individuals should be recalled, namely whether a breach of condition was sufficient, or whether signs of relapse were necessary as well (Chiu, 2019, pp. 75–6). The interviewees also expressed concern about terminating a CD, since this was not provided for in the legislative provision, and described different ways to 'work around the problem' as it was unclear how this should be done (Chiu, 2019, pp. 77–8).

In line with the above discussion about the lack of clarity regarding the objectives of the CD regime, Chiu also found that the interviewees in her study held different views about the goals of the regime, and in particular, about whether a CD order had any therapeutic or rehabilitative element. On the one hand, there was the view that the CD regime was largely aimed at preventing individuals at risk of committing violence from harming others (Chiu, 2019, p. 80). On the other, some interviewees believed that the CD order was beneficial to the patient, for example in terms of (i) better recovery and reintegration into society, (ii) more stability and a greater ability to find employment, (iii) an increased amount of resources invested in them; and (iv) the collaborative effort between healthcare professional and patient, described as a 'team effort' and a 'goal-setting' exercise to facilitate the patient's

recovery and rehabilitation' (Chiu, 2019, p. 80–1). As will be further discussed below, these views on the benefits of the CD regime were not shared by many of the participants of this study.

There is thus a concerning dearth of empirical research on the CD regime in general. This study aims to take a step towards rectifying the lack of research on the service user perspective in particular. In assessing the implementation of the CD regime on the ground, it is imperative that we consider the subjective experiences of individuals on CD, and the problems that these might uncover.

2. Methods

This is a two-part cross-sectional study consisting of a self-reported survey and a semi-structured interview for those who indicated they were willing to be interviewed in the survey. Qualitative interviews were chosen as the main method of data collection because this allowed for an in-depth exploration of the views and perspectives of the participants. All survey and interview questions were informed by a literature review, and developed in consultation with an individual with lived experience of CD.

2.1. Sample and recruitment

Participants were recruited from halfway houses under a major non-governmental organisation (the NGO), one of the largest organisations providing services to persons with mental disability in Hong Kong. Recruitment from halfway houses (i.e. recruitment of persons on CD with a residency condition that requires them to reside at a halfway house) was chosen as the recruitment method because persons on CD without a residency condition live in the community and are difficult to locate. The inclusion criterion was any patient who was on active CD, and exclusion criteria included (i) persons who did not understand written Chinese; and (ii) persons who did not understand the consent form or were otherwise unable to give informed consent.

Surveys were distributed between December 2020 and January 2021 to all persons on CD living in halfway houses under the NGO via a coordinator at each halfway house. Each survey was distributed together with a written consent form that explained the purpose of the research and the two parts of the study. Patients were informed that they could choose to complete the survey only, without taking part in the interview, and that they could cease to participate at any time with no consequences. They were also assured that all information collected would remain confidential and, in particular, would not be shown to any of their past or current physicians. All participants were informed that they would receive a HK\$50 supermarket coupon for completion of the survey and another HK\$50 coupon for the interview as compensation for their time. Where a participant completed the survey and indicated that they were willing to be interviewed, the researcher arranged a time to conduct the interview with the coordinator at the halfway house at which they resided.

2.2. Data collection and analysis

Surveys were completed by the participants and responses were hand-delivered to the researcher via staff of the NGO. All interviews took place in a conference room at the halfway house, and were conducted by the researcher together with one of two research assistants on the research team. The researcher explained the research and confirmed informed consent. Where written consent was given, the interviews were audio-recorded. Three participants requested that their interview not be audio-recorded, and detailed notes were taken during these interviews instead. All audio-recordings were transcribed, and all transcripts and interview notes were coded and analysed by the researcher. The researcher derived analytic themes inductively through a process of familiarisation with and immersion in the raw data (Pope, Ziebland, & Mays, 2000). A constant comparison approach was used to identify and

⁹ See Fistein, Holland, Clare, and Gunn's (2009) argument, as described in Jobling (2019), suggesting that in the context of involuntary treatment, the lack of a capacity criterion together with a less stringent test for risk is likely to enable strongly paternalistic approaches.

¹⁰ Although, as noted by Chiu (2019), these figures do not give us any information on how long these individuals were on CD prior to being recalled, or whether and how many times they had been recalled before.

examine all data relevant to each theme (Pope, Ziebland, & Mays, 2000). After the themes were refined and the number of themes was reduced by grouping them together, key themes were chosen for further investigation and development (Pope, Ziebland, & Mays, 2000). As for the surveys, responses were summarised by descriptive statistics.

Ethics approval was granted by the University of Hong Kong Human Research Ethics Committee, and permission for the study was obtained from the NGO.

