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Rethinking the place of compulsory community mental health treatment in Aotearoa New Zealand: Implications of an assemblage theory approach

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ABSTRACT

Many countries with developed mental health systems permit compulsory treatment for mental illness in community settings. Research has challenged practices associated with the increased use of compulsory community treatment due to non-compliance with human rights and lack of therapeutic efficacy. In the cultural context of Aotearoa New Zealand, this paper introduces a study of the medico-legal process for making compulsory community treatment orders. Drawing on *assemblage* theory, our analysis critically unpacks the idea of *being heard* in the event of a court hearing. We illustrate how relations in-between participants, place, and things, become *territorialised* in ways that reproduce orders. We suggest *reterritorialisation* of these relations is vital to becoming heard. Rethinking the role of compulsory community treatment orders has implications for mental health law reform. This reform provides a rare opportunity to support services in avoiding compulsory treatment in practice.

1. Research context

Since the mid-20th century, human rights movements and advancements in psychiatric medication have transformed mental health systems. In Aotearoa New Zealand (NZ), and elsewhere, the policy transition of de-institutionalisation was marked by the closure of the large psychiatric hospitals (Joseph and Kearns, 1996). Respect for human rights led to Aotearoa NZ enacting its Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act extended the compulsory treatment of inpatients discharged from hospitals as outpatients, which is the primary concern of this paper. The use of outpatient orders, officially called compulsory community treatment orders (CCTOs) is contentious because they impose severe restrictions on people, and lack evidence of therapeutic benefit that might justify overriding human rights (O'Brien et al., 2009). The compulsory assessment and treatment process typically involves up to a month of detainment in a hospital, before a clinician decides whether to apply to a District Court for a judicial order that authorises ongoing compulsory treatment in the community for up to six months. A CCTO allows mental health services to compel outpatients who are living in the community to be treated, typically with medication by injection, without their consent. The CCTO also grants the power to enforce hospital readmission and detainment if that treatment is refused. One of the intended purposes of CCTOs was to provide a legal mechanism to rapidly admit outpatients into hospital and address concerns about the 'revolving door' phenomenon where patients cycled in and out of hospital from the community (Beaglehole et al., 2021). The use of CCTOs is steadily increasing. The Ministry of Health reported the total number of people under CCTOs in the year ended June 30, 2022 was 7009. CCTO rates increased by 6.6%–96 people for every 100,000 people, compared to 90 people for every 100, 000 the previous year (Ministry of Health, 2023).

In countries with mental health systems that use CCTOs, research has identified problems with their unequal and increasing use among population groups (Light, 2014). In Aotearoa NZ, Indigenous Māori were 4.0 times more likely than other ethnicities to be subject to CCTOs (Ministry of Health, 2023). Aotearoa NZ researchers, service users and (or) Māori have argued mental health law, policy and models of service delivery are out of step with the needs and aspirations of service users (Elder and Tapsell, 2013; Gordon et al., 2022). International research reinforces that CCTOs have limited clinical effectiveness and experiences of CCTOs are not therapeutic (Dawson, 2016; Rugkåsa et al., 2017). The United Nations Convention on the Rights of Persons with Disabilities affirms that compulsory treatment specifically for mental illness is discriminatory in law (Committee on the Rights of Persons with Disabilities, 2014).

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The World Psychiatric Association's 2022 position statement calls for action to support the implementation of alternatives to coercion in mental health care and emphasises that the protection of human rights is a central concern (Herrman et al., 2022) .

This paper contributes to international research and commentary on mental health systems focused on a new paradigm of human rights that requires changes to legal frameworks (McSherry et al., 2023). These changes involve moving from substituted decision-making (other people make decisions in a person's best interests and not a person's will and preferences) to supported decision-making (people make decisions for themselves and by themselves with support) (Gordon et al., 2022). The United Nations Convention on the Rights of Persons with Disabilities focuses attention on identifying the physical and societal barriers as elements in supported decision-making processes. This shift has roots in disability and psychiatric survivor movements and challenges the legitimacy of compulsory mental health treatment sanctioned by law (Minkowitz, 2006).

Researchers have highlighted the complex interplay of service-user, health practitioner, institutional and social factors in use of CCTOs (Brophy and McDermott, 2003). However, few studies focus on the CCTO event in terms of the institutional processes, discursive practices, and connections between actors involved in making and sustaining CCTOs. Understanding how CCTO practices sustain their ongoing use, requires attention to exploring relations in-between human and non-human participants in places where mental health and legal systems interact.

Drawing on Deleuze and Guattari (Deleuze et al., 2013; Deleuze and Guattari, 1994) and others (Duff, 2014; Roberts, 2014), we developed and applied an *assemblage* conceptual framework (Schneller et al., 2018). Assemblage thinking affords a focus on the event of the CCTO hearing as the site where multiple practices and complex variables interact. It enables a perspective that highlights the selection and arrangement of different elements (people, documents, place) and their *relations* in-between producing CCTOs. Our question, 'how are CCTOs reproduced?', is directed toward the phenomena of increasing use of CCTOs and concerned with the rights of people subjected to CCTOs.

In Aotearoa NZ the current government policy and legislative agenda to transform mental health law presents a rare opportunity to rethink the place of CCTOs in law and practice. The use of compulsory treatment under the Act was the subject of a nation-wide Government Inquiry into Mental Health and Addiction. The government accepted an Inquiry recommendation to repeal and replace the Act. In 2022, the Ministry of Health commenced public consultation on transforming the mental health law to inform policy advice. In 2023, the government released their agreed policy principles with the next stage being the Parliamentary process to draft, debate and enact new legislation.

