



CREATE

Canterbury Research and Theses Environment

Canterbury Christ Church University's repository of research outputs

<http://create.canterbury.ac.uk>

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g. Patkas, I. (2012) Service users' perceptions of Community Treatment Orders and their impact on interpersonal relationships. D.Clin.Psych. thesis, Canterbury Christ Church University.

Contact: create.library@canterbury.ac.uk



IOANNIS PATKAS, BSc (Hons)

Service users' perceptions of Community Treatment Orders and their
impact on interpersonal relationships

Section A:

Community Treatment Orders: Effectiveness and service users' perceptions:
A literature review

Word count: 5, 485 (plus 560 additional words)

Section B:

A grounded theory study of male service users' perceptions of their Community Treatment
Orders: An investigation

Word count: 8, 484 (plus 768 additional words)

Section C: Critical Appraisal

Word count: 1, 943

Overall word limit: 15, 912 (plus 1, 338 additional words)

A thesis submitted in partial fulfilment of the requirements of Canterbury
Christ Church University for the degree of Doctor of Clinical Psychology

October 2012

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

First and foremost, I would like to thank the participants who made this project possible. I am extremely grateful to them for giving up their time and sharing their experiences, many of which touched difficult and sensitive issues. I hope that the trust they showed me in sharing these experiences will be done justice in the following pages. I would also like to thank all those clinicians, care coordinators and admin staff who, despite their heavy workloads, gave their time to help with recruitment for this study.

I am also indebted to Prof. Tony Lavender and Dr. Caroline Cupitt for their time, support, guidance and inspirational conversations on this journey. Their encouragement and enthusiasm for the current project kept me going and enabled to overcome obstacles along the way. I am really appreciative for their constant assistance.

Finally, I would like to thank my family, friends and my partner for their endless belief in me, for their understanding and their constant support. I hope in the future I will be able to return the generosity, trust and love they showed me.

Summary of portfolio

Section A is a review of the literature on Community Treatment Orders (CTOs) in the context of their recent introduction in England and Wales. A critical review of the literature in relation to CTOs' effectiveness is presented, followed by available evidence on service users' perceptions of CTOs. Consideration of ethical issues that surround compulsory community treatment is also offered. The review highlights gaps in the literature regarding CTOs' impact on service users' interpersonal relationships and on how service users who are based in the UK perceive CTOs. Further qualitative research is recommended.

Section B describes a qualitative study investigating male service users' perceptions of their CTOs and the impact of this intervention on their interpersonal relationships. Grounded Theory was used to analyse interview data from 15 participants. Five higher-order categories and 15 categories were identified which contributed to a preliminary model of how service users develop their CTO perceptions and how CTOs impact on service users' interpersonal relationships. Results are discussed with reference to potentially relevant psychological theories. Clinical implications and directions for future research are also presented.

Section C is a critical appraisal of the study presented in Section B. It provides reflective responses to four questions in relation to the following areas: research skills acquired through conducting the study; what improvements could be made if repeating the study; clinical implications; and directions for future research.

Contents

Section A: Community Treatment Orders: Effectiveness and service users' perceptions: A literature review	Page
Abstract	3
Introduction	4
Definitions of CTO	4
History of CTOs	4
CTOs and their use in England and Wales	6
Evidence base for CTOs	8
Ethical issues	12
Service users' perceptions of CTOs	14
Impact of CTOs on service users' relationships	17
Theoretical underpinnings	18
Conclusions and further research	22
References	24
Appendix A: Literature search strategy	36
Appendix B: Inclusion/Exclusion criteria	37

**Section B: A grounded theory study of male service users' perceptions of their
Community Treatment Orders: An investigation****Page**

Abstract	4
Introduction	5
Definition and history of CTOs	5
CTOs and their use in England and Wales	5
Evidence base for CTOs	6
Ethical issues	7
Service users' perceptions of CTOs	8
Impact of CTOs on service users' relationships	8
Theoretical underpinnings	9
Summary	11
Research rationale	11
Study objectives	12
Methodology	12
Participants	12
Design and method	13
Ethics	14
Procedure	14
Interview schedule	15
Data analysis	15
Quality assurance	16
Results	16

	7
1. Higher-order category: Perception of CTO	17
1.1 CTO as beneficial	18
1.2 CTO as a safety net	18
1.3 Neutral about CTO	18
1.4 CTO as a burden	19
2. Higher-order category: Perception of self and mental health	19
2.1 Self as vulnerable	20
2.2 Self as moving towards recovery	20
2.3 Self as not needing treatment	20
2.4 Self as never had mental health difficulties	21
3. Higher-order category: Past and present social living conditions	21
3.1 Experience of hospitalization	22
3.2 View of community living arrangements	23
4. Higher-order category: The CTO service	23
4.1 View of medication	24
4.2 View of psychiatrist	25
4.3 View of care coordinator and psychology	25
5. Higher order category: Community relationships	26
5.1 Family and intimate relationships	27
5.2 Relationships with friends and local communities	27
Overview of model	28
Discussion	30
Limitations of study and areas for future research	34
Implications for clinical practice	36
Conclusions	37
References	38

Section C: Critical appraisal**Page**

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to develop further?	3
2. If you were to do this project again, what would you do differently and why?	5
3. Clinically, as a consequence of doing this study, would you do anything differently and why?	7
4. If you were to undertake further research in this area what would the research project seek to answer and how would you go about doing it?	8
References	10

List of Tables and Figures

Section B	Page
Table 1. Participant demographic information	13
Table 2. Categories and subcategories representing participants' perceptions of CTOs	17
Table 3. Categories and subcategories representing participants' perceptions of self and mental health	19
Table 4. Categories and subcategories representing participants' past and present social living conditions	21
Table 5. Categories and subcategories representing participants' views of the CTO service	24
Table 6. Categories and subcategories representing participants' views of their community relationships	26
Figure 1. Diagram illustrating the four participant profiles leading to specific CTO perceptions and CTOs' perceived impact on relationships	29

Section D: Appendices**Page**

Appendix 1: NHS Research and Ethics Committee (REC) and Research and Development (R&D) approval	3
Appendix 2: Participant invitation and information letter for responsible clinicians	5
Appendix 3: Participant information sheet	6
Appendix 4: Participant consent form	9
Appendix 5: Example transcript	10
Appendix 6: Semi-structured interview schedule	18
Appendix 7: Excerpts of memos for coding process	20
Appendix 8: Reflexive research diary	21
Appendix 9: Table of categories, subcategories and supporting quotes	28

IOANNIS PATKAS

Section A:

**Community Treatment Orders: Effectiveness and service users' perceptions:
A literature review**

Word count: 5, 485 (plus 560 additional words)

Contents

Section A: Community Treatment Orders: Effectiveness and service users' perceptions: A literature review	Page
Abstract	3
Introduction	4
Definitions of CTO	4
History of CTOs	4
CTOs and their use in England and Wales	6
Evidence base for CTOs	8
Ethical issues	12
Service users' perceptions of CTOs	14
Impact of CTOs on service users' relationships	17
Theoretical underpinnings	18
Conclusions and further research	22
References	24
Appendix A: Literature search strategy	36
Appendix B: Inclusion/Exclusion criteria	37

Abstract

This review evaluates research on Community Treatment Orders (CTOs) in the context of their introduction in England and Wales in 2007. Following definitions of CTOs, a historical overview of their appearance at an international level is presented. Details of their implementation in England and Wales are then outlined, followed by a critical review of the literature in relation to CTOs' effectiveness on health service and service user outcomes. The review then turns its focus on ethical issues that surround compulsory community treatment and subsequently available evidence on service users' perceptions of CTOs is provided. Finally, psychological theories which might be able to explain the motivation behind service users' perceptions of CTOs are considered.

Available research reveals that service users tend to hold mixed views about CTOs. There is also a gap in the literature regarding the impact of this type of community treatment on service users' interpersonal relationships. There are limited quantitative studies focusing on CTOs' direct effects on service users and existing ones often show methodological limitations, while qualitative accounts are mainly reported outside the UK and are likely to be influenced by local context. The review concludes by highlighting a need for further qualitative research: i) to explore service users' perceptions of CTOs in the UK context and ii) to examine the impact CTOs may have on service users' interpersonal relationships.

Introduction

This section begins by providing definitions of Community Treatment Orders (CTOs) and offering an overview of the background to their introduction in various countries around the world. Details in relation to the implementation of CTOs in England and Wales are then presented, followed by available evidence about their effectiveness on health service and service user outcomes. Attention is then drawn to the ethical concerns surrounding compulsory community treatment, followed by evidence regarding service users' perceptions of CTOs. The section continues by presenting evidence regarding the impact of CTOs on service users' relationships and subsequently psychological theories that might be able to explain service users' views about CTOs are discussed. Conclusions and a summary with justification for further research are finally provided.

Definitions of CTO

CTO is a legal provision that provides a framework within which service users diagnosed as having mental health conditions, and who meet specific criteria, may be required to follow a course of treatment while living in the community (O' Reilly, 2004). Swartz and Swanson (2004) provided a more comprehensive definition of a CTO as: "A legal intervention designed to benefit persons with serious mental illness who need ongoing psychiatric care and support to prevent relapse, hospital re-admissions, homelessness, or incarceration but have difficulty following through with community-based treatment" (p. 585).

History of CTOs

CTOs are a type of community treatment law that has been a feature of psychiatric services in New Zealand, Australia, Canada, and the U.S.A since the early 1980s (Power, 1999; Hiday, 2003). They were originally conceptualised as a way of addressing problems created by the widespread closure of

psychiatric asylums and were used to manage individuals with mental health conditions and associated risk issues who found it challenging to adapt to life in the community (Geller, 2000). They subsequently targeted the treatment of the 'revolving door syndrome', which refers to service users with histories of numerous hospital admissions (Geller, 1992), and attempted to address the inadequate community care provided for many service users who were no longer detained in hospital (Appelbaum, 2001). Initially, civil libertarians supported the introduction of CTOs because they considered them as less restrictive to hospitalisation and therefore as ethically preferable (Hiday, 2003).

Over the years, CTOs have evolved into a legal form of compulsory community treatment with alleged health benefits (Churchill, Owen, Singh, & Hotopf, 2007). One of the main factors that led to this transition was the change in the use of CTOs as treatment interventions which targeted service users with 'need for treatment profiles' rather than those who were considered as posing risks to others (Hiday, 2003). Additional factors that contributed to this shift were improved pharmacological treatments for severe mental health conditions and a parallel expansion in community services which enabled more effective care for discharged service users (Geller, 2000). This transition was also evident in research on CTO effectiveness. While earlier studies addressed the question of whether CTOs could manage effectively, the potential risks service users posed to self or others later research focused on whether CTOs could lead to better health outcomes compared to hospitalisation or voluntary community treatment (Churchill et al., 2007). This change in the conceptualisation of CTOs into compulsory community intervention made the civil libertarians stop supporting them, criticizing them as unjustifiable and unnecessary means of social control (Fulop, 1995).

CTOs and their use in England and Wales

CTOs were introduced in England and Wales in November 2007, as part of the amended 1983 Mental Health Act (MHA). The 2007 amendments provide a framework for treatment to be delivered in the community and allow forced recall to hospital for service users subject to CTOs (Brooks & Brindle, 2010). The Code of Practice (DoH, 2008a) states that the purpose of a CTO is to allow suitable service users to be safely treated in the community rather than under compulsory hospital detention and to prevent deterioration of their mental health and any harm associated with it. CTOs are mainly used to support service users who have difficulty adhering to their treatment (usually individuals with severe mental health conditions who are repeatedly admitted to in-patient care) by compulsorily treating them in the least restrictive environment (Taylor, 2010).

Before CTOs were introduced in England and Wales, there were three main mechanisms to supervise service users in the community: i) supervised discharge (revoked by the 2007 amendments), ii) guardianship (Section 7) and iii) leave of absence (Section 17 leave). Under supervised discharge, service users were required to comply with treatment, live where directed and attend assessment appointments but were not obliged to accept treatment (Davies, Bruce & Fallows, 1999). Service users under guardianship are required to make themselves available for assessment and treatment, reside in a specific location and accept visits only from specific persons (Sheehan & Molodynski, 2007). Guardianship is largely reserved for service users with cognitive impairment (Ford, Durcan, Warner, Hardy & Muijen, 1997). Section 17 leave allows service users to be discharged from hospital indefinitely (s.17(2)) or for a specified period but while in the community they remain 'liable to be detained' and their 'leave' may be revoked in case they do not adhere to their treatment or there are concerns their mental health deteriorates (Woolley, 2010). The use of Section 17 leave remains an available option under the amended MHA, but it is now

recommended that clinicians should consider the use of a CTO instead of placing service users on Section 17 for more than seven consecutive days (Molodynski, Rugkasa & Burns, 2010).

Only service users who are detained in hospital involuntarily and are considered as needing ongoing compulsory treatment can be placed on a CTO (DoH, 2008b). In addition, the following criteria must be met: i) the person must have a mental health condition of a nature or degree which makes it appropriate for him/her to receive medical treatment, ii) such treatment must be necessary for their health or safety or for the protection of others, iii) appropriate medical treatment needs to be available without the need for a return to hospital and iv) the responsible clinician should be able to recall the service user to hospital (DoH, 2008b).

The approved clinician in overall charge of the service user's care (commonly referred to as the responsible clinician) along with an approved mental health professional, who would have been given authority to perform a variety of functions under the MHA, are required to agree as to whether to apply a CTO (DoH, 2008b). Two mandatory conditions apply in all cases and these require service users: i) to allow examination by the second opinion appointed doctor (SOAD) in order to authorize treatment and ii) to make themselves available for examination by the responsible clinician in order to extend the CTO as necessary (DoH, 2008b). Once a CTO is initiated, the responsible clinician may impose further non-mandatory conditions without further consultation (DoH, 2008b). These conditions vary but usually require service users to adhere to their medication, attend appointments with mental health professionals and sometimes reside in a specific location (Taylor, 2010).

The Code of Practice (DoH, 2008a) states that the service user would need to agree to the CTO and accept the attached conditions. The responsible clinician has exclusive responsibility to recall a CTO

recipient if he/she is not compliant with the CTO conditions and may do so without consultation. The purpose of the recall, which can last up to 72 hours, is to assess whether the CTO can be maintained or whether compulsory hospitalisation is necessary. CTOs are renewed by the responsible clinician following consultation with the approved mental health professional and at least one more health professional involved in the service user's care. Periods of renewal are six months in the first instance and thereafter every 12 months. Service users may be discharged from the CTO by the responsible clinician or by a mental health review tribunal. It is noteworthy that service users placed on a CTO have the right to an independent mental health advocate and maintain the right to appeal against the order.

It appears that the Department of Health seriously underestimated the number of CTOs that would be applied following implementation of the amended Mental Health Act, predicting some 400 CTOs in the first year (Gould, 2009). However, the actual figure (total accumulative number) was nearer 2000 CTOs in 2008-2009 and approximately 4000 CTOs in 2009-2010 (NHS Information Centre, 2010). In the following year, the number of CTOs increased by almost 30% (NHS Information Centre, 2011). The evidence suggests that the rate of CTOs in England has flattened out (at some 300 to 350 a month), but as it appears that at present fewer people are being discharged from CTOs than are being placed under CTOs, the overall number of people under a CTO will continue increasing (Lawton-Smith, 2010). The ratio of men to women on CTOs in England and Wales is approximately 2:1 and has remained consistent since their introduction in 2007 (NHS Information Centre, 2011).

Evidence base for CTOs

There have been several studies examining CTOs' effectiveness internationally and this research has been systematically reviewed by Dawson (2005) and Churchill et al. (2007). Dawson's (2005) review identified a number of negative aspects of CTOs including, a strong focus on medication

(mainly depot medication), difficulties accessing others types of treatment and their prolonged use. However, several benefits of CTOs were also reported such as therapeutic gains for service users, greater treatment adherence (mainly with medication) and reduced hospitalisation rates. Furthermore, Dawson's review indicated that CTOs contributed to improved relationships between service users and their families, earlier identification of relapse and lower rates of violence and self-harm.

Churchill et al. (2007) stated that their review did not find convincing evidence that CTOs were effective in improving treatment adherence or in reducing hospital readmission rates and overall time spent in hospital. Several studies suggested that CTOs contributed to increased contact with services but the overall evidence on their direct impact on service users was described as inconsistent. Their review also indicated that different stakeholder groups held a variety of perceptions towards CTOs but all tended to view them as a better alternative to compulsory hospitalisation. Furthermore, consistencies in the characteristics of service users on CTOs were identified: "They are typically males, around 40 years of age, with a long history of mental illness, previous admissions, suffering from a schizophrenia-like or serious affective illness, and likely to be displaying psychotic symptoms at the time of the CTO" (p. 109). It is worth mentioning that males outnumbered females in all reviewed studies, with the mean percentage of males across studies being 62% (range 53.8 – 71.8%). Nevertheless, it was reported that the majority of available evidence about the effectiveness of CTOs comes from cross-sectional, non-randomised comparative studies with a number of methodological limitations. It was suggested that it would appear problematic to generalize from the findings of the reviewed studies because of variations in their methodologies, legal frameworks and the healthcare contexts into which CTOs' effectiveness had been examined. This review indicated that there was lack of consistent evidence supporting the use of CTOs.

Two randomised controlled trials (RCTs) have been undertaken in the U.S.A to examine the effectiveness of CTOs. The New York study (Steadman et al., 2001) aimed to evaluate a 3-year CTO pilot programme. Eligible service users were randomly allocated to either CTO and enhanced community services or enhanced community services alone. Follow-up interviews were conducted with participants at 11 months after hospital discharge. This trial did not identify statistically significant differences between the experimental and control groups in hospital admissions, overall duration of hospitalisation, adherence to treatment, perceived coercion and quality of life. However, this study was reported to have methodological problems. Steadman et al., (2001) did not describe their randomization procedure in full, including if they were blind when they allocated participants. In addition, outcome measures were not specified and it was not clear whether those conducting the data analyses were blind.

The North Carolina trial (Swartz et al., 1999) aimed to investigate the effect of CTOs on hospital admissions. This study involved random allocation of suitable participants to either CTO and standard care or to standard care only. Follow-up interviews with participants were conducted every four months for a period of 16 months. When the study concluded, no statistically significant difference was found in the number of hospital admissions between the CTO and control groups. However, secondary analysis suggested that a small group of participants whose CTOs were extended for more than six months and received more regular clinical contact (approximately weekly) had 57% fewer hospital readmissions and overall 20 days less under hospital detention. However, this study had also a number of methodological limitations. As in the previous study, the procedure of randomization was unclear, which made it impossible to determine if the researchers were blind during participant allocation. Although good descriptions of the CTO provisions were provided, there was no way to ascertain if outcome assessments were conducted blind. Additionally, the reporting of attrition rates during follow-up was unclear.