3. Results

The number of survey participants was 47, at a response rate of 70%, and the number of interviewees was 24, at a response rate of 51%. Participant demographics are summarised in Table 1.

3.1. Part 1: Key results from survey data

The results from the survey data suggested that the majority of survey participants had an inadequate understanding of the CD regime. 63.8% of participants did not feel that they understood the CD regime (with 14.9% stating that they did not understand the regime at all, and 48.9% stating that they understood the regime a little). Despite compliance with conditions being a mandatory component of the CD regime, 29.8% stated that they did not know what their conditions were.

The data further suggested that participants lacked understanding of their rights under the regime. 74.5% of participants stated that they did not know how their CD order could be terminated, and 72.3% of them did not know that they had the right to apply to the MHRT to discharge them from their CD order. Of the participants that reported knowing of this right, only 38.5% were able to describe the application process in a way that could be considered correct, although none of these descriptions included details about the actual process of obtaining and submitting the relevant forms.¹¹

In terms of information provision, only 48.9% stated that someone had told them about their rights and responsibilities under the CD regime. Of this group of participants, only 52.2% reported specific information they had been told about their rights and responsibilities, and of that group, 11 out of the 12 participants (or 91.7%) reported only information about their responsibilities or requirements under the CD regime, without any mention of any rights.

Interestingly, despite the general lack of understanding regarding both the regime and one's rights under it, 74.5% of survey participants were able to correctly state the consequences of violating conditions under the CD order. For the full results of the survey, see Table 2.

3.2. Part 2 – Thematic analysis of interview data

In-depth examination of the interview data revealed a number of recurring themes: (i) powerlessness, (ii) lack of understanding; (iii) the

Table 1
Demographics of participants.

| | Overall (n = 47) | Interviewed (n = 24) | Not interviewed (n = 23) |
|-------------------------------|------------------|----------------------|--------------------------|
| Age, mean | 43.6 | 44.7 | 42.3 |
| Male (%) | 85.1% | 82.6% | 87.5% |
| Tertiary Education and up (%) | 8.5% | 4.2% | 13.0% |
| Employed (%) | 27.7% | 33.3% | 21.8% |

¹¹ Participants simply responded that they would apply to the relevant authorities or through healthcare professionals such as doctors, social workers or nurses.

restrictive nature of the CD regime; (iv) poor attitudes of healthcare professionals; and (iv) positive aspects of the experience, each of which are reported on sequentially below. Three additional observations are made on the basis of the data.

3.2.1. Powerlessness

Powerlessness was a permeating theme throughout almost every single one of the interviews. This feeling manifested in various ways. Powerlessness, for example, stemmed from an inability to participate in a range of big decisions that were being made about them, including whether or not they should be placed on CD, what their conditions should be, how much information they could obtain about their situation, and how much help or support they could receive. In most cases these matters were decided by healthcare professionals, and in particular their responsible physician. In some cases these were negotiated by their family members with healthcare professionals, but in neither case was there any input from the individual themselves, as demonstrated by the following quote:

There were no discussions between me and them. The only discussions that took place was between them and my older sister. I have no right to make decisions about my life. The things my older sister says is very similar to what the doctor says. She doesn't ask for my views either. There is no possibility of discussion. (Interview 5).

Powerlessness also extended to the extent to which they were able to participate in regular discussions with healthcare professionals about either the progress of their treatment or their CD status. In relation to treatment, none of the interviewees reported any regular discussion of progress, and the only instances where doctors were reported as having talked to interviewees about treatment were in response to specific questions, complaints or attempts to negotiate a different treatment. In some instances, discussion about treatment was limited to the instruction that they should take their medication:

I asked them what kind of mental illness I am actually suffering from for them to prescribe such strong medication for me. They respond by saying 'just take your medicine, don't have to worry about other things. The most important thing is that you take your medication... In terms of my treatment arrangements, I have asked the doctor what my diagnosis is and he doesn't reply me. He just insists I take my medication. (Interview 14).

In relation to CD status, this was rarely mentioned in most cases, and where it was discussed, this was only to discuss specific aspects of the individual's obligations under CD, rather than a holistic assessment of whether and why the individual needed to continue to be on CD (or for how much longer), or to simply state that they did not know when the CD would end. One interviewee said, for example, "I asked the doctor how long my conditional discharge will last and they said they do not know how to respond to me. They said it depends on my behavior" (Interview 24).

Another demonstration of this pervasive sense of powerlessness was the imbalance in the power dynamic, which was another recurrent theme throughout the interviews. This power imbalance manifested in various ways. There were those that felt healthcare professionals held all the power, and that anything you could get from them was already something to be grateful for.