Real-world challenges in shifting practice related to CCTO use cannot be underestimated. After 30 years, little is known in Aotearoa NZ about how CCTOs work in practice, which limits the potential for research informed policy to guide new mental health law design and application. Towards addressing this limitation, this paper presents a study on the current medico-legal process for making CCTOs. We use "service-user" to refer to a person under a CCTO who, typically, has had clinicians providing compulsory assessment and treatment for a period in hospital before shifting to a CCTO granted by a judge. The larger study focused on relations in-between different participants in various places before and after a CCTO is granted. For the purpose of this paper, the court hearing event is a place of significance in our analysis of CCTO relations in-between participants. A CCTO hearing event occupies a central place in processes as a physical site that brings together participant roles for the purpose of a judicial decision. These sites provide a natural focal point where medical and legal systems intersect and interact conceptually and physically to enact being heard. Drawing on *assemblage* theory, our analysis unpacks the idea of being heard in the event of a court hearing. We illustrate how relations in-between participants, place, and things, become *territorialised* in ways that reproduce CCTOs.

2. Study design and methods

The research aimed to understand more about the everyday practices of producing CCTOs. One objective of the larger study, was to explore what it is about the CCTO medico-legal process itself that contributes to ongoing and increasing use. Another objective was to find out what and where opportunities exist to change the practices around the use of CCTOs.

The study involved all three Auckland region health authorities as sites where Mental Health Act court hearings take place. The three sites included access to staff and service-users for interviews and CCTO hearings observations. As an in-depth inquiry, the research design involved recruitment of participants represented in the CCTO process. This included psychiatrists, nurses, judges, lawyers, district inspectors (appointed lawyers) and institutional advisor roles for consumer, family and Indigenous Māori interests, and service-users under CCTOs. The study explored the practices and interaction in-between participants before, after and during the CCTO hearing event and included an observation of a CCTO court hearing.

A sequenced approach allowed data collected in three phases to inform design of the next. The first phase aimed to identify and collect key documents involved in the CCTO procedure, such as the clinical report template and the Mental Health Act itself. The second phase involved 19 key informant participants in semi-structured interviews where participants shared their views on their role in the CCTO process and their interaction with others, before, during and after the application hearing event. The third phase involved two service-user interviews that aimed to include participants views about their involvement and interaction with key participant roles. This third phase included observation of a participant service-user's hearing of an application to extend a CCTO.

Study design drew on a relational-ontological approach using Deleuze and Guattari because of its critical and generative potential. We aimed to explore this social phenomenon of increasing CCTO use from multiple perspectives of those participants who are involved in reproducing CCTOs. This study applies a critical social science perspective to address the question of how CCTOs are reproduced. By reproduction we mean something that is produced again and again with a focus on the effects of relations between the human and non-human elements involved in the production process. Analysis illustrates how a seemingly neutral concept, such as being heard, materialises in interactions with positive and negative effects for participants. Our focus for this paper unpacks the idea of being heard by rethinking the court hearing event with *assemblage* theory. Our conceptual framework is explained next.

3. Making sense of a CCTO court hearing event using *assemblage* theory

We understand Deleuze and Guatarri's philosophy as an ontology of motion or a constant becoming (Grosz, 2005, 2017; Lorraine, 2011). *Becoming* can be understood as *being* in continual motion and flux, however imperceptible the modifications. It is an understanding that contrasts with *being* as a fixed stable state of all things, existing in past, present or future. Becoming is not given to us from outside our own reality but is constitutive of that reality (May, 2003). It works from inside-out, emerging from within its own interconnections, rather than creating it from elsewhere. Nature and culture, body and world, can no longer be regarded as ontologically distinct and separate entities (Duff, 2014). This approach to thinking gives rise to an immanent form of ethics that is constituted in relations of matter and practice, rather than from above or outside those relations (Hickey-Moody and Malins, 2007). The aim is to evaluate relations as they unfold, founded on experience and observation, rather than proceed from theoretical deductions. Deleuze and Guattari's philosophy prompts an ethics for an indeterminate future; we are already interconnected in the world as a whole, the questions are what relations do we want to encourage and sustain (Lorraine, 2011).

With an *assemblage* approach, the complex nature of events can be summarised in the imagery of lines along two axes (Deleuze et al., 2013, pp. 102–103). On the horizontal axis, the different components of an *assemblage* are either material content or expressive. On a vertical axis, the assemblage has both territorial sides, which stabilise it, and cutting edges of deterritorialisation, which carry it away. These are processes of *territorialisation* and *deterritorialisation*, respectively (Deleuze et al., 2013, pp. 586–587).

The elements of an *assemblage* are "not pieces of a jigsaw puzzle" but like a "dry stone wall and everything holds together only along diverging lines"(Deleuze and Guattari, 1994, p. 23). Each new mixture produces a new kind of assemblage, always free to recombine again and change its nature. In this way, it becomes possible to add, subtract, recombine elements (infinitely) without creating or destroying a unity. Deleuze says "what counts are not the terms or the elements but what is 'between' them, the in-between, a set of relations that are inseparable from each other" (Deleuze et al., 2002, p. viii).

Change in an *assemblage* comes about because of the constant vibrant flux of elements of content and expression and their relations combining and recombining in different ways. Relations are drawn together and held through alliances (DeLanda, 2006, p. 266). The actual and the virtual (potential) conditions are constituted in processes of *territorialisation* and *de-territorialisation*. These combinations of conditioning relations are arranged differently in different *assemblages*, such as in multiple CCTO events involving many different people. Deleuze and Guattari make an important distinction among expressive components, between those which are directly expressive, such as behaviour and those which rely on a specialised vehicle for expression, such as human language. Processes of *territorialisation* give conversation well-defined borders in space and in time. The most obvious expressive component of this assemblage is the flow of words itself. Conversational encounters are also clearly defined because of the physical requirements of co-presence but also because the participants themselves ratify each other as legitimate interactors (DeLanda, 2006, p. 255). These *assemblages of enunciation* comprise a specialised vehicle for expression such as acts and statements, that Lorraine describes as the enacted rules and linguistic practices of speech acts and the signifying and interpreting strategies humans engage in the social field (Lorraine, 2011, p. 13).