A Cochrane review (Kisely, Campbell & Preston, 2006) pooled the results of the above two RCTs to improve study power. It calculated that 85 service users would need to receive a CTO to avoid one hospital admission, 238 to avoid one arrest and 27 to prevent one episode of homelessness. The authors acknowledged that there were methodological limitations in the reviewed studies. They further concluded that more robust RCTs are needed in the field to determine whether it is the intensity or compulsory nature of this type of treatment that affects health service and service user outcomes (Molodynski, Rugkasa & Burns, 2010). A UK-based RCT, the Oxford Community Treatment Order Evaluation (OCTET), is currently underway. This study aims to compare 300 service users after being discharged from hospital. Participants will be randomly allocated to either the experimental group (CTO plus enhanced community care) or to a control group (enhanced community care only) and outcomes will be evaluated after 12 months. This study's main aims are: to examine the effectiveness of CTOs on a number of health service and service user outcomes; to demonstrate if the addition of CTO to enhanced community care has an impact on hospital admissions and/or has any direct effects on service users; identify service user characteristics associated with different outcomes (Molodynski, Rugkasa & Burns, 2010). However, the study is reported to have encountered recruitment difficulties and it is unclear whether all the aims will be achieved.

In conclusion, the impact of CTOs on health service and service user outcomes cannot be determined as there is insufficient evidence and existing reviews have questioned whether CTOs are a better alternative to standard care (Kisely, Campbell & Preston, 2006). Churchill et al. (2007) suggested that future research on CTO effectiveness should compare CTOs with alternative community interventions that have already proven effective or are seen as more acceptable to service users and providers.

Ethical issues

The introduction of CTOs has been controversial partly due to inconclusive evidence about their effectiveness and also due to a number of conceptual challenges, such as the meaning of liberty for service users which cannot be resolved through empirical means (Dawson, Romans, Gibbs & Ratter, 2003). CTO opponents argue that CTOs are inherently coercive and their use raises ethical concerns in relation to the balance between service user autonomy and professional paternalism (Kinderman & Tai, 2008). Those opposing CTOs are concerned that their increasing use is likely to further encourage the general use of compulsion in the community and view them as ethically undesirable because of potential violation of service users' human rights (Burns & Goddard, 1995). There are also concerns that CTOs might be extended for prolonged periods, may be used in excess with people from ethnic minorities and may also interfere with the therapeutic relationship between service users and mental health professionals (McIvor, 1998).

Another major ethical issue is CTOs' medication-dominated focus. CTOs compel service users to take medication that is deemed effective but which can also have debilitating side-effects (Bean & Mounser, 1994). CTO opponents argue that the regular use of CTOs may prevent the mental health system from finding alternative ways to support service users in the community by forcing adherence mainly to pharmacological treatments (O'Reilly, 2004). Furthermore, it has been suggested that CTOs are likely to have adverse effects on service users' long-term recovery prospects, as the effect of perceived coercion might undermine their efforts to take responsibility for managing their difficulties and therefore reduce their sense of autonomy and self-determination (Deegan, 1997). Lawton-Smith (2008) argued that CTOs could be viewed as an admission that community mental health services have not succeeded in offering service users with severe mental health conditions high-quality care that aims to promote trust and choice rather than threat of loss of freedom.

Those supporting CTOs argue that they are less restrictive compared to hospitalisation (Pinfold & Bindman, 2001) and create a necessary period of stability for service users to experience the positive effects of sustained treatment in the community (Dawson & Burns, 2008). O' Reilly et al. (2003) further suggested that the option of compulsory community treatment is no less justifiable than the use of compulsory in-patient care provided that specific legal safeguards exist, e.g. professionals are held accountable and service users can access independent reviews and advice regarding their rights. It has been proposed that the use of compulsory community treatment may be consonant with the recovery paradigm if complimented by high-quality community care and adequate resources are available (Munetz & Frese, 2001).

Another argument in support of CTOs is that compulsory community care which is properly regulated should be allowed, if it is targeting the treatment of the 'revolving door syndrome'. Supporters of CTOs justify this view by pointing to the success of clinicians in Australia and the U.S.A who have directed their involuntary community treatment schemes towards this service user group (Dawson, 2005). Dawson and Burns (2008) further argued that this group of service users often have impaired insight, could potentially lack the capacity to make decisions about their preferred treatment options and therefore might not be attracted to voluntary outpatient care. Therefore, compulsive community treatment is likely to be the most appropriate and least restrictive alternative type of intervention for this service user group (Dawson & Burns, 2008).

However, given that the amended 2007 MHA is risk-based and not capacity-based, serious concerns have been expressed about whether CTOs will be commonly imposed on service users who have capacity to make decisions about their treatment (Lawton-Smith, 2008). CTO opponents are concerned that the capacity to make treatment decisions may be ignored for service users with severe mental health

conditions; a view that appears paradoxical taking into account consistent evidence suggesting that the majority of psychiatric in-patients retain their capacity to provide informed consent about their preferred treatment options (Okai et al., 2007). Nevertheless, according to the guidelines of the Mental Capacity Act 2005 ‘best interest’ standards should be applied when service users are judged as lacking capacity to make treatment decisions.

Furthermore, the ethical controversy surrounding CTOs is maintained due to the additional presence of evaluative difficulties (Dawson et al., 2003). These difficulties concern issues such as how to evaluate the possible benefits of CTOs, e.g. reduced rates of hospitalization, against their potential negative effects on service users, e.g. increased levels of perceived coercion (Mulvey, Geller & Roth, 1987; MIND, 1999). Dawson et al. (2003) further cautioned against drawing conclusions about the degree of satisfaction expressed by different stakeholders, such as clinicians, service users and their families, who hold different degrees of power and whose opinions may often conflict. The question of what constitutes appropriate and proportionate use of compulsion in the community continues to provoke debate among the psychiatric profession (O’Reilly, 2004).

Service users’ perceptions of CTOs

In recent years, a number of qualitative studies exploring the views of service users and other stakeholders about compulsory community treatment have been mainly reported from the U.S.A, Australia and New Zealand. It is noteworthy, that only a small number of related studies using qualitative approaches have been conducted in Scotland (Atkinson, Garner, Gilmour & Dyer, 2002) and England (Canvin, Bartlett & Pinfold, 2002; Gault, 2009). Mental health professionals and family members tend to express mixed views, from opposition to strong support for CTOs (Mullen, Gibbs & Dawson, 2007; Romans, Dawson, Mullen & Gibbs, 2004) but variation of perceptions is particularly pronounced among

service users (Swartz & Swanson, 2004). In several studies, service users expressed ambivalent and often contradictory views about CTOs, simultaneously accepting and rejecting their treatment orders (e.g. Canvin, Bartlett & Pinfold, 2002).

In a number of studies, service users experienced CTOs as being coercive and as restricting their freedom (Canvin, Bartlett & Pinfold, 2002; Gibbs, Dawson, Ansley & Mullen, 2005; McDonnell & Bartholomew, 1997) as well as being extended for prolonged periods (Gibbs et al., 2005; McDonnell & Bartholomew, 1997). Service users also expressed concerns about CTOs' medication-dominated approach, often complained about medication side-effects and about not getting better (Atkinson et al., 2002; Gibbs et al., 2005; McDonnell & Bartholomew, 1997). Other perceived disadvantages of CTOs included stigma, having restricted decision-making capacity and lack of control over treatment (Gibbs, Dawson, Forsyth, Mullen & Tonu Tanga, 2004).

Nevertheless, several studies reported that a large percentage of service users held positive views of CTOs. Many believed that their CTO provided safety and security (Canvin, Bartlett & Pinfold, 2002; O' Reilly, Keegan, Corring, Shrikhande & Natarajan, 2006; Gault, 2009), offered freedom (Gibbs, Dawson & Mullen, 2006; O' Reilly et al., 2006) and gave them the opportunity to be discharged from hospital into community care (Power, 1999). Other perceived advantages included access to mental health professionals and readmission being made easier when desired (Gibbs et al., 2005; Power, 1999). Service users in Australia and New Zealand also believed that CTOs contributed to improved relationships with their families and local communities (Gibbs et al., 2004; McDonnell & Bartholomew, 1997). It is noteworthy that a substantial number of service users expressed a view of indifference about CTOs (e.g. Canvin, Bartlett & Pinfold, 2002).

There is evidence that perceptions of the CTOs' effectiveness are likely to be influenced by how service users view their mental health difficulties and need for treatment (Swartz, Wagner, Swanson & Elbogen, 2004). In addition, Churchill et al. (2007) stated that improvements in care and clinical outcomes tended to be attributed to other factors than the community order except for a small group of service users who had been on a CTO for extended periods. Therefore, service users' views of their mental health and need for treatment as well as their amount of experience of being treated compulsorily in the community are factors that appear to influence their perceptions of CTOs.

CTOs were met with fierce resistance at the time the Mental Health Act (2007) was being debated, particularly by lobbying groups such as the Mental Health Alliance and service user/survivor groups such as Mad Pride. These groups were extremely concerned that the broad criteria of the new supervised community treatment powers would result in large numbers of service users being subjected to excessive coercive controls. More specifically, concerns were expressed that CTOs would be commonly imposed on service users who had capacity and on those who did not have a reported history of non-compliance or disengagement. In the following years, the public debate has continued due to consistent evidence that many more service users had been placed on CTOs than predicted before their introduction; fewer people had been discharged from CTOs than being placed under CTOs; CTOs had been disproportionately used for people from black and minority ethnic groups; and there had been shortcomings in community support for numerous CTO recipients (NHS Information Centre, 2011). In a survey conducted by the Mental Health Alliance, the majority of the CTO recipients who responded found their treatment orders deeply stigmatizing, intrusive and unhelpful because they mainly involved forced medication and were rarely accompanied by adequate community support (Lawton-Smith, 2010). Rufus May (2002) argued that CTOs are a serious step backwards for recovery-oriented mental health services since their 'maintenance' emphasis constrains service users into receiving mainly pharmacological

treatments and catapults them into a child-like role or a lifelong battle of wills, involving a growing void of misunderstanding between them and professionals.

Impact of CTOs on service users' relationships

Several reviews have examined social networks and social support in service users with a diagnosis of schizophrenia (e.g. Buchanan, 1995). Social networks have been shown to differ between general population samples and groups of service users with schizophrenia both quantitatively and qualitatively (Albert, Becker, McCrone & Thornicroft, 1998). Individuals with psychosis are more likely to have substantially smaller social networks than the general population and those networks mainly consist of relatives and other mental health service users (Creswell, Kuipers, and Power, 1992). There is also consistent evidence suggesting that smaller social networks or lower social support for service users with schizophrenia are associated with poorer treatment outcomes and increased use of in-patient psychiatric services (Sherbourne, 1988). However, involuntary hospitalisations are also likely to have a negative impact on service users' interpersonal relationships. For example, a review by Morrison, Bowe, Larkin and Nothard (1999) suggested that involuntary hospital admissions can be experienced as traumatic life events that may contribute to the maintenance of negative beliefs about the self (e.g. view of oneself as an incapable/inadequate person) and others (e.g. 'people cannot be trusted'). Phillips, Francey, Edwards and McMurray (2009) further noted that the combination of experiencing 'positive' psychotic symptoms and enduring distressing life events may often lead to sub-optimal coping responses such as social withdrawal and reluctance to seek support when needed.

It is noteworthy that there has been particularly limited research about the impact of CTOs on service users' interpersonal relationships and social support (Churchill et al., 2007). Some of the studies addressing stakeholder perceptions have examined the impact of CTOs on service users' community

relationships but their findings were mixed. Muirhead & Harvey (2000) reported improved family relationships for service users after their CTO had ended. The New York State Office of Mental Health (2005) reported that service users' relationships with family, friends and local communities improved in the first six months of their CTOs. However, a more recent study showed that CTOs had no impact on the frequency of contact between service users and their families (Ingram, Muirhead & Harvey, 2009). Family members also tended to express mixed views about CTOs (Mullen, Gibbs, & Dawson, 2007). Several reported that they had brought stability in their relatives' lives while others appeared frustrated with the mental health system, viewing themselves as taking the brunt of the burden when the system fails. Finally, service users tended to report that CTOs did not have a negative effect on their relationships with mental health professionals (Atkinson et al., 2002; Gibbs et al., 2005).

Theoretical underpinnings

There have been a number of studies that aimed to explore service users' compliance (e.g. Fawcett, 1995) and non-compliance (e.g. Playle & Keeley, 1998) with treatment protocols but there has been no literature attempting to understand service users' responses to compulsory community treatment (Canvin, Bartlett & Pinford, 2002). Psychological theories could potentially explore factors or processes that influence service users' perceptions of CTOs and might further identify service user 'profiles' for which CTOs might be more beneficial.

One of the psychological theories that might be able to explain service users' responses to CTOs is locus of control (LoC) (Rotter, 1966). LoC is a construct that refers to the extent to which an individual perceives events in their lives as being under their control. A life event can be perceived as resulting from personal efforts and internal factors (internal control) or it can be seen as stemming from environmental factors or other causes such as fate (external control) (Rotter, 1990). Research on the LoC of acute

inpatient samples has consistently demonstrated a more external LoC among individuals with a diagnosis of schizophrenia compared to other psychiatric diagnostic groups (Harrow & Ferrante, 1969; Hansford, Harrow, Groen, Kaplan, & Faull, 2004). Harrow, Hansford & Astrachan-Fletcher (2009) suggested that factors such as chronicity, nature and severity of psychotic symptoms as well as the limited independent living skills frequently observed in most of this clinical group might contribute to this reported externality. In addition, there is evidence suggesting that in psychotic service users, LoC may fluctuate over time due to factors such as increased levels of anxiety and poor self esteem (Harrow et al., 2009).

Several studies have suggested that a more external LoC in service users with a diagnosis of schizophrenia could reduce their motivation to take responsibility over the management of their symptoms and thus could make them less likely to recover while a more internal LoC could make them more resilient to build strengths and resources and therefore could increase their chances of recovery (Hoffman & Kupper, 2002; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003). Warner, Taylor, Powers, & Hyman (1989) showed that acceptance of a mental health diagnosis combined with an internal LoC were associated longer periods of recovery in individuals with psychosis.

The above evidence could be relevant to service users on CTOs who typically suffer from schizophrenia-like or serious affective disorders and have ongoing difficulties adhering with their treatment and managing their mental health conditions (Churchill et al., 2007). We can hypothesize that service users' experiences of their CTOs might be influenced by their LoC but also that CTOs might have a different impact on service users' psychosocial functioning depending on their LoC. For example, placing service users with an external LoC on a CTO is likely to reinforce their beliefs that they are not in control of both their difficulties and treatment and therefore feel acceptable but may prevent them from developing a more internal LoC which is associated with better treatment outcomes. CTOs might also

have a short-term beneficial effect on this group of service users in terms of supporting them with treatment adherence but possibly long-term adverse effects in relation to their recovery prospects because they will prevent them from taking a more active role in managing their difficulties. On the other hand, placing service users with an internal LoC on a CTO might challenge their LoC orientation and therefore feel unacceptable since they would expose them to an otherwise untested approach to managing their difficulties. This group of service users might view CTOs as intrusive and coercive believing that their improved or deteriorated psychological functioning is due to their personal efforts or internal dispositions. However, CTOs may also prove beneficial for this group of service users at times when their mental health is unstable by temporarily supporting them with treatment adherence.

Attachment theory might also be able to explain service users' responses to CTOs and the motivation behind them. Attachment theory has been construed as a way of conceptualizing "the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance...to which unwilling separation and loss gives rise" (Bowlby, 1977, p. 201). While this psychological theory was developed from observations of infants and their caregivers, attachment relationships and attachment styles continue to have long-lasting effects throughout the life-cycle (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1982). Given this, attachment theory could make predictions about how earlier attachment relationships and styles are linked with interpersonal experiences in adulthood and explain how maladaptive interpersonal patterns are perpetuated. Researchers have found increasing evidence that supports the concept of adult attachment and how 'secure' and 'insecure' attachment styles influence interpersonal functioning in adulthood (Goodwin, 2003; Ma, 2006).

Adult attachment theory appears to be of great relevance to the study of severe mental health conditions since there is evidence of strong links between adult attachment insecurity and psychopathology (Berry, Wearden, Barrowclough & Liversidge, 2006). A numbers of studies have shown that psychiatric service user groups present with considerably higher levels of adult attachment insecurity compared to non-clinical populations (Mickelson, Kessler, & Shaver, 1997). Furthermore, individuals with psychosis have been found to have higher levels of insecure adult attachment compared to other psychiatric diagnostic groups (Dozier, Stevenson, Lee & Velligan, 1991). These findings are consistent with evidence suggesting that a high percentage of individuals with psychosis frequently experience difficulties with interpersonal relationships (Berry, Barrowclough & Wearden, 2006), including therapeutic relationships (Dozier, 1990). Furthermore, different coping styles and emotion regulation methods have been predicted by specific adult attachment styles (Mikulincer & Florian, 1998). For example, individuals with a dismissing-avoidant attachment style were shown to be less likely to report distress and held less positive beliefs about help-seeking than individuals with a preoccupied attachment style (Dozier & Lee, 1995).

Given the above evidence, it would be interesting to further explore the role of adult attachment styles on CTO recipients' interpersonal relationships and how they may affect their perceptions towards CTOs. Since there is no literature available in this research area, hypotheses could be made based on existing evidence on the role of insecure adult attachment styles in psychosis. It could be hypothesised that a large percentage of CTO recipients have found it difficult in the past to engage with mental health services and have had ongoing interpersonal difficulties partly due to insecure adult attachment styles. Placing service users with higher levels of insecure attachment on a CTO might result in conflicted responses depending on their adult attachment styles (Mikulincer & Florian, 1998).

Furthermore, there is evidence suggesting that individuals with a diagnosis of schizophrenia tend to have difficulties with peer relationships, with mental health professionals and parents playing a more central role in their social lives (Schomerus et al., 2007). Thus, existing relationships with family, friends and mental health professionals might influence to different degrees service users' views of their CTO. We could hypothesise that for service users with limited contact with family and friends, being placed on a CTO might be perceived as an inappropriate treatment option, since they will be more likely to feel isolated and neglected in the community. However, for other service users the option of a CTO might be a preferable option if they have adequate support networks and are keen to return to the community. Additionally, for some service users having to separate from hospital staff and other inpatients, with whom they might have developed close relationships over time, might further reinforce a negative view of their CTO; while for others, who have experienced their hospitalisations as a negative experience, a CTO might be perceived as a preferable option.

Conclusions and further research

Reviews of the literature on CTOs' effectiveness (e.g. Churchill et al., 2007) have suggested that there is lack of convincing evidence about whether CTOs improve adherence to treatment or lead to significant improvements in clinical outcomes for service users. Research into this area has been beset by a number of methodological challenges (Kisely & Campbell, 2007) and it has been difficult to establish if the services provided under compulsion or the compulsory nature itself that is linked to any benefits observed (Kisely, Smith, Preston & Xiao, 2005). Furthermore, CTO perceptions among service users tend to be mixed and often ambivalent concerning whether the negative effects of CTOs are outweighed by their potential benefits.

The majority of the available evidence in relation to service users' perceptions of CTOs comes from studies conducted outside the UK. Hence, there is a gap in the literature about how service users based in the UK perceive CTOs (Kisely, Campbell & Preston, 2006). Furthermore, although some evidence exists regarding the effect service users' limited social networks have on the utilization of mental health services and vice versa, there is limited literature concerning the impact of CTOs on service users' interpersonal relationships (Ingram, Muirhead & Harvey, 2009). Some researchers have made recommendations that qualitative research methods should be used to explore, in more depth, the opinions of service users who have been the recipients of compulsory community treatment (e.g. Bindman, 2002). Therefore, qualitative research methods could prove valuable in developing a better understanding of how service users based in the UK perceive their CTOs and further explore the perceived impact of compulsory community treatment on their relationships. Such research could improve our existing understanding of factors and processes that contribute to specific perceptions of CTOs and might clarify for whom CTOs might be more appropriate and effective.