This is because the doctor gets to decide everything. All the power is with the doctor, which should not be the case. (Interview 8).

There's nothing you can do. This is like the grace of the emperor, you should be grateful that the doctor is willing to let you out at all. (Interview 13).

Some expressed the view that healthcare professionals disbelieved individuals on CD, or were generally unwilling to engage with or consider their views. Instead, they preferred to talk to the individual's

Table 2
Full results of survey.

| Survey Questions | Number | Percentage of sample (%) |
|---|--------|--------------------------|
| Do you think that you understand what the CD regime is? | | |
| Don't understand at all | 7 | 14.9 |
| Understand a little | 23 | 48.9 |
| Quite understand | 9 | 19.1 |
| Understand fully | 8 | 17.0 |
| Do you think you understand what your conditions under the CD order are? | | |
| No | 14 | 29.8 |
| Yes | 33 | 70.2 |
| If you think you understand what your conditions are, what are they? (Open-ended) ^a | | |
| [Listed at least one condition] ^b | 18 | 54.5 |
| [No valid response] | 15 | 45.5 |
| According to your understanding, what is the consequence of not complying with the conditions? (Open-ended) | | |
| [Correct answer] | 35 | 74.5 |
| [Incorrect answer] | 4 | 8.5 |
| [Participant did not know] | 6 | 12.8 |
| [No response] | 2 | 4.3 |
| Before today, did you know how the CD order can be terminated? | | |
| Yes | 12 | 25.5 |
| No | 35 | 74.5 |
| Do you know you can apply to the Mental Health Review Tribunal to terminate your CD order? | | |
| Yes | 13 | 27.7 |
| No | 34 | 72.3 |
| If you responded yes to the question above, do you know how to make an application? Please describe the application process. (Open-ended) | | |
| [Correct answer] | 5 | 38.5 |
| [Incorrect/incomplete answer] | 5 | 38.5 |
| [Participant did not know] | 2 | 15.4 |
| [No response] | 1 | 7.7 |
| Did anyone tell you about your rights and responsibilities as a person on CD? | | |
| Yes | 23 | 48.9 |
| No | 20 | 42.6 |
| Don't know | 2 | 4.3 |
| [No response] | 2 | 4.3 |
| If so, who? (E.g. doctor, nurse, social worker, family or friend) (Open-ended) | | |
| [Able to name someone] | 22 | 95.7 |
| [Unable to name anyone] | 1 | 4.3 |
| If so, when did they tell you? (Open-ended) | | |
| [Able to name a time] | 17 | 73.9 |
| [Unable to name a time] | 6 | 26.1 |
| If so, what did they tell you? (Open-ended) | | |
| [Response about rights and/or responsibilities] | 12 | 52.2 |
| [Response about something else] | 1 | 4.3 |
| [Participant did not remember] | 5 | 21.7 |
| [No response] | 5 | 21.7 |

^a For all open-ended questions, the categorisation of the responses was determined by the author.

^b This was an optional question on the survey.

carers or family members.

When I tell the doctor, they never believe me. The doctor said of course you would say that, everyone says they are not mentally ill. (Interview 22).

I think if I raised my dissatisfaction regarding my medication with the doctor, he may be willing to change my medication for me. However, it may be harder if I was the one asking for it. It would be easier if my family

were the ones asking for the change in medication. The doctor is less likely to listen to me. (Interview 9).

The use of infantilising terminology, such as “well-behaved” and “obedient”, was also prevalent throughout many of the interviews. These terms were used by interviewees both to describe their own behavior and to describe what was expected of them. For example, when asked whether he had been recalled to hospital before, an interviewee replied, “No, I am well-behaved” (Interview 12). Another interviewee, when asked what he thought his conditions were, responded “I should not have a rebellious spirit... They tell me to be obedient” (Interview 6).

In addition, a common sentiment throughout the interviews was the unwillingness of individuals on CD to ask questions or ask for help from healthcare professionals. This was frequently a result of their feeling that asking was pointless, that the healthcare professionals would continue doing whatever it was that they intended to do, without regard to the questions or requests.

3.2.2. Lack of understanding

Every one of the interviewees exhibited a lack of understanding about some, and in some cases most, aspects of the CD regime. This included who could be subjected to the regime, why they had been subjected to the regime themselves, what conditions they were being subjected to, why they had been recalled to hospital, and how a CD order could end. Additionally, none of the interviewees were able to give a comprehensive account of their rights under the regime, even when prompted with questions about specific rights. This was not always due to a lack of curiosity or interest on the part of the individual. For example, one interviewee said the following when asked about the MHRT:

I have not heard of the MHRT before and did not know that you wouldn't have to go through the doctor to ask for a review. Wouldn't the doctor have to hold a meeting to discuss this in any event? Is the MHRT an independent organization? Do they still look at our illness status? Usually, how many years would you have to be stable for before you can apply for this? (Interview 16).