In *assemblages,* events are not just the things that happen to material bodies in particular circumstances, giving rise to particular expressions of content, events also generate *incorporeal transformations* among bodies assembled in them (Deleuze et al., 2013, p. 91). Deleuze and Guattari cite an example of an *incorporeal transformation* in a juridical (criminal) assemblage of the judge's sentence that transforms the accused into a convict (Deleuze et al., 2013, pp. 93–94). Language expressed is not fundamentally a medium for communication or information, speech acts effect incorporeal transformations of bodies. Here, the word 'body' can be taken in its broadest sense as applying to any formed content, such as objects or thoughts. This relates to the concept of *affect* in assemblage theory. Bodies are defined by their capacities to be affected, not by their forms, substances or fixed attributes. Capacities emerge in-between when "one body or thing assembles with other bodies or things or abstractions in relations" (Fox and Alldred, 2022, p. 627). Incorporeal attributes have clear implications for practical actions in terms of creating a way to think of the real, actual and potential, effects of words on a body's capacity to act. These degrees of power and limits in relations increase or decrease an individual body's capacity to act. What increases or decreases capacity for action are modifications (of forces of speed and slowness) in relations in the assemblage. This means *affect* applies to all participants in an *assemblage*, with variations by degree of power and limits experienced in relations.

To describe how and where processes of *deterritorialisation* occur it is necessary to explain Deleuze and Guattari's conceptual device of abstract lines that cross the elements in the assemblage and make them work together (Deleuze et al., 2002, p. 104). Rather than points or positions, lines draw boundaries, or chart vectors, across a broader field but also imply relation and connection, with no beginning and no end (Windsor, 2015). While lines are creative in this way, Windsor describes how they can also "become a slavish tracing, capitulating to established forms and structures" (Windsor, 2015, p. 157). In this image, lines are initially defining. The more they are traced over, the deeper the grooves, and other lines or new lines are less obvious to the tracer. For Deleuze and Guattari, changes in *assemblages* always have positive and negative effects that cannot be foreseen and so effects of changes in the *assemblage* cannot be predicted or controlled.

However, this does not mean that an *assemblage* can become anything, because its potential is not what is possible. Deleuze and Guattari's concept of *becoming* is not an unrestricted process (Coleman and Ringrose, 2013). Here the question of power is raised. What and how *affects* are expressed can lead to search for the conditions of relations and analysis of how power works through relations to actualise some conditions, events, and not others (Fox and Alldred, 2015). For example, collective *assemblages* of enunciation in mental health and law might mean a search for conditions that produce *affective* flows in which some voices are included and other voices are excluded offering a way to think about what a body can do in making sense of a person's power to act within CCTO relations.

According to Deleuze and Guattari, it is only through the territory that an identity takes form and without it we would be in a chaotic milieu. Because *assemblages* are never fixed and stable this constant flux leads to *deterritorialisation*. So, *territorialisation* is essential for making sense of our complex social world in continual flux. Our analysis of a CCTO *assemblage* was underpinned by the concept of *affect,* together with practices characterised as *territorialisation* and *deterritorialisation* as forces that stabilise and destabilise CCTO relations.

In practice, *assemblage* theory can be characterised by a set of applied methodological commitments, rather than a set of pre-given methodological procedures (Baker and McGuirk, 2017). Synthesising materials gathered at the end of the study, described above, involved inter-connected layers of activity, each of which featured iterative actions of reading, thinking with Deleuze and Guattari concepts, and writing. The interviews were not a means to obtain representations of the world of CCTO-making processes, but evidence of how participants were situated within the assemblage with the primary focus on relations between the roles (Fox and Alldred, 2015). Thinking with Deleuze and Guattari allowed for searching of relations in-between elements of place, things, and people from which to draw critical and creative insights on nuance and complexity of those relations. This activity involved re-reading materials to examine how *affect* linked matter and meaning by which we mean the values, attitudes, emotions, conflicts, beliefs expressed in interviews (Jackson and Mazzei, 2012; Mazzei, 2013). Overall, analysis was inductive and comparative to distil connections, and divergences, that cut across readings of our material content (MacLure, 2013). Inferences about typical practices, were read and interpreted alongside the observation session of a hearing event, the Mental Health Act, and clinical report template.

As described earlier, *assemblage* methodological commitments appear to require a radical departure from conventional research methods centred on subjective human experiences. We made sense of *assemblage* theory in practice by focusing attention on describing the inter-action in-between the human and non-human participant roles. We applied *assemblage* thinking in how those descriptions might be interpreted as constituting relations that serve to either stabilise or destabilise the CCTO event, so as to offer insights on the sustained use of CCTOs. Thinking with the notion of *assemblage* meant describing the practices participants spoke of and then demonstrating how they worked through Deleuze and Guattari concepts of *affect*, *territorialisation* and *deterritorialisation*.

4. How relations in-between participants constrain voices being heard

Our discussion presents a combination of extracts from participants and extracts from a narrative based on an *observation session* as situated and embodied voices. Thinking with *assemblage* tools, we illustrate how relations in-between participants become *territorialised* through venues set up as spaces for hearings, dominant expert knowledge, and clinical reports, in ways that reproduce orders. Different human and non-human elements can be identified interacting in the CCTO event, first we consider the role of place.

4.1. Setting the scene

Participants described hospital-based mental health inpatient units and office buildings in suburban areas, from which community mental health services operate, as typical places for CCTO hearings (for example, the place of our observation session and an image of a hearing room layout is represented in Fig. 1 below). Place established the conditions for the organisation of things and people inside the room. One psychiatrist described the space inside the hearing room, particularly the arrangement of tables and chairs, as "*a classroom situation*" with "*the client, their family and the counsel on one side facing* [the Judge] *and me, the second mental health professional, that other side*" (RC#2). In contrast to a classroom layout, one judge explained his preferred set up.