References

- Adams, N.H. & Hafner, R.J. (1991). Attitudes of psychiatric patients and their relatives to involuntary treatment. *Australian and New Zealand Journal of Psychiatry*, 25 (2), 231-237.
- Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of Attachment: Psychological Study of the Strange Situation*. Hillsdale, NJ: Erlbaum.
- Albert, M., Becker, T., McCrone, P., & Thornicroft, G. (1998). Social networks and mental health service utilisation: A literature review. *International Journal of Social Psychiatry*, 44 (4), 248-266.
- Appelbaum, P.S. (2001). Thinking carefully about outpatient commitment. *Psychiatric Services*, 52 (3), 347-350.
- Atkinson, J.M., Garner, H.C. Gilmour, W.H. & Dyer, J.A.T. (2002). Changes to leave of absence in Scotland: The views of patients. *The Journal of Forensic Psychiatry*, 13 (2), 315-328.
- Bean, P. & Mounser, P. (1994). The community treatment order. Proposals and prospects. *Journal of Social Policy*, 23, 71-80.
- Berry, K., Barrowclough, C., & Wearden, A. (2007). A review of the role of adult attachment style in psychosis: unexplored issues and questions for further research. *Clinical Psychology Review*, 27, 458-475.

- Berry, K., Wearden, A., Barrowclough, C., & Liversidge, T. (2006). Attachment styles, interpersonal relationships and psychotic phenomena in a non-clinical student sample. *Personality and Individual Differences*, 41, 707-718.
- Bindman, J. (2002). Involuntary outpatient treatment in England and Wales. *Current opinion in Psychiatry*, 15 (6), 595-598.
- Bowlby, J. (1977). The making and breaking of affectional bonds. Aetiology and psychopathology in light of attachment theory. *British Journal of Psychiatry*, 130, 201-210.
- Bowlby, J. (1982). *Attachment and loss: Vol. 1 Attachment (2nd Ed.)*. Basic Books.
- Brooks, G. & Brindle, N. (2010). Compulsion in the community? The introduction of supervised community treatment. *Advances in Psychiatric Treatment*, 16, 245-252.
- Buchanan, J. (1995). Social support and schizophrenia. A review of the literature. *Archives of Psychiatric Nursing*, 9, 68-76.
- Burns, T. & Goddard, K. (1995). Community supervision orders for the mentally ill: Mental health professionals' attitudes. *Journal of Mental Health*, 4, 301-308.
- Canvin, K., Bartlett, A. & Pinfold, V. (2002). A 'bittersweet pill to swallow': Learning from mental health users' responses to compulsory community care in England. *Health and Social Care in the community*, 10 (5), 361-369.

- Churchill, R., Owen, G., Singh, S., & Hotopf, M. (2007). *International experiences of using Community Treatment Orders*. Institute of Psychiatry, London.
- Creswell, C. M., Kuipers, L., & Power, M. S. (1992). Social networks and support in long term psychiatric patients. *Psychological Medicine*, 22, 1019-1026.
- Davies, S., Bruce, J., & Fallows, S. (1999). Section 25 aftercare under supervision: the first eighteen months' experience. *Medicine, Science and the Law*, 39, 211-218.
- Dawson, J. (2005). *Community Treatment Orders: International comparisons*. Dunedin, New Zealand: Otago University Press.
- Dawson, J., Romans, S., Gibbs, A., & Ratter, N. (2003). Ambivalence about community treatment orders. *International Journal of Law and Psychiatry*, 26, 243-255.
- Deegan, P. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care*, 25 (3), 11-24.
- Department for Constitutional Affairs (2007). *Mental Capacity Act 2005*. Code of Practice. DCA.
- Department of Health (2008a). *Code of Practice, Mental Health Act 1983*. The Stationary Office (TSO).
- Department of Health (2008b). *Supervised Community Treatment: A Guide for Practitioners*. National Institute of Mental Health in England (NIMHE).

- Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. *Development and Psychotherapy*, 2, 47-60.
- Dozier, M. & Lee, S. (1995). Discrepancies between self-and other-report of psychiatric symptomatology: Effects of dismissing attachment strategies. *Development and Psychopathology*, 7, 217-226.
- Dozier, M., Stevenson, A.L., Lee, S.W., & Velligan, D.I. (1991). Attachment organization and familial over-involvement for adults with serious psychopathological disorders. *Development and Psychopathology*, 3, 475-489.
- Fawcett, J. (1995). Compliance: Definitions and key issues. *Journal of Clinical Psychiatry*, 56 (Suppl. 1), 4-8.
- Ford, R., Durcan, G., Warner, L., Hardy, P., & Muijen, M. (1997). One day survey by the mental health act commission of acute adult psychiatric inpatient wards in England and Wales. *British Medical Journal*, 317, 1279-1283.
- Fulop, N.J. (1995). Involuntary outpatient civil commitment: what can Britain learn from the U.S experience? A civil liberties perspective. *International Journal of Law & Psychiatry*, 18 (3), 291-303.
- Gault, I. (2009). Service user and carer perspectives on compliance and compulsory treatment in community mental health services. *Health and Social Care in the Community*, 17 (5), 504-513.

- Geller, J.L. (1992). Clinical encounters with outpatient coercion at the CMHC: Questions of implementation and efficacy. *Community Mental Health Journal*, 28 (2), 81-94.
- Geller, J.L. (2000). The last half-century of psychiatric services as reflected in Psychiatric Services. *Psychiatric Services*, 51, 41-67.
- Gibbs, A., Dawson, J. & Mullen, R. (2006). Community treatment orders for people with serious mental illness: a New Zealand Study. *British Journal of Social Work*, 36, 1085-1100.
- Gibbs, A., Dawson, J., Ansley, C. & Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, 14, 357-368.
- Gibbs, A., Dawson, J., Forsyth, H. Mullen, R. Tonu Tanga, T.O. (2004). Maori experiences of community treatment orders in Otago, New Zealand. *Australian and New Zealand Journal of Psychiatry*, 38 (10), 830-835.
- Goodwin, I. (2003). The relevance of attachment theory to the philosophy, organization, and practice of adult mental health services. *Clinical Psychology Review*, 23, 35-56.
- Gould, M. (2009). Hazards of a health safeguard. *The Guardian*, Retrieved on the 3rd of October 2012 from (<http://www.guardian.co.uk/society/2009/may/13/supervised-community-treatment-order>).

- Hansford, B., Harrow, M., Groen, E., Kaplan, K., & Faull, R. (2004). Is internal locus of control related to schizophrenia, global outcome and major psychopathology? *Scientific Proceedings of the 2004th Annual Meeting of the Midwestern Psychological Association*, p. 83.
- Harrow, M. & Ferrante, A. (1969). Locus of control in psychiatric patients. *Journal of Consulting and Clinical Psychology*, 33, 582-589.
- Harrow, M., Hansford, B.G., & Astrachan-Fletcher, E.B. (2009). Locus of control: Relation to schizophrenia, to recovery, and to depression and psychosis – A 15-year longitudinal study. *Psychiatry Research*, 168, 186-192.
- Hiday, V.A. (2003). Outpatient commitment: the state of empirical research on its outcomes. *Psychology, Public Policy & Law*, 9, 8-32.
- Hoffman, H., & Kupper, Z. (2002). Facilitators of psychosocial recovery from schizophrenia. *International Review of Psychiatry*, 14, 293-302.
- Ingram, G., Muirhead, D. & Harvey, C. (2009). Effectiveness of community treatment orders for treatment of schizophrenia with oral or depot antipsychotic medication: changes in problem behaviours and social functioning. *Australian and New Zealand Journal of Psychiatry*, 43, 1077-1083.
- Kinderman, P. & Tai, S. (2008). Psychological models of mental disorder, human rights, and compulsory mental health care in the community. *International Journal of Law and Psychiatry*, 31, 479-486.

- Kisely S. & Campbell, L.A. (2007). Methodological issues in assessing the evidence for compulsory community treatment. *Current Psychiatric Reviews*, 3, 51-56.
- Kisely, S.R., Campbell, L.A. & Preston, N.J. (2006). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Systematic Reviews*, 3, CD004408.
- Kisely, S., Smith, M., Preston, N.J., & Xiao, J. (2005). A comparison of health service use in two jurisdictions with and without compulsory community treatment. *Psychological Medicine*, 35, 1-11.
- Lawton-Smith, S. (2010). *Briefing Paper 2: Supervised Community Treatment*, Mental Health Alliance (http://www.mentalhealthalliance.org.uk/resources/SCT_briefing_paper.pdf).
- Lawton-Smith, S., Dawson, J., & Burns, T. (2008). Community treatment orders are not a good thing. *The British Journal of Psychiatry*, 193, 96-100.
- Ma, K. (2006). Attachment theory in psychiatry. Part 1: Conceptualisations, measurement, and clinical research findings. *Advances in Psychiatric Treatment*, 12, 440-449.
- May, R. (2002). A Mad Summers Day. *Asylum magazine*, Vol. 12 (4). Retrieved on October 3, 2012, from <http://studymore.org.uk/mpuj.htm>.

- McDonnell, E., & Bartholomew, T. (1997). Community Treatment Orders in Victoria: Emergent issues and anomalies. *Psychiatry, Psychology & Law*, 4, 25-36.
- McIvor, R. (1998). The community treatment order: Clinical and ethical issues. *Australian & New Zealand Journal of Psychiatry*, 32, 223-228.
- Mickelson, K.D., Kessler, R.C., & Shaver, P.R. (1997). Adult attachment in a nationally representative sample. *Journal of Personality and Social Psychology*, 73, 1092-1106.
- Mikulincer, M. & Florian, V. (1998). The relationship between adult attachment styles and emotional and cognitive reactions to stressful events. In J.A. Simpson & W.S. Rholes (Eds.), *Attachment Theory and close relationships* (pp. 143-165). London: Guilford Press.
- MIND (1999). *Ten questions about compulsory treatment in the community*. London: Author.
- Molodynski, A., Rugkasa, J. & Burns, T. (2010). Coercion and compulsion in community mental health care. *British Medical Bulletin*, 95, 105-119.
- Morrison, A. P, Bowe, S., Larkin W., & Nothard S. (1999). The psychological impact of psychiatric admission. *Journal of Nervous & Mental Disease*, 187(4), 250-253.
- Mullen, R., Gibbs, A., & Dawson, J. (2007). Family perspective on community treatment orders: A New Zealand study. *International Journal of Social Psychiatry*, 52 (5), 469-478.

Mulvey, E.P., Geller, J.L., & Roth, L.H. (1987). The promise and the peril of involuntary outpatient commitment. *American Psychologist*, 42, 571-584.

Munetz, M., & Frese, F.J. (2001). Getting ready for recovery: reconciling mandatory treatment with the recovery vision. *Psychiatric Rehabilitation Journal*, 25, 35-42.

Muirhead, D. & Harvey, C. (2000). *Involuntary treatment of schizophrenia in the community: clinical effectiveness of community treatment orders with oral or depot medication in Victoria*. Royal Australian and New Zealand College of Psychiatrists, Unpublished dissertation.

New York State Office of Mental Health (2005). *Kendra's Law. Final report on the status of assisted outpatient treatment*. New York State Office of Mental Health. New York, NY.

NHS Information Centre (2010). *In-patients formally detained in hospitals under the Mental Health Act, 1983 - and patients subject to supervised community treatment, Annual Figures, England 2009/10*. Published October 2010.

NHS Information Centre (2011). *In-patients formally detained in hospitals under the Mental Health Act 1983, - and patients subject to supervised community treatment, Annual Figures, England 2010/11*. Published October 2011.

Okai, D., Owen, G., McGuire, H., Singh, S., Churchill, R., & Hotopf, M. (2007). Mental capacity in psychiatric patients. Systematic Review. *British Journal of Psychiatry*, 191, 291-297.

- O' Reilly, R.L. (2004). Why are Community Treatment Orders controversial? *Canadian Journal of Psychiatry*, 49 (9), 579-584.
- O' Reilly, R.L., Keegan, D.L., Corring, D., Shrikhande, S. & Natarajan, D. (2006). A qualitative analysis of the use of community treatment orders in Saskatchewan. *International Journal of Law and Psychiatry*, 29, 516-524.
- O'Reilly, R.L., Brooks, S.A., Chaimowitz, G.A., Neilson, G.E., Carr, P.E., Zikos, E., Leichner, P.P., & Beck, P.R. (2003). *Mandatory Outpatient Treatment*. Ottawa: Canadian Psychiatric Association.
- Phillips, L., Francey, S., Edwards J., & McMurray, N. (2009). Strategies used by psychotic individuals to cope with life stress and symptoms of illness: a systematic review, *Anxiety, Stress and Coping*, 22 (4), 371-410.
- Pinfold, V. & Bindman, J. (2001). Is involuntary community treatment ever justified? *Psychiatric Bulletin*, 25, 268-270.
- Playle, J. & Keeley, P. (1998). Non-compliance and professional power. *Journal of Advanced Nursing*, 27 (2), 304-311.
- Power, P. (1999). Community Treatment Orders: the Australian experience. *Journal of Forensic Psychiatry*, 1, 9-15.

- Romans, S., Dawson, J., Mullen, R., & Gibbs, A. (2004). How mental health clinicians view community treatment orders: a national New Zealand study. *Australian & New Zealand Journal of Psychiatry*, 38, 836-841.
- Rotter, J. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs*, 80, 1-27.
- Rotter, J. (1990). Internal versus external control of reinforcement: a case history of a variable. *American Psychologist*, 45, 489-493.
- Shebourne, C.D. (1988). The role of social support and life stress events in use of mental health services. *Social Science and Medicine*, 27, 1393-1400.
- Sheehan, K. & Molodynski, A. (2007). Compulsion and freedom in community mental health care. *Psychiatry*, 6, 393-398.
- Schomerus, G., Heider, D., Angermeyer, M.C., Bebbington, P.E., Azorin, J.M., Brugha, T., Toumi, M. (2007). Residential area and social contacts in schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, 42, 617-622.
- Steadman, H.J., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., & Robbins, P.C. (2001). Assessing the New York City involuntary outpatient commitment pilot programme. *Psychiatric Services*, 52, 330-336.

- Swartz, M.S. & Swanson, J.W. (2004). Involuntary outpatient commitment, community treatment orders and assisted outpatient treatment: what's in the data? *Canadian Journal of Psychiatry*, 49 (9), 585-591.
- Swartz, M.S., Wagner, H.R., Swanson, J.W., & Elbogen, E.B. (2004). Consumers' perceptions of the fairness and effectiveness of mandated community treatment and related pressures. *Psychiatric Services*, 55 (7), 780-785.
- Swartz, M.S., Swanson, J.W., Wagner, H.R., Burns, B.J., Hiday, V.A. & Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *American Journal of Psychiatry*, 156, 1968-1975.
- Taylor, M. (2010). Community Treatment Orders and their use in the UK. *Advances in Psychiatric Treatment*, 16, 260-262.
- Tooth, B., Kalyanasundaram, V., Glover, H., & Momenzadah, S. (2003). Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry*, 11 (1), 70-77.
- Warner, R., Taylor, D., Powers, M., & Hyman, J. (1989). Acceptance of the mental illness label by psychotic patients: effects on functioning. *American Journal of Orthopsychiatry*, 59, 398-409.
- Woolley, S. (2010). Involuntary treatment in the community: role of community treatment orders. *The Psychiatrist*, 34, 441-446.

Appendix A

Literature search strategy

The following databases were searched up to 1st of June 2012: PsychInfo, Medline, PubMed, Web of Knowledge and Cochrane. Only books and journals written in English were included.

An initial targeted search was conducted to obtain information regarding Community Treatment Orders. The following terms were used: “Community Treatment Order(s)”, “Involuntary Outpatient Commitment”, “Mandated Community Treatment”, “Involuntary Outpatient Treatment”, “Mandatory Outpatient Treatment”, “Involuntary Treatment”, “Supervised Community Treatment”, “Compulsory Community Care”, “Community Supervision Order”, “Compulsory Community Treatment”, “Outpatient Commitment”, “Assisted Outpatient Treatment”. This produced a total of 2292 potential results which were subsequently refined by topic to produce 253 potential articles. Of these results, articles were selected according to relevance and applicability to the study.

Combinations of the above group of terms with the following terms were subsequently used: “Service users”, “clients”, “consumers”, “patients”, “mentally ill”, “mental health users”, “experiences”, “perceptions”, “views”, “attitudes”, “responses”, “perspectives”, “coercion”, “coercive”, “compulsion”, “compulsive”, “compliance”, “ethics”, “ethical”, “controversial”, “effectiveness”, “fairness”, “treatment pressures”, “schizophrenia”, “psychosis”, “mental illness”, “mental disorder”, “social functioning”, “quality of life”, “interpersonal functioning”, “psychological functioning”, “well-being”, “patient outcome”, “service use outcome”. The already mentioned electronic databases were searched. This produced a total of 483 potential results which were again refined by topic to produce 96 potential articles. Of these results, articles were selected according to relevance and applicability to the study. Combinations of the above terms were also entered at Google Scholar but no new articles were identified.

In addition, the following terms were searched: “Locus of control”, “internal/external locus”. This search produced a total of 13, 665 potential results, which were subsequently refined by topic to produce 32 potential articles. No articles directly related to Community Treatment Orders were identified. Furthermore, the following terms were also searched: “Attachment”, “attachment style”, “adult attachment”, “insecure attachment”. This search resulted in 26, 907 potential results which were subsequently refined by topic to produce 171 potential articles. Again no articles directly related to Community Treatment Orders were identified.

Finally, manual searches were conducted in relevant books and journals. References were also scrutinized for further relevant research. Clinical researchers who had conducted research on CTOs, including the OCTET RCT authors, were contacted to ensure that literature search included the most relevant and updated information related to the current study.

Appendix B

Inclusion/Exclusion criteria

Inclusion criteria: Individuals were included in the participant sample if they met the following inclusion criteria: 1. they were male; 2. were on a CTO for a minimum of three months; 3. were aged between 18 and 65; 4. were able to communicate in English; 5. were complying with their CTO conditions; 6. were deemed capable of giving informed consent to participate in the study.

Exclusion criteria: Individuals were excluded from the study under the following criteria if they: 1. were assessed by their care co-ordinators as posing current risk to self or others, 2. had current distressing psychotic experiences according to evidence given by their care co-ordinators.

For a detailed account of further ethical considerations see the Participant Information sheet (Appendix 3).