The one aspect that most individuals were able to confidently respond about was the consequences of non-compliance with their CD order or the conditions thereunder, that is, being recalled back to hospital.

3.2.3. Restrictive nature of CD

The restrictive nature of the CD regime was another frequently recurring theme in the interviews. This manifested in various ways, both directly and indirectly. Strikingly, the most commonly discussed restrictions were those imposed by the halfway houses at which these individuals had to live as a result of a residency condition on their CD order. One of the most prevalent examples was that of the 10 pm curfew imposed by their halfway houses, which in turn had a significant impact on their social lives, as well as their ability to find and maintain employment.

Also, when I am with my colleagues, they don't know I have mental issues. So, it is weird that I have to leave at 10 pm like Cinderella. It is very hard to explain to others. Like with karaoke, you would not come back that early. (Interview 16).

Of course! Living in hostels is problematic. I can't go out at night. I can't do anything. I can't engage in normal socializing. Even if I am dating someone, I need to send them home at night after a date. I can't do that either. (Interview 17).

The main negative effect is that being on conditional discharge will force me to live in a hostel, which severely restricts my ability to earn money. Previously...they did not let me go out to work at night. However, I am someone who is not able to wake up early so I can only work at night. (Interview 15).

I used to work in kitchens and used to get off work very late, which is not compatible with hostel life. That is why I stopped working in kitchens and started working other jobs. The conditional discharge order makes it hard for me to accept jobs that have late working hours. (Interview 17).

Other restrictions imposed by their halfway houses included the inability to leave the premises of the halfway house upon initial arrival, for a period ranging from 2 weeks to 4 months,¹² with the majority confined for a period of 1–2 months. Controls were also imposed on spending, with the individuals' ATM cards taken away from them (at times without explanation) and/or the individuals' spending needing to be vetted by halfway house staff prior to approval.

Before I was allowed to handle my own finances, the hostel workers were managing for me. Back then, I could ask them for the ATM card. I would get money from the ATM and tell them how much I took out. Now, I don't need to report to the hostel regarding my spending. They told me that they think I am able to handle my finances on my own so they gave me back this right. (Interview 19).

For example, sometimes I want to go out to eat buffet or sushi with my family but this costs money. However, it is not guaranteed that the hostel would approve of this expenditure. Sometimes they say I have been going too often and they don't know if I am actually going to eat with my family. After every meal, I have to bring back the receipt to the hostel to claim the money. (Interview 9).

The residency condition was in and of itself difficult for many of the interviewees, in addition to the reasons above. One interviewee expressed the sentiment powerfully: "I want to be released from my conditions because I want the freedom to live in some abnormal places" (Interview 5). Others described a strong desire to return home.

Apart from the residency condition, other conditions of CD orders created a number of obstacles as well. For example, the need to see their doctor or receive an injection on a frequent basis often made it more difficult to maintain a job due to the frequent need to take annual leave, often without being able to provide an explanation. This was because of the concerns interviewees expressed about the stigma attached to being known as having mental disability, which they felt would adversely affect their ability to find or maintain employment.

The CD regime also created restrictions in a more intangible manner. Many interviewees expressed the feeling that they had to be much more careful in life, and the imagery of the CD regime being like shackles also appeared on several occasions.

It makes me think twice before acting. It feels like there is a knife or hammer above my head to shank or hit me when I misbehave. (Interview 5).

I feel like it is like a shackle or noose around me so that I cannot freely look for employment. (Interview 15).

Related to this theme was a general sense of endlessness in relation to the duration of the CD regime. A number of individuals expressed the view that a CD order was lifelong, either because this was their own opinion or because a healthcare professional had informed them that this was the case.

It doesn't end, it's for your entire life. There is no deadline, the deadline is when you're dead. (Interview 13).

This view was often accompanied by a strong sense of unfairness about how the CD regime is implemented, both in terms of its length and as a comparison with individuals who had committed crimes but were not under CD because they did not have mental illness. In relation to the former, many interviewees felt that the CD regime would be reasonable if it was for a shorter period, and not for life, which was a perception that came up often in the interviews. In relation to the latter, several interviewees compared themselves to criminals who were incarcerated for committing a violent crime but were released much sooner.