> *For me it's important not to have the Judge sitting away from where the patient is behind a big desk. That to me is not therapeutic, it's not conducive to getting a good discussion going. Most Judges, most courts,* [are] *set up with security and they would normally be sitting between the patient and the Judge* […] *with a big desk and the patient basically feeling they are being brought to a court, like a prisoner coming into a court. Whereas, I will have the furniture sort of with chairs in a circle type situation. The Ministry* [of Justice] *insists that there is some security there, I'd rather not have any security but they insist that there be security. I have the security sitting somewhere out of the way and in a position where they can react in the interests of the court staff rather than the Judge. That's how I do it, and that's how I feel that it should be done.* (J#2)

The description above of chairs in a circle made a difference to "*getting a good discussion going*" (J#2). The Judge's resistance to the security set-up, can also be read as a practice to *deterritorialise* imposed security arrangements and to *re-territorialise* the layout in a way that "it should be done" to minimise negative *affects.* The image of criminal court and the presence of security officers negatively influences the perception of process held by service-users, family and whānau. Another judge suggests the Ministry of Justice [MOJ] had too much influence on layout of a hearing.

> *The venue is fine, but the set up I don't like.* [MOJ] *cite it as security, but* [sigh] *it's not that bad. I mean, it's not.* […] *I suppose it is a hearing, but we've gone to the hospital for that. I've complained about it but they* [MoJ court security] *get all ratty* (J#3).

Placement of things and people are not specifically expressed in the Act. Judges indicated that arrangement for security was inscribed elsewhere, referring to the MOJ staff overseeing the health and safety of their employees.

In the excerpts above judges expressed views that the security arrangements of a uniform court security officer in attendance and the physical layout of chairs and desks in the hearing room itself, potentially made the hearings too formal. The *affect* of security was potentially intimidating for service-users and their families, it could make service-users feel like they were "*a prisoner coming into a court*" (J#2). Perhaps, this *affect* can be read into service-user descriptions that being in front of a judge was "*quite overwhelming*" (SU#1) and that it was "*nerve-racking*" seeing a security officer on entering the room (SU#2). It suggests how a judges' interaction with a service-user might be undermined by the dominance of security that reinforces risk.

Judges and lawyers mentioned the importance of place as therapeutic. Judges were especially sensitive to the space in which their hearings happen and talked about ways they personally tried to counteract physical and psychological barriers to participation and communication within limits of a court-like set up and procedure.

> *Of course, each patient is so different and you have to, well I'm conscious that there's a need to be sensitive about how you do it* […] *in that setting to treat people with dignity because they are in a really vulnerable state. And their families are vulnerable and at their wits end and emotionally upset because of what's happening to a member of their whānau, [family].* (J#3)

The physical "*set up*" (J#3) of the court itself contributed to people feeling able to participate. J#1 considered that a service-user's ability to participate also depended on how well they are at the point in time of the hearing event.

> *There are times when you come back post the crisis phase of admission, for 6 monthly reviews for example, where the symptoms of the illness are reasonably well-managed and that's different. You can have discussion about management and how that's going, in other words about the services and whether they're adequate, much more easily.* (J#1)

The above can be read as framing the relations between participants in the hearing process as attributable primarily to the (mental) condition of the individual service-user. However, this potentially overlooks openings for discussion that might arise "more easily" as a result of a different hearing room set-up or place.

The place and space of CCTO hearings is associated with different perceptions from different perspectives. Place is a geographical location and a material construction *territorialised* by hospital and community mental health centres. Space allows relations between people and things, such as desks, chairs, to be *territorialised* by the MOJ's requirements for staff security and safety over conditions for open and safe discussion for service users, despite some judges' *re-territorialisation* of space. Place is also symbolic in the sense of social meanings people attribute to a place based on experiences. The room's interior also has an impact; things such as art works on the walls can make a room less "*sterile*" (J#3). Things such as the kind of furniture and its arrangement impacts participants in the process and their capacity to interact.

Human participants have required roles under the Act for the CCTO event, namely the judge, the patient, the responsible clinician and at least one other health professional. There are people in roles who are permitted by law to be present, but their absence does not prevent the hearing from going ahead. In the CCTO hearing observation session described below, the husband of SU#2 and her psychologist were not present. In reflecting on the hearing process, J#1 said

> *I actually think they are remarkably human events and we would want to keep it that way. There is a legal process behind it and underpinning it, but I think it's important that both for the patient and the family members that turn up that it doesn't get too formal.* (J#1)

The judge's comment above affirms the roles of service-user and family, and implies that some family might not attend a CCTO event because it is a formal legal process. A legal process has the potential to both enable and disable the capacity of CCTO hearings which are characterised as remarkably "human events".

The human elements involved in CCTO events embody one or more roles inscribed by the Act or employed by mental health services. People who attended the CCTO hearing observation session included the judge, service-user, the psychiatrist (responsible clinician), the registered nurse (second health professional), the lawyer (barrister and solicitor), a court

registrar and a court security officer. In the observation session for the participant service-user (SU#2), things other than furniture included the court registrar's electronic recording equipment, paper files and documents that sat on the tables in front of the participants. The participants referred to documents such as the responsible clinician's report, clinical notes, the statement from SU#2, the second health professional's report, and the psychologist's report. These can be characterised as legal documents by virtue of their inclusion in the hearing process. In the remaining discussion, we present four scenes drawn from the observation session and our analysis of interaction of these elements, including human elements as voices, in a hearing.