IOANNIS PATKAS

Section B:

**A grounded theory study of male service users' perceptions of their
Community Treatment Orders: An investigation**

Word count: 8, 484 (plus 768 additional words)

Contents

Section B: A grounded theory study of male service users' perceptions of their Community Treatment Orders: An investigation		Page
Abstract		4
Introduction		5
Definition and history of CTOs		5
CTOs and their use in England and Wales		5
Evidence base for CTOs		6
Ethical issues		7
Service users' perceptions of CTOs		8
Impact of CTOs on service users' relationships		8
Theoretical underpinnings		9
Summary		11
Research rationale		11
Study objectives		12
Methodology		12
Participants		12
Design and method		13
Ethics		14
Procedure		14
Interview schedule		15
Data analysis		15
Quality assurance		16
Results		16

	3
1. Higher-order category: Perception of CTO	17
1.1 CTO as beneficial	18
1.2 CTO as a safety net	18
1.3 Neutral about CTO	18
1.4 CTO as a burden	19
2. Higher-order category: Perception of self and mental health	19
2.1 Self as vulnerable	20
2.2 Self as moving towards recovery	20
2.3 Self as not needing treatment	20
2.4 Self as never had mental health difficulties	21
3. Higher-order category: Past and present social living conditions	21
3.1 Experience of hospitalization	22
3.2 View of community living arrangements	23
4. Higher-order category: The CTO service	23
4.1 View of medication	24
4.2 View of psychiatrist	25
4.3 View of care coordinator and psychology	25
5. Higher order category: Community relationships	26
5.1 Family and intimate relationships	27
5.2 Relationships with friends and local communities	27
Overview of model	28
Discussion	30
Limitations and research implications	34
Clinical implications	36
Conclusion	37
References	38

Abstract

Background: An overview of research on CTOs' effectiveness reveals limitations in existing understandings regarding how service users based in the UK perceive CTOs and also about the impact of CTOs on service users' interpersonal relationships.

Aims: This study aimed to develop a theoretical model to better understand how male service users based in the UK view CTOs and explore the perceived impact of this intervention on service users' relationships.

Method: Semi-structured interviews were conducted with 15 male CTO recipients, focusing on their perceptions of their CTOs and their subjective impact on service users' relationships with family, friends, partners and local communities. Grounded theory (Glaser & Strauss, 1967) was used to analyse the data and develop a model.

Results: The present theory suggested that following factors appeared to influence participants' perceptions of their CTOs: i) past and present social living conditions, ii) view of self in relation to mental health, iii) view of the CTO service, i.e. view of medication and mental health professionals. Finally, the model showed that CTOs had a limited or no impact on participants' views of their relationships with their families, friends, partners and local communities.

Conclusions: This small-scale qualitative study provided a preliminary model and understanding of how male service users perceive their CTOs and the subjective impact of this intervention on their relationships. Clinical implications, including raising professionals' awareness about the impact of coercion on the therapeutic relationship, are discussed. Despite its limitations, the study's findings indicated new areas for future research.

Introduction

Definition and history of CTOs

A Community Treatment Order (CTO) is a legal mechanism by which service users, who meet specific criteria, may be required to receive compulsory psychiatric treatment while in the community (O'Reilly, 2004). Introduced in the U.S.A, Australia, New Zealand and Canada in the 1980s, CTOs were originally conceptualised as a way of managing individuals, with severe mental health conditions and associated risk issues, who failed to adapt to community life (Geller, 2000). However, over time they evolved into treatment interventions with alleged health benefits (Churchill, Owen, Singh, & Hotopf, 2007), mainly targeting service users with 'need for treatment profiles' rather than those who were considered as posing risks to others (Hiday, 2003).

CTOs and their use in England and Wales

CTOs were introduced in England and Wales in 2007. Their purpose is to allow eligible service users to be safely treated in the community, rather than under hospital detention, to prevent relapse and any associated harm to the person or others (DoH, 2008a). With regard to their implementation, only service users who are detained in hospital for treatment can be placed on a CTO (DoH, 2008b). The service user needs to agree to the CTO and accept a number of conditions (DoH, 2008a) but maintain the right to appeal against the order. If CTO recipients do not comply with the attached conditions or there are concerns they are relapsing, they may be recalled to hospital (DoH, 2008b). Periods of renewal are six months in the first instance and subsequently every 12 months. Service users may be discharged from their CTO by their responsible clinician or a mental health review tribunal.

Evidence base for CTOs

There have been numerous studies examining CTOs' effectiveness internationally, and this research has been systematically reviewed by Dawson (2005) and Churchill et al. (2007). Dawson's review identified several negative aspects of CTOs including, a strong focus on medication, difficulties accessing alternative care and a tendency to become long-term. However, a number of benefits were also identified, such as improved treatment adherence and reduced hospitalisation rates. Churchill et al. (2007) reported that there was inadequate evidence that CTOs were effective in reducing hospital readmissions and length of hospital stay or in improving treatment adherence. Their review suggested possible improvements in contact with services but the overall evidence on the direct effects of CTOs on service users appeared inconsistent. Nevertheless, CTO recipients have been consistently found to share a number of characteristics that is, adult males, diagnosis of schizophrenia or serious affective disorder, history of readmissions, non-compliance with treatment and complex aftercare needs. Churchill's review suggested that it would appear problematic to generalize from the findings of the reviewed studies due to methodological limitations and variations in healthcare contexts into which CTOs' effectiveness had been examined.

Two randomized controlled trials (RCTs) have been conducted to examine CTOs' effectiveness. The New York study (Steadman et al., 2001) did not find any significant differences between the CTO and control groups in number of hospital admissions, overall duration of hospitalization, compliance with treatment and quality of life. The North Carolina study (Swartz et al., 1999) also found no significant difference in readmission rates between those on CTOs and the control group. However, a secondary analysis revealed reductions in the number of readmissions and overall duration of hospitalisation for participants who received CTOs for more than six months and regular clinical contact (approximately weekly). Both studies however, had a number of methodological problems. A Cochrane

review (Kisely, Campbell & Preston, 2006) concluded that the existing evidence on the effectiveness of CTOs was inconclusive. A UK-based RCT, the Oxford Community Treatment Order Evaluation (OCTET), is currently underway and its main aim is to examine the effectiveness of CTOs on health service and service user outcomes (Molodynski, Rugkasa & Burns, 2010).

Ethical issues

CTOs continue to provoke controversy in most of the countries which have adopted them (O'Reilly, 2004). Advocates of CTOs argue that they are less restrictive compared to hospitalisation (Pinfold & Bindman, 2001) and create a necessary period of stability for service users to experience the positive effects of sustained treatment (Dawson & Burns, 2008). Those supporting CTOs further argue that a CTO regime that is properly regulated is no less justifiable than the use of compulsory in-patient care provided that specific safeguards exist (O' Reilly et al., 2003). It has also been suggested that CTOs should mainly target the 'revolving door syndrome' since there is evidence that clinicians in Australia and U.S.A have successfully managed to direct their involuntary out-patient schemes towards this service user group (Dawson, 2005).

Opponents of CTOs have expressed concerns that CTOs are ethically unacceptable because of potential infringement of service users' human rights (Burns & Goddard, 1995), may be extended for prolonged periods (McIvor, 1998) and could be disproportionately used with people from ethnic minorities (Lawton-Smith, 2008). Other concerns include CTOs' focus on medication which is not always effective and could also produce harmful side-effects (Bean & Mounser, 1994).

Service users' perceptions of CTOs

A number of qualitative studies exploring service users' perceptions of compulsive community treatment have been mainly reported from the U.S.A, Australia and New Zealand. In the majority of these studies, services users expressed mixed and often ambivalent views about CTOs (Swartz & Swanson, 2004). Several qualitative studies reported that service users experienced CTOs as coercive (Gibbs et al., 2005); as involving continuing medication and medication side-effects (McDonnell & Bartholomew, 1997); as entailing stigma and restrictions in decision-making capacity (Gibbs, Dawson, Forsyth, Mullen & Tonu Tanga, 2004) and as being maintained for too long (Atkinson, Garner, Gilmour & Dyer, 2002). However, many service users also pointed out that CTOs offer freedom (Gibbs, Dawson & Mullen, 2006), provide security (Canvin, Bartlett & Pinfold, 2002) and gave them the opportunity to be discharged from hospital into community care (Power, 1999). A substantial number of service users expressed neutral views about CTOs (e.g. Canvin, Bartlett & Pinfold, 2002).

Impact of CTOs on service users' relationships

There is consistent evidence suggesting that individuals with schizophrenia are more likely to have substantially smaller social networks than the general population (Albert, Becker, McCrone & Thornicroft, 1998). A number of studies have also shown that smaller social networks or lower social support in service users with schizophrenia are associated with poorer treatment outcomes and increased use of in-patient psychiatric services (Sherbourne, 1988). In addition, psychotic service users often perceive involuntary hospitalisations as traumatic experiences (Morrison, Bowe, Larkin & Nothard, 1999) and it has been suggested that the combination of experiencing positive psychotic symptoms and enduring distressing life events may often lead to sub-optimal coping responses such as social withdrawal and reluctance to seek support when needed (Phillips, Francey, Edwards & McMurray, 2009).

Churchill et al. (2007) reported that the majority of CTO research has focused on health service outcomes and recommended that service user outcomes, such as quality of life, perceived coercion and social support, should be prioritised in future research. There has also been particularly limited research in relation to the impact of CTOs on service users' interpersonal relationships (Churchill et al., 2007) and findings from available studies were mixed. It has been reported that CTOs contributed to improved social functioning, in terms of family (Muirhead & Harvey, 2000) and community relationships (New York State Office of Mental Health, 2005). However, a more recent study found no impact of CTOs on service users' frequency of contact with their families (Ingram, Muirhead & Harvey, 2009). Family members also tended to express mixed views about CTOs (Mullen, Gibbs, & Dawson, 2007). There is more consistent evidence suggesting that CTOs have no adverse effects on service users' relationships with clinicians (e.g. Gibbs, Dawson, Ansley & Mullen, 2005).

Theoretical underpinnings

There is a lack of literature attempting to explain service users' responses to compulsory community treatment from a psychological perspective (Canvin, Bartlett & Pinford, 2002). One psychological theory that might help to explain service users' responses to CTOs is locus of control (LoC) (Rotter, 1966). This theory refers to the extent to which people perceive events in their lives as resulting from internal factors (internal control) or environmental causes (external control) (Rotter, 1990). Research on LoC with psychiatric samples has demonstrated that individuals with psychosis showed a more external LoC compared to other psychiatric diagnostic groups (Hansford, Harrow, Groen, Kaplan, & Faull, 2004). There is also evidence that a more internal LoC increases the chances of recovery in schizophrenia (Hoffman & Kupper, 2002). These findings might be relevant to CTO recipients who typically present with psychosis or serious affective disorders (Churchill et al., 2007). Service users' responses to CTOs might be influenced by their LoC and also CTOs might have a different impact on

service users' psychological functioning depending on their LoC. For example, placing service users with an external LoC on a CTO is likely to reinforce their beliefs that they are not in control of their treatment, and therefore feel acceptable, but may prevent them from developing a more internal LoC which is associated with better outcome. Furthermore, although CTOs might have beneficial short-term effects by stabilizing service users' psychological functioning, long-term adverse effects may occur for service users with an external LoC because they will prevent them from taking a more active role in managing their difficulties.

Adult attachment theory might also be able to explain service users' responses to CTOs. While this theory was developed from observations of infants and their caregivers, attachment relationships and attachment styles continue to have an enduring effect throughout the life-cycle (Bowlby, 1982). Researchers have found increasing evidence that supports the concept of adult attachment and how 'secure' and 'insecure' attachment styles influence interpersonal functioning in adulthood (Ma, 2006). Its relevance to the study of severe mental health conditions is supported by evidence of high levels of attachment insecurity in service users diagnosed with schizophrenia (Dozier, Stevenson, Lee & Velligan, 1991). Given the above evidence, service users' adult attachment styles are likely to influence their responses to CTOs and their interpersonal relationships. For example, placing service users with high levels of insecure attachment on a CTO might result in conflicted responses depending on their adult attachment styles (Mikulincer & Florian, 1998). Furthermore, applying a CTO to service users with insecure attachment styles and related interpersonal difficulties might result in a negative perception of their treatment because they will be more likely to feel isolated in the community. However, for service users with more secure attachment styles, the option of a CTO might be preferable if they have adequate support networks and are keen to return to the community.

Summary

CTOs were introduced in England and Wales in 2007 despite insufficient evidence supporting their effectiveness (Churchill et al., 2007). In addition, service users appear uncertain about whether the negative effects of CTOs are outweighed by their benefits (Swartz & Swanson, 2004). The introduction of CTOs has been highly controversial and continues to provoke debate among mental health professionals (Woolley, 2010). Locus of control and adult attachment theories may offer ways to understand service users' responses to CTOs.

Research rationale

The majority of research on CTO effectiveness has focused on health service outcomes and there has been limited and inconsistent evidence regarding the direct effects of CTOs on service user outcomes such as quality of life, social support and levels of perceived coercion (Churchill et al., 2007). Moreover, most of available evidence in relation to service users' perceptions of CTOs comes from qualitative studies conducted outside UK (Gault, 2009) and is likely to have been influenced by local context. There has also been limited literature about the impact of CTOs on service users' interpersonal relationships (Ingram, Muirhead & Harvey, 2009). This is surprising given existing evidence suggesting that smaller social networks or lower social support for service users diagnosed with schizophrenia are associated with poorer treatment outcomes and increased use of in-patient psychiatric services (Sherbourne, 1988). This link might be particularly relevant to CTO recipients because: i) they typically present with psychotic symptoms and histories of hospital admissions (Churchill et al., 2007), and ii) there is evidence suggesting individuals with psychosis tend to have substantially smaller social networks than the general population (Albert et al., 1998). Therefore, further research into service users' perceptions of CTOs in the UK would address a literature gap and qualitative research methods could prove valuable in

developing an in-depth understanding of how service users perceive CTOs and explore their impact on service users' relationships.

Study objectives

The study has the following primary and secondary objectives:

Primary research objective: To develop a theoretical explanation about how service users perceive CTOs and their subjective impact on their relationships with family, friends, partners and local communities.

Secondary research objectives: To explore service users' perceptions and whether they have changed since being placed on CTOs, about: i) medication, ii) mental health professionals, iii) self and mental health difficulties.

Methodology

Participants

The study's inclusion criteria were: being a male; being on a CTO for a minimum of three months; aged 18-65; good English spoken; complying with the CTO conditions; being able to give consent to participation in the study. Exclusion criteria were: posing current risk to self or others and current distressing psychotic experiences. Only male service users were included due to evidence that the majority of CTO recipients are males (Churchill et al., 2007) and in addition to increase the sample's homogeneity. Participants had to be on a CTO for a minimum of three months to ensure that they had had adequate time to settle in the community and get used to their treatment regime.

The participants were 15 British male service users, aged 26-55 years, who were currently receiving care from a NHS Trust based in an urban area in London. In terms of their living arrangements in the community, seven lived in supported accommodation and eight independently in flats. Eight

participants reported histories of drug or alcohol misuse problems. Most of the participants were unemployed at the time of the interviews. One was working as a volunteer and two were attending college courses. Participants' demographic details are presented in Table 1.

Table 1. Participant demographic information

PSEUDONYM	AGE	ETHICITY	HERITAGE	DIAGNOSIS	LENGTH OF TIME ON CTO
John	29	White British	British	Paranoid schizophrenia	12 months
Paul	26	Black British	Caribbean	Paranoid schizophrenia	4 months
George	49	White British	British	Schizophrenia	2 years
Keith	42	White British	British	Paranoid schizophrenia	10 months
Bob	42	Black British	African	Bipolar disorder	5 months
Mick	28	Black British	Caribbean	Paranoid schizophrenia	7 months
Marvin	34	Black British	African	Schizophrenia	7 months
Mark	30	Other British	Turkish	Schizophrenia	3 years
Bill	35	Black British	Caribbean	Paranoid schizophrenia	4 months
Marlon	36	Black British	African	Paranoid Schizophrenia	3 years
Mani	55	White British	British	Schizophrenia	2 years
Simon	47	White British	British	Paranoid Schizophrenia	5 months
Miles	32	White British	British	Paranoid schizophrenia	16 months
Art	52	White British	British	Paranoid schizophrenia	4 years
Vinnie	34	Other British	Indian	Paranoid schizophrenia	6 months

Design and method

This study was a non-experimental, within-group design using a qualitative methodology. Semi-structured interviews were conducted to facilitate generation of rich data. The interview data were analysed using grounded theory (GT; Glaser & Strauss, 1967), which was identified as a suitable method because “it is designed to facilitate theory generation” (Willig, 2001; p.32). Furthermore, GT seemed ideally suited for this study because it provides a systematic and emergent understanding of psychological processes (Henwood & Pidgeon, 2003) and ensures rigour and control of subjectivity when analysing data (Mays & Pope, 1995).

The data analysis was positioned within a critical realist framework, assuming that real events occur but “each person experiences and gives meaning to events in light of his or her own biography or experiences, according to gender, time and place, cultural, political, religious and professional backgrounds” (Corbin & Strauss, 2008, p.10).

Ethics

Ethical approval was obtained from the London-Surrey and Borders Research Ethics Committee and relevant Research and Development department (Appendix 1).

Procedure

Suitable service users were identified from administrative staff responsible for managing the databases of CTO recipients within the NHS Trust. The researcher was given the contact details of their care coordinators and an e-mail was subsequently sent asking to refer clients who may be willing to take part in the study. The e-mail sent also contained a summary of the study’s rationale and aims. Potential participants were informed that they had two weeks to decide whether to take part. Service users who agreed to participate gave their verbal consent to be contacted by the researcher. Their care coordinators then informed the researcher about their clients’ decision and briefly discussed their current clinical presentation, risks issues and capacity to consent. Following this, the researcher made contact and arranged interviews. Participants’ responsible clinicians were also sent letters informing them about their clients’ decision to take part in the study (Appendix 2). All interviews took place in NHS clinical settings (e.g. local community mental health centres). Before the interview, the researcher provided participants with information about the study, i.e. via going through with them the Participant Information Sheet (Appendix 3), and were subsequently asked to provide written consent by completing a form (Appendix

4). Interviews lasted between 20 and 50 minutes and were audio-recorded before being transcribed for analysis (see Appendix 5 for an example of a transcribed interview).

Interview schedule

The interview schedule (Appendix 6) was developed with the research supervisors; a consultant clinical psychologist with a strong research interest in CTOs and extensive experience in psychosis and a researcher with similar experience in the area of psychosis. The selected questions covered the following areas: respondents' perceptions of their CTOs and whether CTOs had any impact on their relationships with friends, family, partners and local communities. Questions also covered respondents' views of the above relationships prior to the onset of their CTO. Additional questions included participants' past and present views of self and mental health, medication and mental health professionals. The interview schedule was discussed with Salomons Advisory Group of experts and piloted with one CTO recipient. Interviews were semi-structured.

Data analysis

Data analysis was conducted in line with the methods described by Corbin and Strauss (2008) and Charmaz (2006). The iterative process of data analysis, as described by Corbin and Strauss, involved continually comparing raw data and emergent concepts. Initially, all interviews were coded line-by-line and memos were written concurrently (see Appendix 7 for memos excerpts). When using GT, data synthesis involves concurrent data collection and analysis, using concepts generated from earlier data to guide more focused collection of data, as the researcher seeks to saturate categories; a process called theoretical sampling (Corbin & Strauss, 2008). For this study, due to difficulties in arranging gaps between interviews, it was not always possible to analyse each interview and also look for emergent concepts before moving to the next one. After conducting the first eight interviews and completing their

initial coding, a more conceptual coding began, attempting to represent larger blocks of raw data. As soon as initial categories were established, axial coding was used to connect them with emergent concepts. Data was repeatedly compared within and between initial categories and new categories continued emerging. After completing the axial coding of the first set of data, a more focused conceptual coding of each of the remaining seven interviews was conducted. Finally, when it was established that no new concepts were emerging, the identified concepts were organised into a number of categories and subcategories. These were scrutinised in great detail and higher order categories developed, which were then shifted and sorted in different ways until they appeared to create a meaningful storyline (i.e. selective coding). Re-reading existing memos and creating diagrams proved invaluable to the final integration of the identified concepts.