This is my view: I used to be a triad although I am no longer one. It has been over 10 years since I was involved in any triad activity. It is just that I picked up some bad habits from my triad days. I had been in prison before so I know this: There are triads who, after taking drugs, start attacking people with knives. After they get caught, they are sent to prison for 3 years. Within 6 months of getting out, they are caught attacking people with knives again and are sent to prison again. Those people have spent 6 of the last 10 years in prison for fighting with others. Those people are way more dangerous than I am. Just because they are a member of a triad group doesn't make it ok for them to attack others. Yet, after they get released, they are not subject to requirements as stringent as we are. At most, they must not re-offend for another 2 years. If they offend, they will have to go back to prison. But it would not be for life unlike being on the conditional discharge regime.

(Interview 23)

3.2.4. Poor attitudes on the part of healthcare professionals

Another recurrent theme was dissatisfaction regarding poor attitudes on the part of healthcare professionals. Some felt that their doctors didn't care about them, or that they would not and did not want to help them.

But I also got the sense that he did not have a lot of patience for my questions and didn't want to chat with me... It is hard to discuss this stuff with the doctor because if I ask my doctor a few questions, the nurses would usually tell us to stop bothering the doctor... I have not told the doctor these thoughts because it is very hard to find an opportunity to speak with the doctor. A lot of the times it is obvious the doctor is not interested in hearing our thoughts at all. It is harder to see the doctor than to see Chow Yun Fat.¹³ I basically can't see the doctor. (Interview 23).

I don't think there is anyone that can actually help me because the senior doctors and lawyers won't get involved. Those who actually have the power to do something will not help. There won't be much help even if I ask my doctor. (Interview 1).

The first time I got out of psychiatric prison, they actually sent a community psychiatric nurse to see me. She came up to my home to ask me if I was taking my medication. I told her I was and my medicine was with me. She did not seem to question or care about my answer but there was also not much she could do for me. Because ultimately, my illness did flare up again and I started missing my medication. There was one time I ran into her in the hospital but she ignored me so I thought that they were very cruel and rude. (Interview 15).

Some thought this was because the doctors needed to protect themselves from liability:

The doctor won't help me. Doctors help each other – the key is not to affect their job. They won't be so generous as to let you off [conditional

¹² This individual reported that they were not allowed to leave the premises at all during these four months.

¹³ A famous actor from Hong Kong.

discharge]; if something goes wrong they will be in big trouble. (Interview 13).

Some attributed this to the fact that the doctors were too busy:

I want to as well [in response to a question asking whether the individual and their doctor discussed and decided treatment objectives together], but the doctor is really so busy, he's so busy that he kicks me out in 5 minutes. (Interview 13).

The sense that doctors were too busy appeared in other contexts as well, for example in terms of the amount of time the doctor had to assess the individual:

Perhaps he thought I looked very calm so deduced my illness was under control. This is because the flare up of my illness was not so obvious to see. So, that is perhaps why he was not able to notice that my illness was flaring up again. It is not that the doctor did not ask me detailed enough questions, but that we were just having an informal chat because he has too many patients to see. Therefore, we did not have a lot of time together. (Interview 15).

Some interviewees reported a lack of understanding on the part of doctors regarding the realities of being on CD. A poignant example of this is as follows:

When I ask them when I can be released, they reply to the effect that as long as I do not make any mistakes, whether I have conditions attached to my release will be irrelevant. In my mind, that is like telling someone who has not committed murder to go out onto the streets wearing a sign saying he is murderer. That is how I feel when I heard the doctor say that. It is not like I used a knife to chop people into pieces yet they are labelling me with this.

(Interview 23)

3.2.5. Positive aspects of the experience

Despite the many negative aspects of CD experienced by the interviewees, many also discussed positive aspects of CD. Several interviewees talked about positive changes in their lives, including becoming better at communication and broadening their lives through meeting new friends at halfway houses, being able to save up more money (e.g. by having basic necessities like food and housing covered with a relatively lower rent), and having more order and goals in their lives, which in turn allows them to systematically receive help from healthcare professionals.

The conditions have helped me restart my life, allowed me to meet new people and be in a new environment so I won't have to constantly think about drugs. It has given me some new goals in life. Also, it has allowed me to have a different circle of friends. (Interview 23).

Conditions scared me into making changes and stop taking drugs, fighting, and doing whatever I want; the doctor, my family, the workers here, my fellow halfway house mates here all treat me very well. They are arranging a straight and moral path for me to walk... It is nice that I can meet more friends and I do not need to borrow money anymore. I have confidence in myself again. I have more pride. I do not need to look like I am deranged on drugs. (Interview 24)

3.2.6. Other observations

In addition to the five main recurring themes explored above, there were several observations from the interviews that are worthy of note.