The main entry and exit to the hearing room was through door 1. (See Fig. 1). Inside the room there were three rows of attachable chairs in lines across the width of the room, one row against the back wall, a middle row, and a third row behind a line of tables joined across the room. In the front row of chairs, behind a row of tables, sat from left to right the Responsible Clinician, Lawyer, Service-user and Second Health Professional with their documents. On the right wall of the room, there were 3 large windows with a view to the building next door. In front and opposite the row of chairs and tables was a space of about 3 m and another two tables and chairs where the Judge was already seated behind a table, with documents and files in front of him. The court registrar sat on the right-hand side of the Judge, she also had document files in front of her and a computer and recording device. To the left of the Judge, about 2 m in front of the front row of tables and chairs sat the court security officer near exit doors 2 and 3. A landscape painting was hanging on the wall and, a noticeboard with some papers pinned on it.

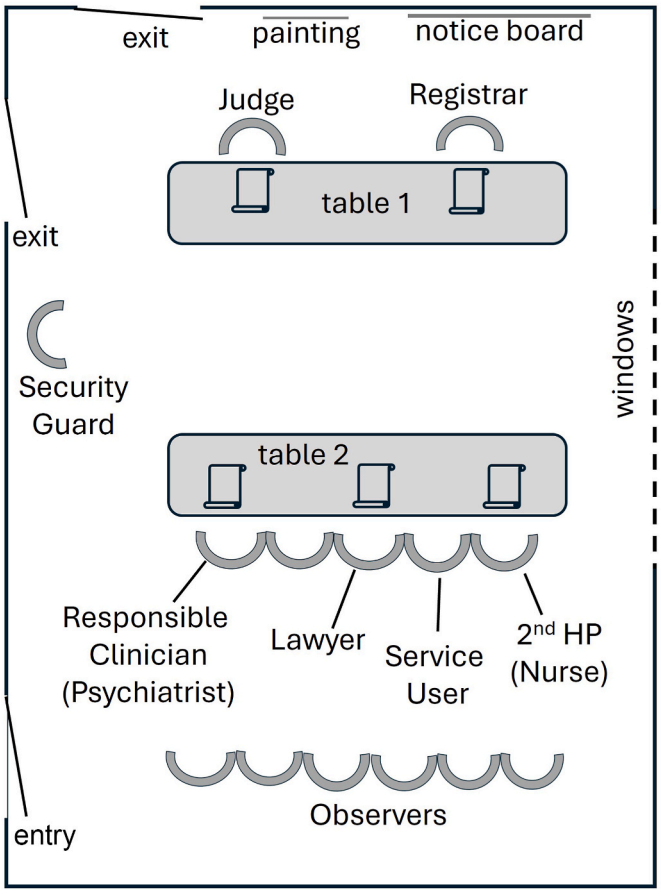

Fig. 1. Diagram based on Participant Observation Schedule and researcher field note.

4.2. Scene 1: Leading roles

Judge: *Dr, I have read the contents of your report.*

Judge to Lawyer: *Is your client opposed or unopposed to the application?*

Lawyer: *Opposed Sir.*

Judge to Psychiatrist as Responsible Clinician (RC): *Dr., can you confirm the contents of your report, with the copy of the notes attached?*

RC: *Yes. Correct.*

Judge to SU#2: *I've received your statement to the court. Would you like to read out the statement you've provided so that it goes 'on the record'?*

SU#2 holds and reads out statement: *If I continue on the CCTO, the results are feelings of shame and hopelessness. I would benefit from 1:1 counselling or talking therapy and it would be better value for money, but I am told that none is available. I feel the CCTO is pointless. My goal is to increase my wellness, be off medication and return to a form of employment.*

Judge to RC: *What's your opinion about what SU#2 has said Dr?*

RC: *It's my opinion that the CCTO is necessary. SU#2 does much better when she is taking medication. In the past, last several years, SU#2 has demonstrated that when she's not taking medication the result is hospital admission.*

In the observation session, the judge stated in his introduction that he had read the responsible clinician's report and asked the psychiatrist to confirm its contents. Under the Act, the responsible clinician must send the Director of Area Mental Health Services his or her opinion of the patient's condition, and any relevant reports from other health professionals involved in the case. The responsible clinician's opinion outlined in the clinical report is a key participant in the hearing and plays a dominant role. Administration guidelines for lawyers' state that the most relevant document is the doctor's report. One judge referred to the responsible clinicians' report as the "*core document*" (J#1).

Judges have access to other documents relating to CCTOs applications, including "*specialist reports*" (J#3) held on the mental health court file about the same service-user. Judges described reading the file the morning or night before the hearing (J#1). It was important that judges have time to prepare and digest the information, so as to go into the hearing with "*a feel*" (J#3) for the person's current situation and their clinical history. Based on the file information, judges described noting questions to ask the responsible clinician and the service-user. If there is no or little information about family, judges may ask those questions too.

The professional legal roles of "barrister or solicitor" and "lawyer" are included in the wording of the Act. A 'patient' is entitled to legal advice and representation to be heard by the Court. In the observation session, it is the lawyer, not SU#1, who is asked by the judge whether SU#2 is opposed or unopposed to the application. Service-users who oppose CCTOs are described by legal participants in this study as doing so mainly on the basis of medication issues, but there were also service-users who believe they do not have a mental disorder. Legal representation, therefore, has implications for a service-user's voice being heard.

Clinicians involved in CCTOs must have professional qualifications, be certified and registered. Professionals such as a "nurse", "psychologist", "psychiatrist", "medical practitioner" are listed in the Act. The "responsible clinician" role is typically filled by a psychiatrist and the role of "second health professional" is typically filled by a registered nurse. Although the law also permits other health professionals across both roles.

Only a judge can determine whether a patient is "mentally disordered" and, on the basis of this, order a CCTO. This expression of

"mental disorder" underpins the responsible clinician's opinion and clinical report on whether a patient may be released from compulsory status or not. Here the classification and diagnosis of mental illness for the purposes of the Act, folds back into a legal, rather than a clinical, definition of a mental disorder in the Act. There also appears to be an association between assessment of risk, and management by medication, that identifies the role of medical prescriber as the clinician who is in charge. This underscores the significant role played by the clinical report.