Quality assurance

Elliot, Fischer and Rennie's (1999) guidelines were followed throughout the study, to assure quality assurance control. In order to ensure reflexivity, research supervisors were consulted during data collection and analysis and a reflective diary (Appendix 8) was kept. Although respondent validation (Henwood & Pidgeon, 2003) was not addressed due to participants' unavailability, the research supervisors judged the accuracy of the main categories and ensured that the author's preconceptions were examined and their potential influence on the results was addressed. To further increase credibility of the findings, a research supervisor coded a transcript extract and all interviews were coded line-by-line.

Results

The model presented here illustrates the researcher's understanding of how service users perceive their CTOs and their perceived impact on their relationships. The first higher-order category presented in this model is 'Perception of CTO' and consists of four categories i.e. four different CTO perceptions. Three higher-order categories follow: 'Past and present social living conditions', 'Perception

of self and mental health’, and ‘The CTO service’, which represent the group of factors which were found to influence participants’ perceptions of their CTOs. Finally, the last higher-order category, ‘Community relationships’, represents participants’ views of their relationships with their families, friends, partners and local communities and how they have been affected by CTOs. An overview of the model is presented at the end of this section and is also depicted in Figure 1 (further below). Throughout this section, quotes are provided to illustrate identified subcategories and pseudonyms are used to protect participants’ real-life identities. Due to the word limitations, it was not possible to provide quotes for every subcategory (see Appendix 9 for further quotes).

1. Higher-order category: Perception of CTO

The analysis identified four categories which distinguished the different participants’ perceptions of CTOs. These categories are summarised in Table 2.

Table 2. Categories and subcategories representing participants’ perceptions of CTOs

Categories	Subcategories
CTO as ‘beneficial’	<ol style="list-style-type: none"> 1. Providing more freedom compared to hospitalisation 2. Providing opportunities for socialising 3. Providing opportunities for leisure 4. Providing accommodation 5. Contributing to stable mental health 6. Providing a sense of normality 7. Increasing motivation 8. Improving independent living skills
CTO as a ‘safety net’	<ol style="list-style-type: none"> 1. Monitoring mental health 2. Providing structure 3. Keeping patients away from trouble
‘Neutral’ about CTO	<ol style="list-style-type: none"> 1. Staying out of hospital 2. Set of rules to follow
CTO as a ‘burden’	<ol style="list-style-type: none"> 1. Restrictive 2. Punishing 3. Ineffective 4. Psychologically damaging

1.1 CTO as ‘beneficial’

Three of the 15 participants viewed their CTO as ‘beneficial’. They all experienced it as providing more freedom compared to hospitalisation: *“I find it very helpful now that I am out of hospital, it’s much better for my freedom...”* (Miles). These service users appreciated having accommodation in the community and stated that their CTO gave them a sense of normality. Other advantages identified were more opportunities for leisure activities and socialising: *“I can paint, I can play music for the whole night, smoke cigarettes, meet with my mates...actually a life of great leisure”* (Art). These participants added that being on a CTO contributed to more stable mental health, increased motivation and improved independent living skills.

1.2 CTO as a ‘safety net’

Five of the 15 participants experienced their CTO as providing safety. They valued the protection it offered in terms of having health professionals monitoring their mental health (Mark: *“...services are taking a close relationship with the patients when they are in the community to make sure that they don’t relapse...”*). This group of service users felt vulnerable living in the community and valued the structure their CTO offered (Mark: *“Basically it gets you to do things, when you wouldn’t do anything, basically I attend my appointments, adhere to medication, so my mental health has improved...”*).

1.3 ‘Neutral’ about CTO

Four of the 15 participants appeared ‘neutral’ about their CTO, viewing it as a set of rules to follow (John: *“... my life is pretty much the same, CTO hasn’t really done great wonders in my life; I just have to follow some rules”*). This group of service users showed little understanding of what their CTO

involved and what seemed to matter to them was that they were out of hospital: “...*the only difference is I am not in hospital*” (Marvin).

1.4 CTO as a ‘burden’

Three of the 15 participants expressed negative views about their CTO. They viewed it as restrictive and felt punished for having to comply with the conditions to stay out of hospital (Vinnie: “*I think it is an infringement of my personal liberties*”). Those service users also experienced CTOs as ineffective (Bill: “*It’s not helpful because they are not doing anything for us...and they are claiming they are doing something for us...*”) and two of them felt that their CTOs had a detrimental effect on their mood.

2. Higher-order category: Perception of self and mental health

The analysis also identified different participants’ perceptions of themselves and their mental health, as falling into one of four categories. These categories are summarised in Table 3.

Table 3. Categories and subcategories representing participants’ perceptions of self and mental health

Categories	Subcategories
Self as ‘vulnerable’	<ol style="list-style-type: none"> 1. Vulnerable due to unstable mental health 2. Vulnerable due to lack of support systems 3. Vulnerable due to medication side-effects 4. Vulnerable due to stigma 5. Vulnerable due to demands of community life
Self as ‘moving towards recovery’	<ol style="list-style-type: none"> 1. Managing difficulties well with current treatment And living arrangements 2. Feeling stable due to natural processes
Self as ‘not needing treatment’	<ol style="list-style-type: none"> 1. Having recovered due to self-determination 2. Having recovered due to natural processes
Self as ‘never had mental health difficulties’	<ol style="list-style-type: none"> 1. Always have been mentally well 2. Having difficulties of a different nature

2.1 View of ‘self as vulnerable’

The group of participants who perceived their CTO as a ‘safety net’ viewed themselves as ‘vulnerable’. They reported experiencing unstable mood and/or psychotic symptoms, despite the fact they were taking their medication: *“I don’t feel any difference at all by taking the medication...I still suffer from paranoia, I still hear voices...”* (Keith). Two of them felt vulnerable due to medication side-effects: *“...I don’t get erection, I cannot flirt with girls, so, I won’t get better quicker, faster, so I can do something with my life...”* (Simon). Other factors that appeared to increase the remaining three participants’ feelings of vulnerability were lack of support systems, stigma and having to deal with the demands of community life.

2.2 Self as ‘moving towards recovery’

The group of participants that perceived their CTOs as ‘beneficial’ viewed themselves as ‘moving towards recovery’. These service users reported improved mental health and were optimistic about the future: *“I find it much more peaceful with myself...I just feel like things are moving on, I feel much better with myself”* (Miles). Two of these individuals attributed their improved mental health to adhering to their treatment while one believed that it was due to natural processes. These participants valued their current living arrangements and felt they were leading active lives in the community: *“I live at home, I do my occupation, I don’t need permission to be in and out of hospital, I cook, clean, live an active life...”* (Art).

2.3 Self as ‘not needing treatment’

The group of participants that appeared ‘neutral’ about their CTO admitted having mental health difficulties in the past but they currently believed they had recovered: *“I reached the end of my mental health, I don’t feel paranoid, I don’t feel threatened, I don’t feel psychotic...”* (Marvin). These service users attributed their recovery either to their self-determination or to natural processes.

2.4 Self as ‘never had mental health difficulties’

The participants who perceived their CTO as a ‘burden’ believed that they never had mental health difficulties and two of them felt that their past or current difficulties were of a different nature, e.g. physical. One participant believed that he had suffered a ‘break down’ in the past but felt he had overcome it: “...I don’t have any mental health difficulties. But when I was on that 9-month binge 11 years ago, when I was taking a lot of Class A drugs... that caused me to have audio and visual hallucinations...” (Vinnie). These respondents felt that their diagnoses were not applicable to them.

3. Higher-order category: Past and present social living conditions

The categories which were developed about participants’ experiences of their past hospitalisations and current community living arrangements will be summarised in Table 4.

Table 4. Categories and subcategories representing participants’ past and present social living conditions

Categories	Subcategories
Experience of hospitalisation	<ol style="list-style-type: none"> 1. Restricting freedom 2. Beneficial under specific conditions 3. Having adverse effects on health 4. Contributing to stable mental health 5. Safety net 6. Step backwards
Experience of community living arrangements	<ol style="list-style-type: none"> 1. Better alternative to hospitalisation 2. Sign of improvement 3. Providing opportunities for socialising 4. Helpful with medication adherence 5. Providing freedom 6. Not providing structure 7. Anxiety provoking 8. Contributing to better quality of life 9. Contributing to stable mental health 10. Feeling neglected 11. Feeling indifferent

3.1 Experience of hospitalisation

Ten out of the fifteen participants viewed their past hospitalisations as restrictive: “... *you can't get out, you can't do anything, I would be stable for the first weeks, I would then start building up my leave over time, but they can cancel your leave if they want, I didn't agree with that*” (Marlon). Six participants also referred to their past hospitalisations as ‘steps backwards’ which had negative effects on their psychological functioning: “*You lose your freedom. It's very depressing and psychologically damaging for an individual*” (Vinnie). Furthermore, two respondents found hospital admissions more appropriate for service users who posed risk to themselves or others (John: “...*same putting someone in hospital, again I can understand if they are violent or if they are gonna hurt themselves...*”). It's noteworthy that the participants who perceived their past hospitalisations as restrictive were the service users who were ‘neutral’ about their CTOs as well as those who viewed them as ‘beneficial’ and as a ‘burden’. Participants who viewed their CTOs as ‘beneficial’ held less negative views about their past hospitalisations compared to the other two groups.

The participants who perceived their CTOs as a ‘safety net’ viewed hospitalisations as providing good quality of care and as contributing to more stable mental health: “...*coming to hospital is always helpful, you get fed, there are clean clothes, clean room...perhaps they should consider it to be part of the healing*” (Mark). Furthermore, three respondents from this group viewed hospital admissions as providing safety which helped them with medication adherence and drugs or alcohol misuse problems: “*Because they can look after me and I won't be able to take drugs, and the medication would be more effective without drugs, I know the meds will be there on time*” (Simon).

3.2 View of community living arrangements

Apart from the participants that viewed their CTOs as a ‘safety net’, the rest perceived their community living arrangements as a better alternative to hospitalisation. Service users who viewed their CTOs as ‘beneficial’ believed that living in the community was a sign of improvement and two of those who lived in supported accommodations added their placements supported them with medication adherence, benefited their mental health and made them more active and sociable: *“I feel better with myself, I made a lot of friends here, I can go out every day of the week.... I go swimming, I do art, groups...”* (Miles). Nevertheless, most of the participants who were ‘neutral’ about their CTOs or those who viewed them as a ‘burden’ also reported benefits in relation to their community living arrangements. They stated that they offered them freedom and more opportunities for socialising and leisure activities: *“...cause I am back to the free world again...I can visit my friends more, they can visit me, we can do that in hospital but it’s not the best environment”* (Vinnie). Some of the participants who belonged to those two groups appeared indifferent about their community living arrangements.

Participants who viewed their CTOs a ‘safety net’ did not appear pleased with their community living arrangements. Most of them felt neglected and preferred staying in hospital where they received better care: *“...but it’s not like hospital, when you have a problem you cannot get anything soon”* (Bob). Furthermore, these service users often felt vulnerable and anxious: *“it’s been going from worse to the worse...that’s why I said I feel vulnerable when I am on the outside”* (Simon). They also tended to report that they had no daily structure while living in the community.

4. Higher-order category: The CTO service

Participants expressed views about four aspects of the CTO service and these are summarised in Table 5.

Table 5. Categories and subcategories representing participants’ views of the CTO service

Categories	Subcategories
View of medication	<ol style="list-style-type: none"> 1. Involving harmful side-effects 2. Means of social control 3. Ineffective 4. Necessary to avoid relapse 5. Contributing to stable mental health
View of psychiatrist	<ol style="list-style-type: none"> 1. Understanding 2. Helpful with hospital discharge 3. Not empathetic enough 4. Hiding information from service users 5. Neutral view 6. Not supportive enough
View of care coordinator (CC) and psychologists	<ol style="list-style-type: none"> 1. CC as helpful with practical tasks 2. CC as not understanding 3. CC as main source of support 4. Neutral about CC 5. Psychology as providing space for discussion 6. Psychology as ineffective 7. Unsure about effectiveness of psychology

4.1 View of medication

All participants were currently taking medication but held a variety of views about it. Service users with ‘neutral’ CTO views and those who viewed them as a ‘burden’ perceived medication as involving harmful side-effects (Vinnie: *“Some of them are known to make you really fat, some of them are known to make you really lazy”*), while everyone apart from the group that viewed their CTOs as ‘beneficial’, stated that medication had so far proved ineffective in treating their difficulties (Bob: *“I still have my problems, and they’ll never gonna go away with the sort of help that is on offer”*). Most of the service users who viewed their CTOs as a ‘burden’ perceived medication as a means of social control (Paul: *“I don’t know why people want other people to be subdued in such a way, you know easier to control, easier to fit in line”*). Those with negative views of medication reported that they were currently compliant to avoid going back to hospital. However, participants who viewed their CTOs as ‘beneficial’ or as a ‘safety net’ believed that medication contributed to stable mental health and viewed it as necessary

to avoid relapse: “...*the medication helps me stabilise my mood and my tempo and the voices, the medication stabilises all those feelings*” (Mark).

4.2 View of psychiatrist

Participants who were ‘neutral’ about their CTOs tended to hold more neutral views about their psychiatrists, reporting that since their CTO started they had hardly seen them (John: “*I never see him; I’ve never seen him since I left hospital, four months now*”). Participants who viewed their CTO as ‘beneficial’ believed that their responsible clinicians were understanding and appeared appreciative that they helped them leave hospital: “*He tends to listen...we get along very well, he helped me to get into the CTO in the first place. Otherwise I would still be in hospital now*” (George). Service users who perceived their CTO as a ‘burden’ viewed their psychiatrists as not empathetic (Bill: “*I find them utterly patronising and they have no sense of social norms*”). The participants who viewed their CTO as a ‘safety net’ felt that their clinicians were not supportive enough and one of them believed they were hiding information from him: “*That’s why I am telling you, they are hiding something; he said he wasn’t my psychiatrist when I last saw him*” (Simon).

4.3 View of care coordinator and psychologist

Participants who perceived their CTOs as ‘beneficial’ and most of those who viewed them as a ‘safety net’ found their care coordinators helpful, especially with practical issues: “*We get on well; sometimes he takes me to the hospital for my blood tests, very good working relationship*” (Keith). Three of those who viewed CTOs as a ‘safety net’ experienced their care coordinators as their main source of support. However, the remaining two perceived them at times as not understanding, adding that they often put pressure on them to engage in activities they didn’t want to (Keith: “*My CPN, he is always pressurises me to get into an activity, he doesn’t understand that I feel paranoid when I am around people...*”).

Participants who were ‘neutral’ or viewed their CTO as a ‘burden’ appeared indifferent about their care coordinators, stating they had a formal relationship.

Only two of the 15 participants reported receiving regular psychological input and both of them viewed their CTOs as ‘beneficial’. These participants stated that their therapists provided them with space to explore their difficulties (Miles: *“I suppose... the psychologist I see, she sits down and listens to me... which is good...”*). Respondents who held ‘neutral’ views of their CTO or those who viewed them as a ‘burden’ expressed doubts regarding the usefulness of seeing a psychologist while most of those who perceived their CTOs as a ‘safety net’ felt that psychological input was ineffective. (Keith: *“I don’t feel that counselling has helped me too much...it’s not really made any drastic returns into my way I am feeling”*).

5. Higher-order category: Community relationships

Participants’ perceptions of their relationships in the community related to two groups of people and these categories of community relationships are summarised in Table 6.

Table 6. Categories and subcategories representing participants’ views of their community relationships

Categories	Subcategories
Family and intimate relationships	<ol style="list-style-type: none"> 1. More frequent family contact since CTO 2. Limited family contact due to difficult relationship or distance 3. Lack of family contact due to difficult relationship or other reasons 4. Improved relationship with partner since CTO 5. Lack of partner due to stigma
Relationships with friends and local community	<ol style="list-style-type: none"> 1. Lack of friends 2. Limited contact with friends 3. Difficulty forming new friendships while on CTO 4. More frequent contact with friends since CTO 5. Lack of or limited close friendships 6. No contact with local community 7. Limited contact with local community

5.1 Family and intimate relationships

Ten participants reported lack of or limited contact with their families adding that CTOs had made no impact on their family relationships. Two reported lack of family contact because their parents had passed away while three were not in contact with their families due to living far from them: *“I really don’t see much of my family, my mother lives in Place X, and my brother lives in Place Y, I haven’t seen them for a few years...”* (Keith). The remaining five participants reported that they had limited or no contact with their families due unstable and difficult relationships. However, the participants who perceived their CTOs as ‘beneficial’ and two who were ‘neutral’ about them reported that since the onset of their CTO they had been in more regular contact with their families: *“I see my mum every day at work, I pop to her work to see her”* (Miles). Only one of the 15 participants was married and reported that since he was placed on a CTO his relationship with his partner had improved. However, the rest of the respondents were single and five of them attributed this to the stigma attached to their diagnoses: *“Maybe the mental health services put you in a category in society whereby you know, girls are not attracted to you because you are thought in a certain way”* (Mark).