The first is in relation to reported behaviors and statements made by interviewees that suggest a problematic understanding and/or implementation of the CD regime by healthcare professionals. For example, several interviewees described recall experiences that suggested that the only consideration being taken into account was whether there was a breach of a condition. One particularly problematic account, excerpted below, suggests that a medical assessment was not even conducted at the time of recall, and that the recall was merely on the basis of the failure of a condition.

Yes, I have been recalled because I relapsed on drugs. The doctor did not explain why I was recalled because once you are in hospital, it is very hard to see the doctor. Unless you have something important to speak to him about, they will not pay any attention to you. I remember that not doing drugs was one of my conditions, so I was recalled because I failed this condition. (Interview 23).

In another example, the confusion regarding when a patient can be recalled was demonstrated in an interviewee's report of how the CD regime was explained to him:

He said it is fine if you want to leave the hospital, but it has to come with conditions. When I asked him what conditional discharge meant, he said it is basically life imprisonment. He said I do not care how minor your infractions are, as long as you slip up, we will throw in you in hospital. (Interview 24).

This particular example also suggests a problematic understanding on the part of healthcare professionals in relation to when a CD order can be terminated. Several interviewees similarly reported problematic explanations of when a CD order could end. For example, an interviewee reported that their doctor told them the CD order would end if the doctor approved it, and that the executive committee of the hospital would have to have a meeting to authorise the doctor to sign the release (Interview 19). In some cases, such as Interview 24 above, the CD order was described as lifelong or something that would follow them their whole lives.

The second observation of note is that there appears to be a range of views regarding if or how the CD order is beneficial for the individual on CD. When asked about the suggested benefits to the individual raised by the interviewees in Chiu's study (2019), as discussed above, the response from the interviewees was mixed. In relation to the suggestion that being on CD led to better recovery and reintegration into society, there was a number of interviewees who felt the CD regime had been helpful in facilitating one or both of these aspects, but the majority did not agree that the CD order had helped in either. When asked if being on CD gave them more stability and a greater ability to find employment, a slight majority of interviewees did agree that their lives had become more stable and that it was easier to find work, although many others felt that this was not true, either because the CD had affected their ability to find work or because they felt the CD order had not made much difference. In relation to whether being on CD meant an increased amount of resources invested in them, while a slight majority again agreed that this was true, a number of these interviewees expressed the view that the resources themselves, such as visits from the community psychiatric nurse or social worker, were not helpful. Finally, when asked whether they felt that the CD was a collaborative, goal-setting exercise between healthcare professional and patient to facilitate the patient's recovery and rehabilitation, the vast majority of interviewees disagreed that there was any form of collaboration or setting of recovery goals. Of the four that did agree, one stated that no concrete goals had been set, and another couldn't remember what the goals were.

The final, and perhaps most concerning, observation of note was the allegation of abuse in the hospital setting, independently raised by four of the interviewees. Physical abuse was described by all four. This included beatings by hospital care assistants:

When they are helping the older patients bathe, it is not unusual to hear loud smacking sounds behind closed doors (usually it is the sound of smacking the back). (Interview 5).

It was horrifying. There was one time I was tied up then they [health care assistants] started beating me. After that, they stepped on my chest. (Interview 11).

This also included beatings by nurses. One interviewee described being beaten constantly in the hospital, especially if they scolded the nurses (Interview 22). Another interviewee described seeing patients beaten by nurses (Interview 23). Other forms of physical assault were also reported, such as the use of thick rubber bands to hit patients' eyes:

From the nurse's perspective, they think that the only thing that can make the patients listen is when they bring out the rubber bands. So the nurses will drag them to a room and we will be able to hear smacking sounds emanating from the room. It really is scary. (Interview 23).

Finally, forms of emotional abuse were also reported. For example, one interviewee described having his own phlegm wiped back on his face by a health care assistant after he spit it out on a tissue (Interview 11), while another described seeing patients ask for a bit more food, and the nurses preferring to throw it in the trash rather than give it to them (Interview 23).

4. Discussion

This study is the first to examine the perspective of service users of the CD regime in Hong Kong. It has adopted a stringent sampling method with a clear sampling frame, whereby the exact number of potentially eligible candidates in a particular setting was known, and all of them were invited to complete the survey (and subsequently the interview, if the participant agreed to complete the survey). This, together with the relatively high response rate, has generated data that can be said to be more representative and less biased, and which provides us with valuable insights into how the CD regime is experienced on the ground. This is crucial for the evaluation of the design and implementation of the regime, and to consider how the implementation in particular can be improved prior to a comprehensive reform of the legal framework, which is likely to be a mammoth and time-consuming undertaking.