4.3. Scene two: medication tension

Judge to RC: *What is included in the treatment plan?*

RC: *Treatment is medication and attending a psychology group. The Psychologist feels SU#2 benefits most from the group when on medication.*

Judge to RC: *It's usual in these situations to take the medication in order to gain insight, is that the case?*

RC: *Correct.*

Judge to RC: *Regarding SU#2's statement to the court, is there any advantage to 1:1 counselling?*

RC: *It's the combination of counselling and the medication*

Judge: *What's the aim of both in the treatment plan?*

RC: *Taking medication prescribed by professionals who have evaluated her status, over a period of time. And you can ask the Keyworker, who has known SU#2 a long time.*

Judge to 2ndHP: *Can you confirm your report?*

2ndHP: *Yes. And I have the clinical psychologist's report here too.*

Judge: *I'll read aloud part of the report to give the 'gist of it' as follows. 'SU#2's participation deteriorates significantly when not taking medication. SU#2 benefits when taking medication'.*

SU#2 to Judge: *Can I answer to that?*

Judge to Lawyer: *Counsel, you may wish to take a moment to check with your client.*

Medication was another significant element referred to in the CCTO hearing *observation session*. The effectiveness of other options, such as talking therapy, were contingent on SU#2 taking medication as prescribed. The effect of SU#2 not taking medication was hospital readmission. Although SU#2 expressed her goal to "*be off medication*", the question of how this might be achieved was not inquired into, rather the expressed aim of the proposed treatment plan was to continue medication. The role played by medication as *the* treatment enforced in CCTO relations features before, after and during the hearing to sustain the CCTO.

In the *observation session* the judge (silently) reads the keyworker's second health professional report. The second health professional is not asked any questions by the judge or lawyer specific to her opinion, except whether the CCTO is necessary. The keyworker introduces a third report from the psychologist involved in the treatment of SU#2. The responsible clinician responds to questions from the judge about the treatment plan and adds "*… ask the Keyworker, who has known the patient a long time*". This expression implies the psychiatrist has not known SU#2 a long time and that the keyworker has more in-depth knowledge of SU#2 and will further support the application for a CCTO. This infers a different kind of knowledge about SU#2 is held by the second health professional, and not held by the responsible clinician, due to the keyworker's many interactions with SU#2 over time.

The judge in the *observation session* did not receive an advanced copy of the psychologist's report and neither did the lawyer or SU#2. The psychologist's report was introduced by the second health professional, not the responsible clinician, and there was no explanation for why the psychologist was not attending the hearing in person. SU#2's request to the judge to speak in response to the psychologist's report was acknowledged through her lawyer. The judge did receive an advanced copy of SU#2's statement, and invited her to read it during the hearing. Reading her report aloud is one way to demonstrate SU#2 is being heard. The responsible clinician and the second health professional (psychiatric nurse) were not invited to read out their reports. Instead, these were presumed to be received and read by the judge and the lawyer.

4.4. Scene three: supporting roles

Lawyer to Judge: *SU#2 says that wasn't the situation with the psychology group when she wasn't taking her medication.*

2ndHP: *I asked SU#2 husband to attend. He said he was okay to do that if SU#2 agreed.*

Judge to Lawyer: *Without input from the husband as someone who spends most time. with SU#2, it's hard to make a decision. The husband could say how it is for SU#2 day to day. I am entitled to have someone come and give me their opinion.*

Lawyer: *Yes, I understand.*

Judge to Lawyer: *Please explain to SU#2, clarify that I'm entitled to get opinions, to get impressions about the wellbeing and health of a person. Everyone is entitled to the best possible treatment. We can do section 18 hearing today and make a decision later. The court would benefit from hearing from the husband if he was present.* […] *Would you like to get further instructions from SU#2?*

Lawyer to Judge: *Yes, thank you.*

In the *observation session* the judge was prepared to delay the hearing for a week or two to enable SU#2's husband to attend, so that the Court could hear from him. However, SU#2 withdrew her opposition to the application and the judge proceeded to a decision on the CCTO. As illustrated in the scene above, family members are permitted to attend CCTO hearings. The Act allows the judge to consult with other persons as the Judge thinks fit, concerning the patient's condition. It also gives power of the court to call witnesses. The Act requires the responsible clinician who is providing an assessment or treatment to a patient to consult with the "family or whānau" of the patient. We note the Māori term whānau, in modern usage extends the notion of family members connected by blood and in law, to include people with close relationships and who come together for a shared purpose. Even where family or whānau are identified, willing and available to provide support, the limited capacity of family or whānau to fulfil such a role is reflected in low levels of attendance at hearings. Most participants spoke of the low numbers of family that do attend, with J#2 and L#1 estimating only 20% of hearings have family or whānau attending. Some reasons for low numbers were explained by service-users not identifying, wanting or requesting family or whānau presence for support (L#1, RC#3, RN#3). Judges acknowledged the responsible clinician's clinical report, with a tick box for family consultation, enabled questions to be put to the responsible clinician and the second health professional about the extent of family support and involvement. Descriptions of family or whānau involvement were to provide support for service-users (J#3, L#1, RC#1, RC#2) and as "*sources of evidence*" (J#1).

The judges refer to specific sections of the Act to authorise their conduct of the hearing. One effect is that the Act imposes law on the judge who then imposes law on participants in an application hearing. The Act has a role in defining what is and is not lawful procedure, independently of those who have a role exercising powers under the Act. Thinking with Deleuze and Guattari invites interaction with the Act, and selected sections in it, as a non-human element participating in actively

producing CCTOs. Second, it allows thinking about statements and language in the Act as expression (forming part of a collective assemblage of enunciation). These interactions involve human elements, people who read, interpret, apply the Act in ways that attribute legal authority to their spoken and written words. In these ways, the Act role functions both to stabilise (*territorialise*) and to cut the edges that carry away (*deterritorialise*) the CCTO assemblage.