5.2 Relationships with friends and local community

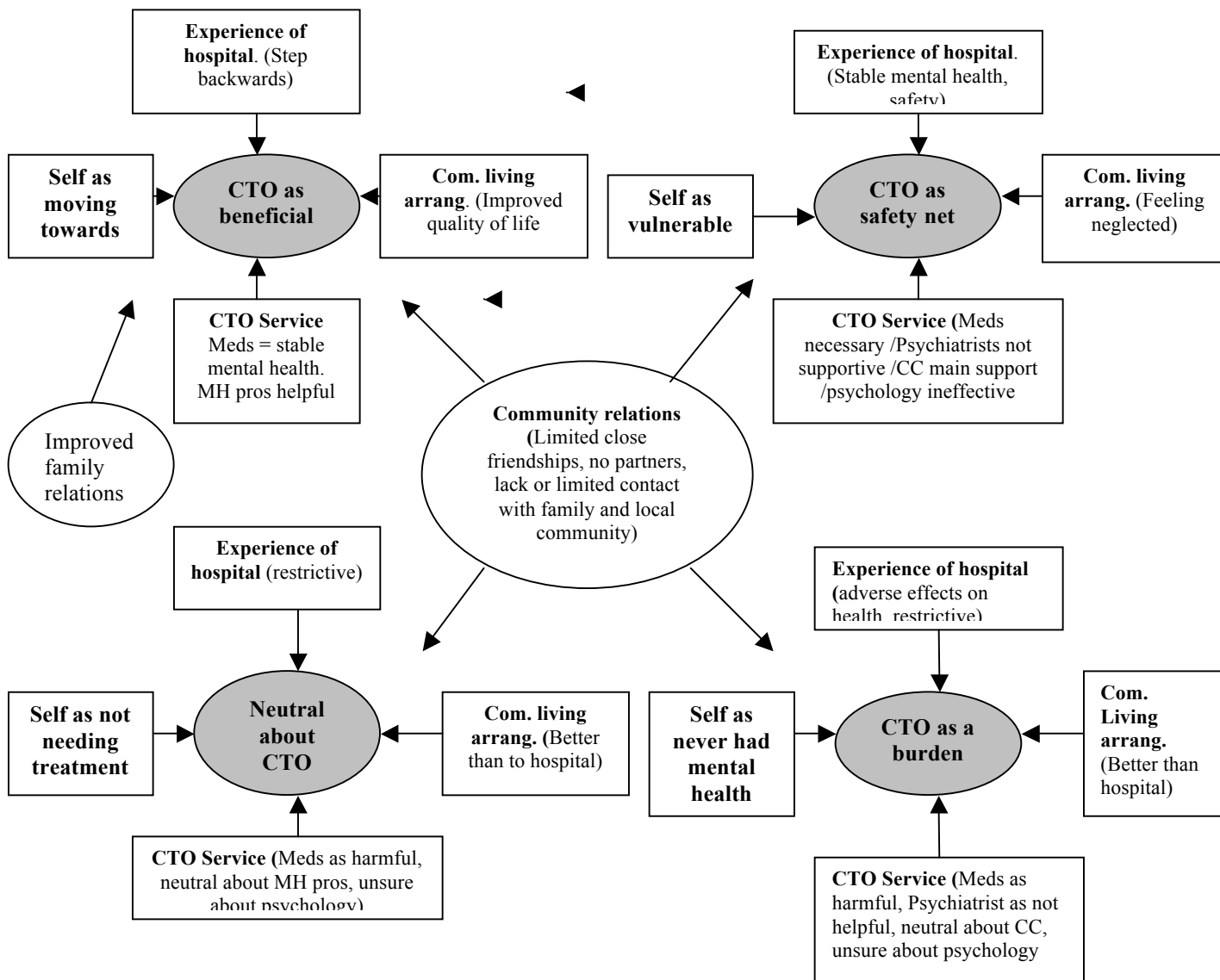
Six participants reported being in more regular contact with their friends since they moved back to the community. However, 11 out of the 15 participants stated they had limited or no close friendships and added that CTO had made no impact on their community relationships (Manny: *“...No close friends, not really, just acquaintances, I drink sometimes with them”*). Four participants describe how it was difficult to form new relationships while on a CTO. It’s noteworthy, that participants who viewed their CTO as a ‘safety net’ tended to report feeling isolated in the community (Mark: *“I have no friends, everybody tries to use me... I am by myself”*). Most of the participants reported limited

relationships with their local communities. Only two respondents of African origin stated they were in regular contact with their local communities.

Overview of model

Conceptual analysis of relationships between the categories-subcategories contained in the higher-order categories, 'past and present social living conditions', 'perception of self and mental health' and 'the CTO service', suggested four 'participant profiles' where each appeared to lead to a specific CTO perception. It is worth noting that participants' views of themselves in relation to their mental health were directly linked with specific perceptions of CTOs. However, the majority of participants (with the exception of those who viewed CTOs as a 'safety net') held more similar views about past and present living conditions. Participants' views of the 'CTO service' were more or less consistent with their overall perceptions of their CTOs. Finally, the results showed that CTOs had limited or no impact on participants' community relationships. Only participants who perceived their CTOs as 'beneficial' reported improved family relationships. Each one of the identified 'participant profiles' is presented in Figure 1.

Figure 1. Diagram illustrating the four participant profiles leading to specific CTO perceptions and CTOs' perceived impact on relationships



Discussion

This study aimed to develop a theory to better understand how service users perceive their CTOs and explore their subjective impact on service users' relationships. Participants expressed a variety of views, from fierce opposition to strong support for CTOs, replicating findings of previous qualitative studies conducted both in the UK (e.g. Canvin, Bartlett & Pinfold, 2002) and in other countries (e.g. Gibbs, Dawson, Ansley & Mullen, 2005; McDonnell & Bartholomew, 1997). Nevertheless, a distinctive aspect of this study was that all participants appeared to hold consistent views about their CTOs, unlike previous qualitative studies where participants often expressed ambivalent and sometimes contradictory views about their treatment orders. More specifically, four different perceptions of CTOs were identified. Three participants viewed their orders as 'beneficial' and identified several gains such as having more freedom compared to hospitalisation, better quality of life and more stable mental health. Five respondents experienced their CTOs as a 'safety net', reporting that their orders provided them structure and safety. Three participants perceived their CTOs as a 'burden', reporting that their treatment regime was coercive and punishing. Finally, four participants appeared neutral about their CTOs, perceiving them as a set of rules they had to follow to remain out of hospital. The pattern of 'CTO perceptions' observed in this study appears comparable to those of similar qualitative studies conducted both in the UK (e.g. Cault, 2009; Canvin, Bartlett & Pinfold, 2002) and in other countries where CTOs have been used (Gibbs et al., 2005; O' Reilly et al., 2006).

Findings suggested that the following factors appeared to influence participants' perceptions of their CTOs: i) experience of past hospitalisations and perceptions of community living arrangements, ii) view of self in relation to mental health, iii) perceptions of the CTO service, i.e. view of medication and mental health professionals. Participants associated with each of the identified four perceptions of CTOs appeared to have different profiles based on their views of these factors. One factor that appeared to be

crucial in determining participants' perceptions of their CTOs was how they viewed themselves in terms of their mental health difficulties. Participants who viewed themselves as 'moving towards recovery' perceived their CTOs as 'beneficial'. Those who viewed themselves as 'vulnerable' experienced their CTOs as 'safety net'. The group of participants who viewed themselves as 'not needing treatment' appeared 'neutral' about their orders. Finally, those who viewed themselves as 'never had mental health difficulties' perceived their CTOs as a 'burden'. This finding is consistent with evidence suggesting that perceptions of the fairness and effectiveness of CTOs are likely to be influenced by the service users' views about their mental health difficulties and need for treatment (Swartz, Wagner, Swanson & Elbogen, 2004).

Bartholomew's (1990) model, which describes four adult attachment styles: secure, dismissing, preoccupied and fearful, might be of particular relevance. Two earlier adult attachment paradigms have described three adult attachment styles: Main, Kaplan & Cassidy (1985) named them secure-autonomous, dismissing and preoccupied while Hazan & Shaver (1987) suggested the terms secure, avoidant and anxious. Bartholomew (1990) argued that the dismissing attachment put forward by Main and colleagues and the avoidant attachment proposed by Hazan and Shaver described two different types of avoidance, which possibly have different motivations: defensive self-sufficiency and avoidance of rejection respectively. In this study, Bartholomew's (1990) proposed adult attachment styles might be linked to the four 'views of self' identified in this study. This hypothesis is also supported by evidence suggesting that different adult attachment styles can predict specific coping styles and emotion regulation methods (Mikulincer & Florian, 1998).

Participants who experienced their CTO as 'beneficial' believed that their mental health had improved and seemed confident about their recovery prospects. These service users appeared to hold more

positive beliefs about help-seeking. They appreciated mental health professionals' input, held less negative views about their past hospitalisations and acknowledged the benefits of taking medication. In addition, these individuals seemed to have maintained closer family relationships and seemed more motivated to form new relationships in the community. The hypothesis to emerge from the study is that this group had the least insecure adult attachment style compared with the rest of the participants.

Participants who experienced their CTO as a 'safety net' viewed themselves as 'vulnerable' and acknowledged the importance of taking medication to avoid relapse. They seemed preoccupied with safety, were more likely to report distress and held positive views about help-seeking. They valued past hospitalisations but held less favourable views about their current living arrangements, stating that they preferred receiving more 'intense care'. This group typically felt isolated in the community and reported limited or lack of support systems. The hypothesis is that these individuals may have a preoccupied attachment style, as described by Bartholomew (1990). This is supported by evidence suggesting that individuals with preoccupied attachment styles tend to hold more positive attitudes towards help-seeking, but despite that, they typically remain ineffective in regulating their emotions (Mikulincer & Florian, 1998).

Participants who appeared 'neutral' about their CTOs viewed themselves as having recovered from their mental health difficulties and felt they did not need further treatment. This group held negative views about help-seeking. They viewed their past hospitalisations as restrictive and perceived taking medication as ineffective. They all stated that they complied with the CTO conditions to stay out of hospital. Participants that fitted this profile described not having close friendships and often found it difficult to talk about their relationships in the community. The hypothesis is that this group of participants

are likely to have a fearful adult attachment style (of an avoidant nature) where the motivation is likely to be avoidance of rejection (Bartholomew, 1990).

Participants who viewed their CTOs as 'burden' believed they never had mental health difficulties. They viewed past hospitalisations as restrictive and found living in the community a better alternative. This group held negative views about help-seeking, viewed health professionals as unhelpful and inconsiderate and believed that medication involved harmful side-effects. They also reported that they complied with the CTO conditions to stay out of hospital. They appeared to hold positive views about themselves but their accounts revealed difficulties with emotional regulation and often fragile self-esteem. For example, when they talked about their peer relationships, their accounts often appeared contradictory, simultaneously complaining about lack of close relationships and rejecting their importance. These service users reported limited contact with family, lack of close friendships but appeared pleased with their community relationships. The hypothesis is that this group of service users may have a dismissing attachment style which typically involves overt positive self-view, avoidant coping skills and a tendency to dismiss the importance of close relationships (Bartholomew, 1990). Bartholomew & Horowitz (1991) demonstrated that persons with dismissing attachment styles typically express more hostility, tend not to report distress and are more likely to hold negative beliefs about help-seeking.

The findings in relation to participants' past and present views of their relationships with their families, partners, friends and local communities could also be explained in terms of adult attachment theory. Several participants reported ongoing interpersonal difficulties. This seems consistent with evidence that a high proportion of people with psychosis experience difficulties with interpersonal relationships (Berry, Barrowclough & Wearden, 2006). It could be that for the majority of participants,

their interpersonal difficulties are likely to be linked to insecure adult attachment styles. Nevertheless, the vast majority of participants felt that their CTO had no impact on their relationships.

LoC theory did not seem to be able to explain participants' responses to their CTOs as clearly as attachment theory. All participants appeared to have an external LoC, although not formally assessed, replicating earlier findings that individuals with a diagnosis of schizophrenia are more likely to present with an external LoC (Hansford et al., 2004). Participants in this study perceived events in their lives as caused or influenced by external factors such as significant others, illicit drugs, natural processes or 'fate'.

The theory proposed here identified a number of factors that appeared important in influencing service users' perceptions of their CTOs and also explored CTOs' perceived impact on recipients' relationships. However, our hypothesis that specific adult attachment styles can predict how service users perceive CTOs is tentative and must be treated with caution.

Limitations and research implications

The recruited sample was small and partially self-selected, which may have influenced the findings. Service users who volunteered may have had more stable mental health or held more positive views about mental health professionals. CTO recipients with less stable mental health or those who held extremely negative views about health professionals may have chosen not to take part. Furthermore, despite the variety of CTO perceptions expressed, all participants at the time of the interviews, according to their care coordinators, were complying with the conditions of their orders and seemed to have relatively stable mental health. Along with the small sample size, these factors may further limit any generalisability of the study's findings, since not all CTO recipients comply with their treatment regime or have stable mental health.

The researcher may have also exerted bias since he is likely to have been perceived by some participants as being part of the system that was subjecting them to coercion. Had the researcher identified himself as a service user rather than a trainee clinical psychologist, participants might have expressed more negative views about their CTOs or they might have talked in greater detail about the experience of receiving compulsory treatment in the community. Furthermore, with previous experience of working with service users with severe mental health conditions in the community, the researcher may have introduced a further bias, since he conducted the interviews and analysed the data. The researcher had preconceived ideas and understanding of mental health conditions such as psychosis, psycho-social community interventions and the impact of compulsion on service users' well-being which may have biased to a degree the collection, coding and analysis of the data, despite attempts to limit the impact of this bias (e.g. through regular supervision).

Attempts were made to adhere to the standard Grounded Theory procedures in order to ensure quality and limit bias. Difficulties with recruitment entailed that analysis of a large percentage of the interview data was not performed alongside data collection, as recommended by Corbin and Strauss (2008). In addition, due to the large variety of responses received, theoretical sampling solely involved the modification of interview focus and questions rather than the selection of individuals. Nevertheless, memos were written throughout the processes of data collection, coding and analysis. Axial coding was used to link categories with emerging concepts and data was continually compared within and between categories. Finally, selective coding was used to ensure that the developed categories remained constant and that data was not being forced into the categories but rather that the categories represented the data. Furthermore, due to participants' unavailability, the researcher did not rely on respondent validation as a way of checking the accuracy and validity of his interpretations. While, the research supervisors judged the accuracy of the emerged conceptual categories, respondent validation would have further ensured that

the researcher's interpretation of the data fully captured the participants' lived experiences. Another methodological limitation was a lack of triangulation. For example, by additionally interviewing family members about their perceptions of the impact CTOs have on service users and their relationships with their service user relatives. Improved triangulation is likely to have generated more credible and valid findings.

Future research examining the role of attachment styles on how service users respond to CTOs may be productive. This could be achieved quantitatively by developing a 'CTO perception' measure and additionally using existing adult attachment assessment measures to empirically investigate potential associations between service users' perceptions of CTOs and adult attachment styles. It would also be interesting to conduct a follow-up qualitative study to assess whether findings are replicable. Such a study could aim to examine factors that influence service users' perceptions of CTOs and further explore the impact of CTOs on service users' relationships. Finally, future research on service users' perceptions of CTOs in the UK should include female CTO recipients.

Clinical implications

This study's findings have a number of potential clinical implications. The findings suggested that the majority of participants seemed uncertain about the usefulness of psychological input or perceived it as ineffective. Frese (1997) proposed that once a CTO is initiated, any advice given by a clinician may be perceived by the service user as an order or threat. Therefore, it is likely that the coercive nature of CTOs may reinforce in service users beliefs that it is not possible to work in a collaborative way with mental health professionals. Clinical psychologists could play a more active role in drawing professionals' attention to the effects of coercion on the therapeutic relationship. The assignment of a CTO needs to be made in a collaborative and transparent way by informing service users are about their rights along with

the expectations placed on them in the community treatment plan (O' Reilly et al., 2003). That will be more consistent with the Government's aim to increase service users' choice in mental health (Care Services Improvement Partnership, 2006).

Furthermore, the findings of this study suggested that CTOs did not seem to have a significant impact on service users' relationships with family, friends, partners, local communities. This might mean that CTOs do not include provisions that aim to help service users improve their social networks in the community. Clinical psychologists are well placed to raise other professional's awareness of psycho-social interventions that could help service users' with their patterns of relating which may inhibit the development of more positive relationships. A community-based service provision system that involves a range of psycho-social interventions with a more recovery-orientated approach might have more long-term effects on CTO recipients' community relationships.

Conclusion

This study provides a preliminary theory on how service users develop their perceptions of CTOs and the perceived impact of this intervention on their relationships. It also highlights the potential of adult attachment theory in explaining CTO recipients' responses to compulsory community treatment. The findings of this study suggest that CTOs did not have a significant impact on service users' relationships. This highlights limitations of existing community-based service provision systems in terms of supporting service users to develop their social networks in the community. This is a small-scale study and findings should be treated with caution. Additional research, using both quantitative and qualitative methodologies, needs to be conducted to shed further light on aspects of the present theory.

References

- Albert, M., Becker, T., McCrone, P., & Thornicroft, G. (1998). Social networks and mental health service utilisation: A literature review. *International Journal of Social Psychiatry*, 44 (4), 248-266.
- Atkinson, J.M., Garner, H.C. Gilmour, W.H. & Dyer, J.A.T. (2002). Changes to leave of absence in Scotland: The views of patients. *The Journal of Forensic Psychiatry*, 13 (2), 315-328.
- Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships*, 7, 147-178.
- Bartholomew, K. & Horowitz, L.M. (1991). Attachment styles among young adults. A test of a four-category model. *Journal of Personality and Social Psychology*, 61, 226-244.
- Bean, P. & Mounser, P. (1994). The community treatment order. Proposals and prospects. *Journal of Social Policy*, 23, 71-80.
- Berry, K., Barrowclough, C., & Wearden, A. (2007). A review of the role of adult attachment style in psychosis: unexplored issues and questions for further research. *Clinical Psychology Review*, 27, 458-475.
- Bowlby, J. (1982). *Attachment and loss: Vol. 1 Attachment (2nd Ed.)*. Basic Books.
- Burns, T. & Goddard, K. (1995). Community supervision orders for the mentally ill: Mental health professionals' attitudes. *Journal of Mental Health*, 4, 301-308.

Canvin, K., Bartlett, A. & Pinfold, V. (2002). A 'bittersweet pill to swallow': Learning from mental health users' responses to compulsory community care in England. *Health and Social Care in the Community*, 10 (5), 361-369.

Care Services Improvement Partnership (2006). Our choices in Mental Health. Care Services Improvement Partnership (<http://www.csip-plus.org.uk/CPT/Our%20Choices%20Doc%20-%20Final.pdf>).

Charmaz, K. (2006). *Constructing grounded theory*. Thousand Oaks, CA: Sage.

Churchill, R., Owen, G., Singh, S., & Hotopf, M. (2007). *International experiences of using Community Treatment Orders*. Institute of Psychiatry, London.

Corbin, J. & Strauss, A. (2008). *Basics of qualitative research: techniques and procedures for developing grounded theory (3rd Ed.)*. Sage Publications.

Dawson, J. (2005). *Community Treatment Orders: International comparisons*. Dunedin, New Zealand: Otago University Press.

Department of Health (2008a). *Code of Practice, Mental Health Act 1983*. The Stationary Office (TSO).

Department of Health (2008b). *Supervised Community Treatment: A Guide for Practitioners*. National Institute of Mental Health in England (NIMHE).

- Dozier, M., Stevenson, A.L., Lee, S.W., & Velligan, D.I. (1991). Attachment organization and familial over-involvement for adults with serious psychopathological disorders. *Development and Psychopathology*, 3, 475-489.
- Elliott, R., Fisher, C. T., & Rennie, D. T. (1999). Evolving guidelines for publication of qualitative research in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Frese, F. (1997). The mental health service consumer's perspective on mandatory treatment. In M.R. Munetz (Eds.). *New directions for mental health services. Can mandatory treatment be therapeutic?*, Vol. 75. San Francisco: Jossey-Bass (p. 17-26).
- Gault, I. (2009). Service user and carer perspectives on compliance and compulsory treatment in community mental health services. *Health and Social Care in the Community*, 17 (5), 504-513.
- Geller, J.L. (2000). The last half-century of psychiatric services as reflected in Psychiatric Services. *Psychiatric Services*, 51, 41-67.
- Gibbs, A., Dawson, J. & Mullen, R. (2006). Community treatment orders for people with serious mental illness: a New Zealand Study. *British Journal of Social Work*, 36, 1085-1100.
- Gibbs, A., Dawson, J., Ansley, C. & Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, 14, 357-368.

- Gibbs, A., Dawson, J., Forsyth, H. Mullen, R. Tonu Tanga, T.O. (2004). Maori experiences of community treatment orders in Otago, New Zealand. *Australian and New Zealand Journal of Psychiatry*, 38 (10), 830-835.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. New York: Aldine.
- Hansford, B., Harrow, M., Groen, E., Kaplan, K., & Faull, R. (2004). Is internal locus of control related to schizophrenia, global outcome and major psychopathology? *Scientific Proceedings of the 2004th Annual Meeting of the Midwestern Psychological Association* (p. 83).
- Hazan, C. & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52, 511-524.
- Henwood, K. & Pidgeon, N. (2003). Grounded Theory in Psychological Research. In P.M. Camic, J.E. Rhodes, & L. Yardley (Eds.). *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. APA Publications (p. 131-155).
- Hiday, V.A. (2003). Outpatient commitment: the state of empirical research on its outcomes. *Psychology, Public Policy & Law*, 9, 8-32.
- Hoffman, H., & Kupper, Z. (2002). Facilitators of psychosocial recovery from schizophrenia. *International Review of Psychiatry*, 14, 293-302.