The results of this study reflect many of the themes that have arisen from studies on the experiences of those on CTOs, including a lack of understanding about the system, a sense of powerlessness, negative sentiments about restrictions and positive sentiments about beneficial aspects of the system (Brophy, Kokanovic, Flore, McSherry, & Herrman, 2019; Schwartz et al., 2010). What stands out in particular about the Hong Kong experience is the significant extent to which many of these concerns are demonstrated, in one instance to the point that the restrictions involved may have constitutional implications, as discussed below.

For example, both the survey and interview data demonstrate that most of the study participants lacked even a minimal level of understanding in relation to their rights under the CD regime. This is exacerbated by the fact that there is no mechanism for automatic referral of a CD case to the MHRT, unlike compulsory detention in hospital, which means that many years can go by without the appropriateness of their CD orders being reviewed by an independent tribunal. The survey data also showed that a not insignificant number of participants did not feel that they had a good understanding of what their conditions were, which has direct and serious implications, given that non-compliance with conditions will in many cases mean recall and detention in hospital.

Surprisingly, however, the majority of participants in both the survey and interview were able to clearly state the consequences of non-compliance, suggesting that, where information has been provided to the participants, this is where the emphasis of the information provision has been placed. This is further supported by the fact that, of the survey participants that responded that they had been given information about their rights and responsibilities, most of them reported only information about their responsibilities and nothing about their rights.

Another example is the extent of the powerlessness experienced by the study participants. In addition to the inability to participate in a range of major decisions relating to them, the study participants reported a general lack of willingness on the part of healthcare professionals to engage with them in discussions about their treatment or CD status, even when asked specifically about this. Responses to the effect that they need not worry about such issues suggests that this disempowerment stems from a paternalistic attitude that persons with mental disability are not able to appreciate or handle such matters, and that these should be left solely to healthcare practitioners because they know what is best for such persons. This is further supported by the imbalance in power dynamic reported by the study participants,¹⁴ which extends to the use of infantilising terminology such as 'well-behaved' and 'obedient', suggesting that the healthcare practitioners do not perceive them as adults who can be responsible for themselves.

The restrictions reported by the participants were also restrictive to a significant degree. Those imposed by the halfway houses at which the participants resided were of particular concern. There does not appear to be any legal authority for measures in relation to the control of residents' finances and the imposition of the strict 10 pm curfew, with the latter restriction appearing to have a disproportionately severe effect on the employment opportunities and social life of the residents in light of the arbitrary nature of the limit. Furthermore, the imposition of an initial period in which the resident is unable to leave the premises freely (in some cases at all) is particularly problematic, and raises concerns of an unlawful deprivation of liberty in violation of Hong Kong's Basic Law and Bill of Rights.

Outside of the halfway house setting, discussions about the duration of the CD order, experienced by many as 'endless', aligns with concerns about the lack of a formal termination mechanism and proper safeguards in this regard.

In addition to a number of recurrent themes, the data also brought out several other important points. For example, there appears to be a problematic understanding of the CD regime by healthcare professionals regarding such issues as when an individual on CD should be recalled and when a CD order can be terminated. This aligns with the findings of Chiu's study, where, as discussed above, these have been noted as points of confusion (Chiu, 2019, pp. 75–8). The apparent lack of understanding does not appear to be limited to the CD regime itself, but also how the CD regime is experienced by its users. This is demonstrated by another point of note from the data, which is that there appears to be a mismatch in perception of the CD experience between healthcare professionals and individuals under CD. While Chiu's study (2019) suggests that some healthcare professionals may believe that the CD regime is beneficial for individuals on CD for a number of reasons, the data from this study indicates that this view may not be shared by individuals on CD themselves, although it is noted that positive experiences and effects were reported by some of the participants. The poignant imagery in Interviewee 23's statement above, where he feels as though he is being asked to wear a sign saying he is a murderer despite his doctor assuring him the CD label is irrelevant as long as he does not make mistakes, demonstrates further that there may be a lack of understanding of the realities of what individuals on CD go through when they are given this label. Thus, it can be seen that there is a stark and notable contrast between the

¹⁴ See McCubbin and Cohen (1996) for an in-depth discussion on power dynamics in psychiatry.

perspective of the service provider, as demonstrated in Chiu's study (2019), and the service user perspective demonstrated here.