4.5. Scene four: the final judgment

> **Lawyer:** *SU#2 wants to reach a point of not taking medication. If she can get* support *to do that, she will consider withdrawing opposition to the CCTO.*
>
> **Judge to RC:** *In your reviews, Dr., as you are professionally obliged to do so, you consider side effects etc. Can you give reassurance? And I am asking you because SU#2 wants to hear it. If assurance is given by SU#2 to take medication, you're confident that she will be made informal?*
>
> **RC:** *If SU#2 agrees to take medication, yes. The majority of our patients are on a voluntary basis.*
>
> **Judge:** *Then you'd agree to take her off the Act sometime in the future?*
>
> **RC:** *I would agree to, yes.*
>
> **Judge to SU#2:** *That gives you some assurance. The health system is obliged under law, the Bill of Rights, to provide you with health care. I understand your concern about cost, but it's not the main concern here.*
>
> **Judge to Lawyer** *It's in liaison with the RC, to take her off the Act and make informal.*
>
> […]
>
> **Judge:** *The order is necessary, having seen and heard from the RC and the 2ndHP. I wish you all the best SU#2. I'll make one other observation. You want to go back to the workforce. Any employer would want confirmation from the health professionals assessing you.*

SU#2's patient history of not taking medication has a significant role in determining the CCTO extension. A relation between cause and effect of SU#2's current CCTO, seems to be that not taking medication would lead to an inpatient admission and so medication not taken in the future will likely lead to a repeat inpatient admission. Another sense of history implied as evidence to extend the CCTO, is expressed by the second health professional who has known SU#2 for a long time. SU#2's own plans and aspirations for the future were raised by her, but not discussed in the duration of the hearing. The judge's expression to the psychiatrist of SU#2's potential to come off the Act was limited to an unspecified time in the future.

The notion of being heard in a hearing was expressed as an important purpose served by the CCTO event. Judges apply the law to attain a balance between permitting treatment and protecting rights (J#2). Interaction in a hearing event tends to be associated with service-users' rights conceptualised as legal entitlements described by a judge as follows.

> *I think, for my part, it's very important that the patients have the right to be heard and the right to a hearing, which they feel is fair, and that may be based on the way it's conducted and also the time that it takes. I think that some patients feel that they are very much on the back foot with these hearings, and to an extent, they are, and that there is a decision made prior to them even getting to the room. It's not the case; it's certainly the way that I like to conduct hearings.* (J#2)

The judges' descriptions illustrate *territorialisation* in their practices of applying the law, in adapting their approach within each hearing because each presents a different situation. It also suggests *affect*, in-so-far as a sense of fairness is related to "using that time in court" (J#3) and "the time that it takes" (J#2). A linear (clock) sense and an experiential sense of time are both useful for understanding what it means to *being heard*.

However, in hearings service-user voice was constrained by the *affect* of a legal logic that represented and judged them. After the CCTO hearing, SU#2 spoke of how she felt about the outcome; the Judge's decision to grant the psychiatrist's application and extend the CCTO for a further six-month period.

> *I felt defeated. When they read out that excerpt from the psychologist's report, I felt there was incorrect information in it. I had not met that psychologist when I wasn't taking my medication. And I'd seen that doctor once* […] *I don't see why they have to put that spin on it, that I'm non-compliant, making me sound like a recidivist. But I attend all appointments.* (SU#2, *Observation session* field note, June 2019)

Negative feelings of disappointment, frustration, and perhaps even anger can be read in the excerpt above. SU#2's expression, "*But I attend all appointments,*" challenges the legitimacy of the medical and legal authority of a CCTO over her. SU#2 complies with treatment in a broader sense, if not with the element of medication as it currently exists, so expressions such as "*non-compliant*" and "*like a recidivist*" give a negative "*spin*" negatively impacting SU#2 relations with her clinical team and her own ability to become well. The word "*spin*" used by SU#2 above, gives multiple readings in the speed and slowness of *territorialisation* and *deterritorialisation.* Spin generates images such as to draw out and twist fibre into yarn or thread; to form a spider-thread by extruding a viscous rapidly hardening fluid; to feel as if in a whirl. The process of *territorialisation* that rendered SU#2 powerless to turn the CCTO event otherwise continues to work, even solidify, after particular things (and not others) are drawn out then twisted into a CCTO.

5. A CCTO hearing *assemblage*

The observation session discussed above is a concrete example of an *incorporeal transformation* of SU#2 (already a "service-user") into a "patient". SU#2 is the subject person of a responsible clinician's application who is then legally transformed into a "patient" that is "mentally disordered" when a judge decides it is necessary to make a compulsory treatment order. In the Act, the word "patient" is used for both inpatient and community compulsory treatment orders.

In the CCTO event, *territory* is defined by the physical location and space in which the event takes place. There are also territorial limits on the roles of participants (who is permitted and qualified to attend a hearing), the speaking order of participants and the subject matter (what is relevant documented and oral evidence). Similar to conversations, CCTO hearing events have a well-defined temporal order, initiating and terminating the hearing, and taking turns at speaking during the hearing may all be legally enforced by the judge, in addition to being normatively enforced by the participants.

In terms of the place and the set-up of hearings, perception plays an important role in some judges deciding how to arrange the hearing space. Judges spoke of the constraints in getting a discussion going, or enabling conversation. In some cases, judges chose to sit beside, and not behind a desk, so *deterritorialising* the hearing space with alternative seating arrangements. Court Security rules imposed the presence of uniformed security officers and seating arrangements.