- Ingram, G., Muirhead, D. & Harvey, C. (2009). Effectiveness of community treatment orders for treatment of schizophrenia with oral or depot antipsychotic medication: changes in problem behaviours and social functioning. *Australian and New Zealand Journal of Psychiatry*, 43, 1077-1083.
- Kisely, S.R., Campbell, L.A. & Preston, N.J. (2006). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Systematic Reviews*, 3, CD004408.
- Lawton-Smith, S., Dawson, J., & Burns, T. (2008). Community treatment orders are not a good thing. *The British Journal of Psychiatry*, 193, 96-100.
- Ma, K. (2006). Attachment theory in psychiatry. Part 1: Conceptualisations, measurement, and clinical research findings. *Advances in Psychiatric Treatment*, 12, 440-449.
- Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: a move to the level of representation. In I. Bretherton & E. Waters (Eds.), Vol. 50. *Growing points of attachment theory and research. Monographs of the Society for Research in Child Development* (p. 66-104).
- Mays, N. & Pope, C. (1995). Qualitative research: Rigour and qualitative research [Electronic version]. *British Medical Journal*, 311, 109-112. Retrieved on June 1, 2012, from <http://bmj.bmjournals.com/cgi/content/full/311/6997/109>

- McDonnell, E., & Bartholomew, T. (1997). Community Treatment Orders in Victoria: Emergent issues and anomalies. *Psychiatry, Psychology & Law*, 4, 25-36.
- McIvor, R. (1998). The community treatment order: Clinical and ethical issues. *Australian & New Zealand Journal of Psychiatry*, 32, 223-228.
- Mikulincer, M. & Florian, V. (1998). The relationship between adult attachment styles and emotional and cognitive reactions to stressful events. In J.A. Simpson & W.S. Rholes (Eds.), *Attachment Theory and close relationships* (pp. 143-165). London: Guilford Press.
- Molodynski, A., Rugkasa, J. & Burns, T. (2010). Coercion and compulsion in community mental health care. *British Medical Bulletin*, 95, 105-119.
- Morrison, A. P, Bowe, S., Larkin W., & Nothard S. (1999). The psychological impact of psychiatric admission. *Journal of Nervous & Mental Disease*, 187(4), 250-253.
- Mullen, R., Gibbs, A., & Dawson, J. (2007). Family perspective on community treatment orders: A New Zealand study. *International Journal of Social Psychiatry*, 52 (5), 469-478.
- Muirhead, D. & Harvey, C. (2000). *Involuntary treatment of schizophrenia in the community: clinical effectiveness of community treatment orders with oral or depot medication in Victoria*. Royal Australian and New Zealand College of Psychiatrists, Unpublished dissertation.

- New York State Office of Mental Health (2005). *Kendra's Law. Final report on the status of assisted outpatient treatment*. New York State Office of Mental Health. New York, NY.
- O' Reilly, R.L. (2004). Why are Community Treatment Orders controversial? *Canadian Journal of Psychiatry*, 49 (9), 579-584.
- O' Reilly, R.L., Keegan, D.L., Corring, D., Shrikhande, S. & Natarajan, D. (2006). A qualitative analysis of the use of community treatment orders in Saskatchewan. *International Journal of Law and Psychiatry*, 29, 516-524.
- O'Reilly, R.L., Brooks, S.A., Chaimowitz, G.A., Neilson, G.E., Carr, P.E., Zikos, E., Leichner, P.P., & Beck, P.R. (2003). *Mandatory Outpatient Treatment*. Ottawa: Canadian Psychiatric Association.
- Phillips, L., Francey, S., Edwards J., & McMurray, N. (2009). Strategies used by psychotic individuals to cope with life stress and symptoms of illness: a systematic review. *Anxiety, Stress and Coping*, 22 (4), 371-410.
- Pinfold, V. & Bindman, J. (2001). Is involuntary community treatment ever justified? *Psychiatric Bulletin*, 25, 268-270.
- Power, P. (1999). Community Treatment Orders: the Australian experience. *Journal of Forensic Psychiatry*, 1, 9-15.

Rotter, J. (1966). Generalized expectancies for internal versus external control of reinforcement.

Psychological Monographs, 80, 1-27.

Rotter, J. (1990). Internal versus external control of reinforcement: a case history of a variable. *American*

Psychologist, 45, 489-493.

Shebourne, C.D. (1988). The role of social support and life stress events in use of mental health services.

Social Science and Medicine, 27, 1393-1400.

Steadman, H.J., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., & Robbins, P.C. (2001).

Assessing the New York City involuntary outpatient commitment pilot programme. *Psychiatric Services*, 52, 330-336.

Swartz, M.S. & Swanson, J.W. (2004). Involuntary outpatient commitment, community treatment orders

and assisted outpatient treatment: what's in the data? *Canadian Journal of Psychiatry*, 49 (9), 585-591.

Swartz, M.S., Wagner, H.R., Swanson, J.W., & Elbogen, E.B. (2004). Consumers' perceptions of the

fairness and effectiveness of mandated community treatment and related pressures. *Psychiatric Services*, 55 (7), 780-785.

Swartz, M.S., Swanson, J.W., Wagner, H.R., Burns, B.J., Hiday, V.A. & Borum, R. (1999). Can

involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *American Journal of Psychiatry*, 156, 1968-1975.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*.

Buckingham: Open University Press.

Woolley, S. (2010). Involuntary treatment in the community: role of community treatment orders. *The*

Psychiatrist, 34, 441-446.

IOANNIS PATKAS

**Service users' perceptions of Community Treatment Orders and their impact
on interpersonal relationships**

Section C: Critical Appraisal

Word count: 1, 943

Contents

Section C: Critical appraisal	Page
1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to develop further?	3
2. If you were to do this project again, what would you do differently and why?	5
3. Clinically, as a consequence of doing this study, would you do anything differently and why?	7
4. If you were to undertake further research in this area what would the research project seek to answer and how would you go about doing it?	8
References	10

Development of research skills and abilities

Developing the research proposal was a particularly time-consuming and challenging process, especially ascertaining relevant psychological theories to justify the study's purpose. The specific research area was relatively new and there was little literature attempting to explore it from a psychological perspective. However, this process proved valuable since it gave me the opportunity to become familiar with a number of psychological theories through carrying out systematic literature searches and having ongoing discussions with the researcher supervisors. Applying for NHS ethics approval was another important learning experience. This process involved a great amount of scrutiny which prompted me to study in great detail the process of taking consent from people with severe mental health conditions. Nevertheless, becoming familiar with these procedures will facilitate my future NHS-based research.

Recruitment was another aspect of the project that proved time-consuming and challenging. Whilst one of the research supervisors introduced me to a number of professionals who could give me access to potential participant pools, the target service user group was hard-to-reach and most of the individuals approached, refused to participate possibly because I did not offer them any incentives, apart from paying for their travel expenses. An additional recruitment challenge was being reliant on care coordinators to refer potential participants, since that was the guidance given by the NHS ethics committee. Despite my persistence in contacting care coordinators and reminding them about my study, I gradually learned that the most effective way to successfully recruit was through attending multidisciplinary team meetings and through initial discussions with team managers and responsible clinicians.

This research project has also allowed me to develop my qualitative research skills. Despite preparing my interview schedule with particular thoroughness, through consultation with service users and

the research supervisors, it was often challenging to get rich interview data from participants, many of whom had histories of difficulties engaging with mental health professionals. Nevertheless, explaining in detail the rationale and aims of the study and being flexible during the interviews helped me to develop good rapport with most participants and collect some comprehensive accounts of their experiences. Furthermore, I often felt overly sympathetic towards participants who talked about their traumatic experiences of receiving compulsory treatment. This made it at times challenging for me to retain an objective stance. Thomas and James (2006) have argued that it might be difficult for researchers to set aside their assumptions when developing new theories as it has been suggested by Glaser and Strauss (1967). Nevertheless, the use of a reflective diary and ongoing discussions with the research supervisors helped me consider my role in the research process and supported me in maintaining a neutral stance during the interviews.

With regards to data analysis, I initially found it challenging to compare and contrast raw data with emerging concepts. I had to learn this particularly at the point of starting the axial and more focused coding so that a model could be developed and accurately represent the participants' experiences. Finally, I learned about the importance of keeping memos while collecting and analyzing the data, which provided valuable information about the context of participants' accounts and often revealed new areas of investigation.

Research skills that I would like to develop further include improving my skills in conducting grounded theory analysis and learn to use other qualitative approaches in order to fully experience the evolving and dynamic nature of this way of conducting research. Furthermore, I would like to improve my knowledge in using various quantitative methodologies and become familiar with conducting mixed

methods research through which I can combine the collection and analysis of both qualitative and quantitative data.

Retrospective appraisal of the research design

Recruitment of suitable participants was one of main challenges of this project. In repeating the study, I would contact service users' responsible clinicians from the beginning of the recruitment process. Most of the potential participants received care from Assertive Outreach Teams (AOTs) that were often small and their members had busy workloads. Furthermore, care coordinators' focus was mainly on engaging service users, so asking them to inform their clients about the study was often perceived as adding more work to their already busy schedules. Requesting help with recruitment from the responsible clinicians would probably be more effective since I would be less reliant on care coordinators.

As the study did not collect demographic data in a more systematic way (e.g. via asking some standardized questions at the beginning of the interview), the aim of 'situating the sample' (Elliot, Fisher & Rennie, 1999) might have been improved. If conducting this study again, it may be interesting to collect more detailed data regarding service users' alcohol/drug history, forensic history, past living arrangements and support networks since it was unclear to what extent these factors influenced their perceptions of CTOs. Furthermore, exploring participants' adult attachment styles through administering standardized measures (e.g. Adult Attachment Interview; Main, Caplan & Cassidy, 1985) could have provided more credible evidence regarding the role of adult attachment styles on how participants responded to their CTOs.

A number of steps were taken to assure quality, e.g. via asking a research supervisor to code a transcript extract, through using a reflective diary. However, given that the data collection and analysis

were completed exclusively by the researcher, validity was most likely affected. If conducting a similar study again, I would attempt to discuss identified concepts with participants (i.e. respondent validation; Henwood & Pidgeon, 2003) in order to improve the validity and accuracy of the main categories. In addition, due to recruitment difficulties, analysis of a large percentage of the interview data was not performed alongside data collection, as recommended by Corbin and Strauss (2008). In repeating the study, I would try to arrange larger gaps between interviews (although that would mean access to a larger participant pool), in order to have adequate time to concurrently transcribe and analyse the data. This would have been a more accepted approach for theoretical sampling (Corbin & Strauss, 2008).

The recruited sample was small and partially self-selected which might have affected the findings. A larger sample that could also include female CTO recipients would increase the generalisability of the study's findings and would potentially determine sex differences in service users' perceptions of CTOs. Furthermore the sample might not have been as representative since only service users who complied with terms of their CTO were included. Many service users refused to participate and it was unclear whether they were not motivated enough to take part or their care coordinators did not spend enough time explaining to them what the study involved. In repeating this study, I would possibly include incentives (e.g. vouchers) in order to attract a more representative sample. Finally, improved triangulation (e.g. involving family members, friends, care coordinators, residential staff) may have also generated more credible findings in relation to the impact of CTOs on participants' interpersonal relationships. For example, it may have been interesting to additionally interview family members about the impact of CTOs on their relationships with their service user relatives with the intention of triangulating the same experience.

Research outcomes pertaining to my future clinical work

Concerns have been raised about the potential impact of CTOs on the therapeutic alliance (McIvor, 1998). Studies on service users' perceptions of CTOs have found that the majority of CTO recipients believe that compulsory community treatment did not affect their relationships with their clinicians (e.g. Gibbs, Dawson, Ansley, & Mullen, 2005). The findings of the current study showed that the majority of participants held a variety of views about mental health professionals involved in their CTOs but the majority seemed unsure about the usefulness of psychological input or felt that it was ineffective. The fact that the majority of participants did not receive psychological support while on a CTO raises the question of whether CTO recipients find it more difficult to engage collaboratively with psychologists, and in general with mental health professionals. It has been suggested that once a CTO is initiated, service users are more likely to perceive any advice given by a clinician as an order or threat (Frese, 1997). Therefore, the coercive nature of CTOs may reinforce in service users beliefs that it is not possible to liaise with mental health professionals on the basis of choice and trust.

When working with other professionals and in team discussions I would now draw more attention to the effects of coercion on the therapeutic relationship and I would highlight the importance of promoting respect for autonomy of people with mental health conditions. I imagine there will also be opportunities to gently challenge psychiatrists' ways of approaching and explaining the reasons for applying CTOs to their clients. CTOs are inherently non-collaborative and service users are entering an agreement in which their options are severely constrained: either they agree to be treated compulsorily in the community or they face ongoing hospital detention (Kinderman & Tai, 2008). Therefore, the assignment of a CTO must be a transparent process where service users are informed about their rights alongside the expectations placed on them in the community treatment plan. Transparency in the treatment process has been shown to have a positive effect on adherence to treatment (Davidson & Campbell, 2007).

Furthermore, in multidisciplinary meetings I would try to raise professionals' awareness about psychosocial interventions that can compliment pharmacological treatments for service users with severe mental health conditions. I would also encourage colleagues to work with their clients using a more recovery-orientated approach to create for them more opportunities for participation in community life, including work, engaging with families, developing friendships and living independently (Nelson, Lord, & Ochocka, 2001). The findings of this study revealed that CTOs do not appear to include provisions specifically aiming to support service users' with their relationships in the community. Service providers need to place greater emphasis on providing access to treatments and community services that could help CTO recipients to integrate better to community life and improve their relationships. Such provisions could include regular psychological therapy, therapeutic groups as well as opportunities for community activities such as sports, art and education. In addition, clinical psychologists are well placed to train other mental health professionals about how to engage service users more effectively and how to minimize distress and promote positive relationships.

Further research ideas

The study's results suggest a follow-up research project is needed to further examine the extent to which adult attachment styles can predict how service users respond to CTOs. This would clarify whether the four adult attachment styles proposed by Bartholomew (1990) are linked to the four different perceptions of CTOs identified in this study. Such a study could be conducted quantitatively, by employing existing measures to test adult attachment insecurity and by developing a measure of 'CTO perceptions' to further explore the relationship between adult attachment styles and specific responses to compulsory community treatment.

In addition, further research could attempt to replicate this study's findings by seeking to explore factors or processes that could influence service users' perceptions of CTOs and their impact on service users' relationships. Recruiting more participants and including female CTO recipients would make the sample more representative. Grounded Theory or Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) could be appropriate methodologies, but improved triangulation by including family members or mental health professionals, could further increase the credibility of the findings.

These research proposals could improve our understanding about factors or processes that influence service users' perceptions of CTOs and might shed light on what type of provisions could improve CTO recipients' community relationships. These potential research projects might also be able to answer the crucial question, 'for whom CTOs might be the appropriate and beneficial type of treatment?'

References

- Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships*, 7, 147-178.
- Corbin, J. M. & Strauss, A. (2008). *Basics of qualitative research: techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.
- Davidson, G. & Campbell, J. (2007). An examination of the use of coercion by assertive outreach and community mental health teams in Northern Ireland. *British Journal of Social Work*, 37 (3), 537-555.
- Elliott, R., Fisher, C. T., & Rennie, D. T. (1999). Evolving guidelines for publication of qualitative research in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Frese, F. (1997). The mental health service consumer's perspective on mandatory treatment. In M.R. Munetz (Eds.). *New directions for mental health services. Can mandatory treatment be therapeutic?* San Francisco: Jossey-Bass (p. 17-26).
- Gibbs, A., Dawson, J., Ansley, C. & Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, 14, 357-368.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. New York: Aldine.

- Henwood, K. & Pidgeon, N. (2003). Grounded Theory in Psychological Research. In P.M. Camic, J.E. Rhodes, & L. Yardley (Eds.). *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design*. APA Publications (pp. 131-155).
- Kinderman, P. & Tai, S. (2008). Psychological models of mental disorder, human rights, and compulsory mental health care in the community. *International Journal of Law and Psychiatry*, 31, 479-486.
- Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: a move to the level of representation. In I. Bretherton & E. Waters (Eds.), Vol. 50. *Growing points of attachment theory and research. Monographs of the Society for Research in Child Development* (pp. 66-104).
- McIvor, R. (1998). The community treatment order: Clinical and ethical issues. *Australian & New Zealand Journal of Psychiatry*, 32, 223-228.
- Nelson, G., Lord, J., & Ochocka, J. (2001). *Shifting the paradigm in community mental health*. Toronto: University of Toronto Press.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory Method and Research*. London: Sage.
- Thomas, G. & James, D. (2006). Reinventing grounded theory: some questions about theory, ground and discovery, *British Educational Research Journal*, 32 (6), 767–795.

IOANNIS PATKAS

Section D: Appendices

Section D: Appendices**Page**

Appendix 1: NHS Research and Ethics Committee (REC) and Research and Development (R&D) approval	3
Appendix 2: Participant invitation and information letter for responsible clinicians	5
Appendix 3: Participant information sheet	6
Appendix 4: Participant consent form	9
Appendix 5: Example transcript	10
Appendix 6: Semi-structured interview schedule	18
Appendix 7: Excerpts of memos for coding process	20
Appendix 8: Reflexive research diary	21
Appendix 9: Table of categories, subcategories and supporting quotes	28

Appendix 1: NHS Research and Ethics Committee (REC) and Research and Development (R&D) approval

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

Appendix 2: Participant invitation and information letter for responsible clinicians

Dear Dr. [REDACTED],

My name is [REDACTED] and I am a Trainee Clinical Psychologist, studying in Canterbury Christ Church University. I am sending this letter to inform you that one of your clients and CTO recipient, Mr [REDACTED], accepted my invitation to take part in my major research project.

The current study seeks to explore male patients' understanding and views of the Community Treatment Order (CTO) they are currently on and the impact of this community intervention on their lives. The potential influence of participants' current relationships with their families, friends, mental health professionals and 'medication' on their perceptions of CTOs will also be explored.

The study's inclusion criteria are the following:

- Participants have to be male adults
- Participants have to be on a CTO for at least 3 months
- Participants need to understand verbal and written English
- Participants must be capable of giving their consent to take part in the study

Mr [REDACTED] will be interviewed for approximately an hour and will be asked for his views about his CTO, what it involves, its impact on his life (if any) and details about his current interpersonal functioning. The interviews will be recorded and later analysed using a qualitative analysis method. Mr [REDACTED] will have to give his written consent to take part in the study.