4.1. The way forward

In light of these findings, what is the way forward for the CD regime? It is submitted that a comprehensive overhaul of the regime is necessary,¹⁵ and while an in-depth discussion of legislative reform is beyond the scope of this study, a few points can be made. First, serious thought needs to be given as to whether this regime should be retained at all, in light of Hong Kong's commitments under the CRPD¹⁶ and the lack of clear justification for placing individuals under it. Even if it were to be retained, significant amendments will need to be made. For example, it is crucial that a finite length be conferred onto the CD order, with a proper renewal process justifying its continuation, much like the CTO order in the UK. The responsible clinician should also be granted a clear, explicit power to discharge an individual from CD.¹⁷ There should be clearly specified purposes for which conditions can be imposed if necessary and appropriate. Not yet explored here but equally worthy of attention is the need for an opportunity for reassessment upon recall, prior to the decision to revoke the CD order. These are but a few of the issues that need to be addressed.

More importantly, this study focuses on how implementation of the CD regime can be improved prior to major law reform, bringing out a number of points that should be taken into account in the implementation of this restrictive regime. The first is that regular engagement and discussion between individuals on CD and healthcare professionals are needed to empower individuals, both to provide them with the necessary information to fully comprehend and evaluate their situation, and for better health outcomes, among others (Fitzsimons & Fuller, 2002; McCubbin & Cohen, 1996; World Health Organization Regional Office for Europe, 2010). This should extend to discussions about their health status, including their diagnosis, treatment options and treatment progress, as well as their CD status, including how long their CD is likely to continue and what kinds of factors are being taken into account when deciding whether they need to remain on CD. Concrete information about their rights, including specific procedures for applying to the MHRT, is necessary to ensure that they are able to sufficiently protect their rights.

The second is that the practices of important institutions involved in the CD order, such as halfway houses and other residence options,¹⁸ need to be examined closely to ensure that they are necessary, proportionate and compliant with human rights. This is in particular true where such practices involve significant restrictions of civil liberties. This further relates to a third point, which is the importance of a Code of Practice for the implementation of the CD regime and other regimes under the MHO, as well as an independent monitoring agency, like the Care Quality Commission in the UK. In addition to guidance about residence-related restrictions, a Code of Practice can provide key guidance in relation to how certain legal provisions should be implemented, so as to assist with the apparent confusion about how certain mechanisms such as recall and termination should be applied. A monitoring

agency is vital in ensuring compliance with good practice, and to detect and handle cases of horrific abuse such as those independently raised by several participants of this study. As one interviewee powerfully reminds us, 'I am a human, not an animal.' Those who are subjected to mental health legislation are often in positions of great vulnerability for a number of reasons, and heightened scrutiny of related institutions and personnel is crucial for the adequate protection of such individuals.

5. Conclusion

This study, the first of its kind, examines the service user experience of being subjected to the CD regime in Hong Kong. The results of this study demonstrate that, in addition to a number of previously identified legal concerns, there are also major concerns in relation to how the CD regime is implemented on the ground. This is particularly worrying in light of the call by the Review Committee on Mental Health for the strengthening of the CD regime to 'further safeguard the health and safety of the patient and others in the community' in its 2017 Mental Health Review Report (Review Committee on Mental Health, 2017, p. 201). While an overhaul of the entire CD regime is warranted in light of the significant legal concerns discussed in section 1.1 above, comprehensive law reform is a lengthy process. There is a dire need to improve the implementation of the current regime in the meantime, in particular in the ways suggested in section 4.1 above, to better protect the rights and quality of life of the individuals subjected to it.

The limitations of this study include the fact that it was limited to individuals on CD living in halfway houses, which means that a survey of individuals on CD without a residency condition was not conducted. Additionally, only individuals living in halfway houses under the NGO were recruited. Future research on the service user perspective should include both individuals without a residency condition and those living in halfway houses and other long-term care facilities under a range of organisations. Further research on the legal concerns of the CD regime should also be conducted, including an examination of the recall system and the abovementioned lack of a mechanism for reassessment upon recall, as well as ambiguities in the 'detention and recapture' provision in the MHO and how it applies to individuals on CD.¹⁹

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Declaration of Competing Interest

None.

Data availability

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¹⁵ It is noted that legislative reform of the CD regime may carry the risk of broadening the criteria for placing an individual on the order, which may in turn significantly increase the number of people placed under one. This may not be justifiable, and is also not a position I am necessarily advocating.

¹⁶ See Cheung et al. (2020) for a discussion about Hong Kong's international human rights commitments and how these impact on future directions for reform of compulsory mental health treatment in Hong Kong. While the article focuses on compulsory mental health admission and treatment, many of the human rights principles identified and discussed are similarly applicable in this context.

¹⁷ We also raised similar points in Cheung et al. (2020).

¹⁸ For example, long-term care facilities such as Long Stay Care Homes.

¹⁹ In particular, the ambiguities and difficulties associated with section 43(6) of the MHO.

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