Interaction appeared pre-determined by the content and expression of the clinical report as evidence of "mental disorder" and what happened during admission as an inpatient. The dominant role of the clinical report seemed to be strengthened by the absence of family (service-user chosen support persons) to contest or contextualise that evidence, in addition to the way in which service-user "patient views" were typically represented. The described practice of reducing service-user views as "opposed or unopposed" to the CCTO had an effect of limiting the capacity for service-user voice and the hearing of their own history to be heard. A service-user history is not one authored from a service-user's own perspective.

The Act's expression of "mental disorder" is an example of *territorialisation* that excludes certain meanings and includes others by discursive practices expressed in the dominant knowledge bases of law and psychiatry. These meanings include a mind-body split, the subject as a rational individual, and biomedical understandings of wellbeing. Being mentally disordered, as a concept, seems to override being heard where it is associated with a presumption of lack of/nil insight - being "unwell" - so not capable of rational thought. However, one judge expressed the view that medication issues for example could be raised by service-users.

> *As far as I'm concerned everything can be raised, it's their hearing. That probably differs from the majority of other judges who probably won't allow it [medication] to become an issue, saying that it's just part of the treatment programme and they're only concerned about whether the [mental disorder] criteria are there and […] anything else really is not part of the hearing process. That's not what I do*. (J#2)

This judge acknowledged the above approach to conducting hearings was different from "the majority of other judges" with a judicial approach focused on the legal definition of "mental disorder". Thinking with Deleuze and Guatarri, the above approach emerging from within rather than outside the law, might also be understood as *deterritorialising* dominant thinking and practice about how hearings ought to be conducted to exclude medication issues. The judge's practice might also be understood as a demonstrating the capacity of what the law can do.

Since 1992, the Act hearing procedure has smoothed over hard edges in *territorialised* interactions between lawyers, judges and psychiatrists and nurses, some of whom bring their past knowledge of service-users and other participants into present hearings. *Territorialisation* helps make sense of change over time in participants repeated interactions. For example, RC#3 suggested "more of a partnership" of lawyers, judges, and psychiatrists towards the service-user's "best interests".

> *I remember when the lawyers were pretty fired up advocates and they really did, sort of cross-examine and it was quite adversarial. … you had to really defend your position. But I've noticed over time that quite a lot of those lawyers … they have their own experience of representing people at various points in their life and their illness and they have seen people when they are really unwell and they also have learnt what happens to them if they don't take their medication and they're nowhere near as challenging anymore. … That's the same with the Judges too. I feel like the Judges now really just rubber stamp it and that there's very little genuine exploration of the reasons*. (RC#3)

> *It's sort of softened, you know it doesn't, it's not this kind of hard-edged anymore. But my belief is that it is all done for the person's best interests. But I do have concerns at times about the sense that the Judge has read the report and you know if it's not opposed then it's very fast and a bit, very superficial*. (RC#3)

The above "softened" characterisation of historically "hard-edged" relations evokes imagery of smooth surfaces producing less friction and resistance when there is contact in-between moving parts. Although another effect is potential for moving parts to be shaped in different ways through resistance and friction when in contact is also diminished. This effect can be read into perception of RC#3 that lawyers are challenging the applications less than they used to and that judges "just rubber stamp it". Relations in hearing events combine in ways that tend to limit the capacity of (service-users) *being heard* and move judgment towards reproduction of CCTOs. The conditions of legal representation and judgment afford limited openings to destabilise confirmation of "mental disorder" and so might be understood as reproducing CCTOs. We reflected that not being heard in a space that superficially presents the idea of being heard is paralysing because it adds another layer of silencing and it undermines attempts to question the hearingness of the hearing.

6. Conclusion

Recent research and commentary is concerned with ways to reduce or eliminate coercive practices such as CCTOs in mental health and legal systems. Our results contribute to existing research that highlights concerns about human rights and discrimination and support for therapeutic effectiveness of CCTOs is lacking. The international human rights context and state of evidence brings into sharp relief the significance and importance of being heard in coercive practices. Using the logic of *territorialisation* in a CCTO *assemblage* afforded us the opportunity to disrupt the notion of being heard in a hearing and demonstrate how a service-user voice can be overridden and silenced in the process.

The event of a CCTO hearing shows the role played by various human and non-human elements. As the event unfolds in time, these combinations inevitably transform the hearing space in ways that include dominant voices and exclude marginalised ones; limited opportunities exist for being heard. In Aotearoa NZ, multiple CCTO events occur weekly across twenty health administration areas. Each event involves different people in roles as service-users, responsible clinicians, second health professionals, lawyers and judges. The Act procedure helps ensure the consistency of connections between the elements in single and multiple events, across institutional areas. CCTO events tend towards applications becoming granted. We present a CCTO *assemblage* that is *territorialised* by lines determining rights that enable psychiatric treatment to be provided outside of hospital settings. Enacting the concept of *being heard* is a way to make sense of an expressed desire by clinicians and other participants to keep service-users well by continuing CCTOs. Yet the *relational affects* of interaction to maintain service-user stabilisation of health through being held under a CCTO seems to deny the dynamic process that is health and life itself – towards becoming heard.

We argue that the making of a CCTO over a service-user is an example of an *incorporeal transformation* associated with negative feelings that serve to diminish, as opposed to enhance, capacity in the *assemblage*. The logic of *territorialisation* disrupts conventional ways of thinking about the physical location, arrangement and interaction of elements in a hearing space. Through an examination of relations in the CCTO event, we pin-point discursive practices that may be shown to influence their sustained use. Immediate implications for practices within the existing mental health and law system include; design and use of a clinical report template, review of the physical places where hearing events are held and in repeal and replacement of the Act itself. We demonstrate that *reterritorialisation* of these relations is vital to becoming heard and transforming current law and practice. Conventional logics of intervention may not be sufficiently disruptive to question the hearingness of a hearing so as to lead to transformational shifts in practice. There are future policy implications for re-imagining how we might live differently, with or without CCTOs, under a new law.

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The data that has been used is confidential.

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