Mr [REDACTED] was identified through [REDACTED] (responsible person for managing the database of the CTO recipients in the Borough of [REDACTED]) and met the study's inclusion criteria stated above. Mr [REDACTED] (care co-ordinator) was contacted, and we discussed about the possibility of Mr [REDACTED] taking part in my research project. I requested from him / her to inform Mr [REDACTED] about my study and give him a participant information sheet which I enclose for your records. Mr [REDACTED], agreed to take part in my research project and an interview appointment will be arranged soon. For any questions please contact me on:

[REDACTED]

Yours sincerely,

[REDACTED]

Trainee Clinical Psychologist (Year 2)
Canterbury Christ Church University

Appendix 3: Participant information sheet

Participant information sheet

Male patients' views of CTOs and their impact on patients' lives

I am a trainee clinical psychologist and I would like to invite you to take part in this research study. This study is an educational project and is part of my clinical training (PhD in Clinical Psychology). Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask your care co-ordinator if there is anything that is not clear or whether you would like more information. Take time to decide whether or not you wish to take part.

What is the research about? The purpose of this research study is to explore patients' views of the Community Treatment Order (CTO) they are currently on and the impact CTO has had on their life. We are approaching you because you are currently on a CTO.

Why am I doing this research? I am carrying out this research study because there is not enough evidence regarding which aspects of CTOs patients find helpful and which they find less helpful. Finding out more about patients' perceptions of CTOs will help me make suggestions on how to improve CTO patients' quality of life and may potentially identify other treatment options.

Do I have to take part? It is up to you to decide. Initially, your care co-ordinator will describe you what this study is about and will go through this information sheet with you. You will then be given up to 2 weeks to decide whether you want to participate. If you agree to take part I will have to ask you to sign a consent form to show you have agreed to participate. Prior to meeting with you, I will contact your allocated psychiatrist to inform him/her about your decision to participate in the study.

What will happen if I don't want to take part? You are free to refuse to take part in the study. Even if you initially agree to take part and you later change your mind, you can withdraw at any time, without giving a reason. This would not affect the standard of care you receive. If you decide to withdraw from the study any information you may have given me will be destroyed.

What will taking part include? As soon as you decide you are interested in taking part in the study, your care co-ordinator will give me your contact details. I will then ask you to meet with me. Our meeting will involve going through this Participant Information Sheet together and then asking you to give me written consent for your participation. After this I will interview you. I will send you an appointment letter prior to our meeting which will include further details about the time and the place the interview will take place. If you prefer to contact me to arrange an appointment, feel free to do so. Your care co-ordinator will give you my contact details. The interview will involve asking you to provide me with some information about your understanding and view of your CTO and how your life has changed (or has not) since you were placed on a CTO. I will also ask you some questions about your relationships with your family, friends, neighbours, key worker, psychiatrist and authorities and whether CTO has had any effect on your relationships with these people.

Our meeting will last for approximately an hour. Because it will be difficult to remember everything we will discuss, I will record our conversation, using a voice recorder. The interview will take place in a room of your local CMHT or Assertive Outreach Team's base. Travel expenses up to £10 will be paid if you agree to take part.

What are the possible disadvantages to taking part? It is possible that I will ask you questions about topics that you might find more difficult to discuss. In case you feel distressed during the interview, feel free to tell me to change subject or not to answer at all. In case you feel distressed after the interview, I will make sure that appropriate sources of support will be available for you. If you have any questions or concerns, you should either speak to me or your care co-ordinator. We will do our best to answer your questions and address your concerns. If you still remain concerned about any aspect of the study, you also have the option to contact my research supervisor, [REDACTED] (contact number: [REDACTED]). Finally, if you wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the professionals you are currently in contact with (e.g. your care-coordinator, psychiatrist).

The current study has received approval from Canterbury Christ Church University and the Research & Development department of [REDACTED] NHS Trust. The study is carried out in accordance with the Research Governance Framework and Social Care 2005 and the researcher ([REDACTED]) is required to adhere to the Code of Ethics and Conduct of the British Psychological Society. Canterbury Christ Church University provides insurance coverage against potential negligent harm, for: 1. the participants, arising from the management and/or design of the study, and 2. for the researcher while he is undertaking this research study.

What are the possible benefits? Although you will not benefit directly from taking part in the research the results will help to guide practice regarding the use of CTOs and their effects on patients' lives.

Will my taking part in the study be kept confidential? Yes. All the information which is collected about you during the course of the interview will be kept strictly confidential and any information that is stored will have your name and address removed so that you cannot be identified. Your personal information will only be available to authorised staff such as me and the two research supervisors.

However, if during the course of my contact with you I become concerned about your safety or the safety of others, I will have to break confidentiality and inform your care co-ordinator. Confidentiality will also be broken if you are in breach of your Community Treatment Order (e.g. if you are not taking your prescribed medication).

As I mentioned earlier the information you will give me during the interview will be recorded and anonymised quotes might be used in the final report. Feel free to refuse your quotes to be used in the report. However, if you do not agree with your interview being recorded, you will not be eligible to take part in the study. Recording of the interviews is a necessary requirement for all participants.

What will happen to the results of the study? I intend to publish the results of my study in scientific journals where it will have the most influence. So I will publish in psychology journals

as well as making sure that participants will have access to a summary of the findings if they request it. You will not be identified in any of those reports.

Who has reviewed this study? All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity.

Appendix 4: Participant consent form**Participant Consent form****Male patients' perceptions of CTOs and their impact on patients' lives.**

Name of the Researcher: Ioannis Patkas (Trainee Clinical Psychologist)

Please put your initials into the box if you agree with each statement:

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I consent to the interview with me being digitally recorded.
4. I consent that the researcher will inform my psychiatrist about my participation in the current study.
5. I consent that my care co-ordinator will be contacted by the researcher to discuss my psychological state prior to the interview.
6. I consent to quotations from my interview to be used in the final report of the study and that I will not be identifiable from these.
AGREE DON'T AGREE
7. I agree to take part in this study

 Name of patient date signature

 Name of person taking consent date signature

When completed
 1 copy is for the participant
 1 copy is for the research file

Appendix 5: Example transcript

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

THIS HAS BEEN REMOVED FROM THE ELECTRONIC COPY

Appendix 6: Semi-structured interview schedule

Semi-structured Interview Schedule

Remember: 1. Remind participants of voluntary nature of participation, 2. Go through the main parts of information sheet with participants, make sure they understand the rationale of the study and what involves and then ask for written consent, 3. Remind participants that they can take breaks during the interview or they can stop the interview at any time, 4. Remind participants about purpose of the interview and limits of confidentiality, 5. Explain my role as researcher, do not forget to remind participants that for the interview occasion I am not a therapist, 6. Ask participants at the beginning of the interview about their age, ethnic background, diagnosis and how long they have been on their CTO, 7. Order of questions flexible to suit participants.

In terms of questioning remember to ask open questions.
If respondent gives sort answers try prompts.

Examples: Can you tell me a bit more about that? Why? How? How did you feel? Sorry if this is a stupid question but what do you mean by XXX? I am interested in how...

1. **Warm up questions.** Age, ethnic background, diagnosis, duration of difficulties, type of accommodation he currently stays at, for how long, where was he staying before his move to current accommodation
What led you being sectioned? What was happening in your life at that time?
Why were you placed on a CTO? How long have you been on a CTO?
2. **What's your understanding of your CTO? Do you know what it involves? How do you feel about being placed on a CTO? Who explained to you what your CTO involves?**

Possible prompts: Which are the terms of your CTO? What are you supposed to do while in the community? Are there any rules you need to follow?

3. **In what ways has your life changed since you were placed on a CTO? What sorts of things are different? What is the same? How do you feel about that?**

Further prompts regarding impact of CTO on perceived quality of life/psycho-social functioning/everyday life

4. **What do you like / do not like about being back to the community?**
5. **What type of treatment would you prefer if you were given the choice?**

Prompts: Psychology, groups, work, hospital, community

- 6. Tell me some things about your medication? In what ways it has been helpful/unhelpful? Have you had the same/different view about your medication in the past? What do you think of the fact that you have to take medication to stay out of the hospital?**

Prompts: Were you taking medication regularly in the past? What's your view of medication?

- 7. How do you find it being in regular contact with mental health professionals to monitor your medication / mental health? How is your relationship with your psychiatrist /care co-ordinator? In what ways it has been the same/different compared to how it was prior to your CTO? Have you ever seen a psychologist? Do you currently see a psychologist? How do you find it seeing a psychologist? Would you like to have contact with a psychologist while on CTO?**
- 8. How is your relationship with your family / friends? In what way has it changed (if it has changed) since you were placed on a CTO? How were these relationships prior to your CTO?**

Prompts: If something has changed in these relationships, why? When? Have they been helpful, supportive? How do you feel about them?

- 9. What your view of authorities such as police, doctors, teachers? In what ways it has been affected since you were placed on a CTO?**

Prompt: Do you find it helpful having people giving you directions? How do you find having to follow certain rules?

- 10. How is your relationship with your neighbours / local community? In what ways have those relationships been affected since you were placed on a CTO?**

Prompts: Did you have the chance to meet any of your neighbours? How are they like towards you?

Thank participants for their time and cooperation

Appendix 7: Excerpts of memos for coding process

Memo 1: Impact of CTO

October 2011: I interviewed 5 participants last month. They all talked about their experiences of living in the community and receiving compulsory community treatment. They all stated that living in the community was a better alternative to hospital detention and many talked about having more freedom and opportunities for leisure activities and spending time with friends and family. However, I have been struck by the fact that all of them believed that CTOs had made no impact on their lives and psychosocial functioning. Even people that said their mental health or quality of life had improved or deteriorated, believed that that was due to other factors such as living in the community, lack of social networks or even natural processes. I may need to change the wording of my questions in order to get a better sense of how participants perceive their CTOs. My impression is that CTOs are not understood by the participants as a type of treatment. They mainly think that they are a type of 'supervision' in the community. Another impression I have is that most of the participants do not seem overly concerned about the compulsive nature of CTOs. Most said that after so many hospital detentions, living in the community and having somewhere to stay is a positive experience. Maybe all of those participants are compliant with their orders and hold positive views of mental health professionals. I was expecting the opposite but it seems that the majority of service users are somehow so used to compulsory treatment that CTOs do not make any difference to them. There is also a possibility that service users who are against CTOs might have decided not to take part in my study. I am worried that I will not recruit a representative enough sample. I hope I will manage to get a larger variety of views in the future so that to form a better idea about the impact of CTOs on service users' psychological functioning and relationships with others.

Memo 2: View of self

December 2011: I have completed 8 interviews so far. When I was designing the interview schedule a year ago, I had in mind to include a question about participants' diagnoses with the aim to collect some basic demographic data. However, asking participants to talk to me about their psychiatric diagnoses was like inviting them to tell me about how they viewed themselves in more general sense. Most answered in an impersonal way without questioning the rationale behind the label 'schizophrenic'. It seemed like it was part of who they were. However, the interviews started revealing certain patterns in terms of how participants view themselves in relation to their mental health difficulties. Most admitted past or present mental health problems but they positioned themselves in different ways. Some told me their mental health had been stable in recent months and seemed confident about knowing what to do to stay well. These seemed convinced that taking medication was necessary to stay out of hospital. Others talked about still having unstable health and appeared somehow defeated or very vulnerable. They were compliant with their medication as well but some felt that it had proved ineffective so far. Two service users I interviewed this month told me that they had recovered but did not seem to bother about having received psychiatric diagnoses. In a way they were just trying not to think about it and get on with their lives. However, the most interesting participant was a man who held extremely negative views about his CTO, medication and professionals. He was very eloquent and talked in detail about what he thought of his diagnosis. He believed he had never had mental health difficulties and thought his diagnosis was not applicable to him. He felt stigmatised and believed that people were prejudiced towards him because of this label. This man was the only one who had a very good understanding of what his CTO involved as well as what his rights were as a CTO recipient. His care coordinator mentioned before the interview that he was a really interesting guy but quite challenging. However, my intuition was telling me that he was the only one who had a good awareness of his treatment and the wider context he lived in. How come and the one who was considered to be the most 'unwell' participant seemed to me the only one with the most stable mental health?

Appendix 8: Reflexive research diary

Date	Diary entry
December 2010 – January 2011	<p>Since having a lecture on Community Treatment Orders some time ago, I have been thinking that I would like my MRP to focus on this area. I contacted the lecturer and asked her if she would like to be my MRP external supervisor and she accepted. I was very pleased with that. Choosing a supervisor without having a clear research idea seems unorthodox, but I feel it is important to have the right people to guide me through this journey.</p> <p>I had a meeting with the external research supervisor to discuss potential research ideas. She told me that there is a gap in research on how service users based in the UK perceive CTOs. However, she suggested I should read the main critical reviews on CTOs' effectiveness to narrow down my study's focus. I need to act quickly because I need to start preparing my research proposal.</p>
February 2011	<p>I decided to explore service users' perceptions of their CTOs and further examine CTOs' impact on their interpersonal relationships. I met again with the external supervisor and she seemed open to my idea. It was agreed that the study will be qualitative and I will most likely use Grounded Theory to analyse the data. However, I am still looking for relevant psychological theories to justify the study's purpose.</p> <p>I have also been looking for an internal supervisor and eventually the person who was my first choice agreed to get involved. I am very pleased with the persons who agreed to supervise my project.</p> <p>I prepared the NHS ethics proposal and had a meeting with two academic tutors at Salomons. I have had difficulty finding psychological theories which might be relevant to my study's rationale and aims. Attachment theory seems an obvious choice if I am looking at the impact of CTOs on participants' relationships. Locus of control was another theory that was suggested which seems relevant considering the compulsive nature of CTOs. I need to go through these theories and find out more about their relevance to my study.</p> <p>I sent the ethics form to the NHS committee and arranged a review meeting for the 17th of March. Busy month!</p>
March 2011	<p>I had the ethics review meeting. I was quite surprised that none of the committee members was a clinical psychologist. I expected them to ask me a number of questions about my study and the broader research area but the meeting lasted only 5 minutes! They said they will send me a letter with their final decision. Until I get their approval I cannot start making plans regarding recruitment.</p> <p>I received a response from the NHS ethics committee. They asked me to make a number of amendments in the recruitment process section and in the participant information sheet. I was finally asked to make changes in the consent form</p>

	<p>regarding my plan to inform participants' psychiatrists about their participation. Concerns were also expressed about contact with such a vulnerable service user group. It seems that it might take longer until I get ethics approval. I will try to send the amended proposal by the end of this month. I was reassured by my supervisors that this is a standard process.</p> <p>Another busy month bearing in mind that I need to prepare an essay for April and finish my child placement.</p>
April 2011	<p>I have read the two main systematic reviews on CTO effectiveness and went through details about their implementation in England and Wales. This research area seems quite complex since it involves a number of ethical and political issues. There is not enough evidence to justify their use but in the first years since their introduction in England and Wales they have been used extensively. I also have a better understanding of the psychological theories I will consider for my MRP, i.e. adult attachment and locus of control theories.</p> <p>I haven't heard from the Ethics Committee yet.</p>
May 2011	<p>I finally received a letter from the ethics committee. I was given permission to start the recruitment process. However, I realise that it is going to be a challenging process and wonder whether I will get the 12-15 participants I aim for. My external supervisor linked me with admin staff that manage the CTO recipients' database of the NHS Trust I was given permission to recruit from.</p> <p>I had a meeting with the main administrator and discussed how many service users fit my study's inclusion criteria. She gave me a list of 8 potential participants.</p> <p>My external supervisor who works for an Assertive Outreach Team (AOT) linked me with a CTO recipient for a pilot interview. He is not an eligible participant because he just got placed on a CTO but I am excited to conduct my first interview.</p>
June 2011	<p>I conducted the pilot interview and I felt it went quite well. The service user was quite talkative and very much against CTOs. He believed they were restrictive but admitted he preferred living in the community rather than in hospital. He was initially suspicious towards me and said that he accepted to be interviewed because of my research supervisor.</p> <p>I have contacted care coordinators and explained to them the rationale and aims of my study. I requested from them to talk to their clients about my study and asked them whether they would be interested to take part.</p> <p>It's almost the end of month and only one of the 10 potential participants agreed to be interviewed. The rest refused to participate. I wonder whether this is because I don't offer any incentives (e.g. vouchers or money). The first interview was arranged for the first week of July.</p>
July 2011	<p>The service user who agreed to be interviewed cancelled his appointment 3 times and he was finally interviewed in the last week of this month. He appeared unmotivated and the interview lasted for 20 minutes. He was quite monosyllabic</p>

	<p>in his responses and that made the interview challenging. Afterwards I realised that I asked a lot of ‘close’ questions, possibly because of my anxiety to get as much information as I could from the respondent. I realise that I need to improve my interview skills and re-visit my interview schedule. Feeling a bit disappointed about the progress of the recruitment.</p> <p>I received an informal complaint from the responsible clinician of the first participant. She said that the letter sent to her did not contain enough information about what the study involved. I sent her the participant information sheet. She found my study interesting and suggested to contact her in case I have recruitment difficulties.</p> <p>I got hold of 6 more names of potential participants and contacted their care coordinators. It’s the end of the month and I still haven’t heard back from them.</p>
August 2011	<p>I had a meeting with the external supervisor to review the progress of the study before the summer break. We discussed the recruitment difficulties I experienced and she suggested I should visit local teams (during weekly multi-disciplinary meetings) and meet care coordinators in person. Later, I contacted the care coordinators of the potential participants and arranged to meet them in their work base by the end of the month. I hope that would make a difference because I start getting anxious that I will not recruit an adequate number of participants.</p>
September 2011	<p>I managed to arrange 5 interviews after attending two multidisciplinary meetings and got to know better the care coordinators of the teams I visited.</p> <p>I completed all interviews but finding time to transcribe and analyse each interview before moving to the next one (as suggested by Corbin & Strauss (2008) was not possible. Some respondents gave rich accounts of their experiences while others did not engage in the same way. Unlike the first participant this group of service users were either neutral or in favour of CTOs.</p> <p>My new placement is in an AOT service in Brighton. I had a meeting with my new placement supervisor and said that I will be in contact with a number of service users on CTOs. It’s a shame that I don’t have ethical permission to recruit potential participants through my new placement. However, I am excited that I will gain first-hand experience in working alongside professionals who are involved with CTO recipients.</p>
October 2011	<p>I have completed the initial coding of the first set of data and had feedback from my internal supervisor. I start familiarise myself with the principles of grounded theory and started reading about data collection and analysis.</p> <p>I have been contacting care coordinators and leaving messages when I cannot reach them but it’s proving difficult to get hold of most of them. It’s frustrating that many of them don’t seem to return my calls or respond to e-mails. I even contacted the care coordinators that provided the first group of participants but there were no CTO recipients that fitted the inclusion criteria of the study. The external supervisor said that the AOTs of the Trust are small and professionals who work for them have heavy workloads. She suggested that I should be persistent and have in mind that the recruitment for this particular study will be</p>

	probably the most challenging aspect of it.
November 2011	<p>I have got two more interviews arranged for the same day of this month which is encouraging. I've also had contact with admin staff from the other two boroughs of the NHS Trust trying to find more participants. I eventually got a list of 5 more participants who fitted the study's inclusion criteria.</p> <p>I have been reading the memos of the existing 8 transcriptions trying to make sense of the data I am collecting. Some patterns started emerging. Most participants view living in the community as a better alternative compared to hospitalisation. However, any reported benefits were not attributed to CTOs but to a variety of factors such as living in the community, having accommodation, potential for contact with family and friends etc. Furthermore, according to the respondents CTOs did not seem to have any impact on their relationships with family, friends and local communities. In addition, no one was involved in an intimate relationship.</p> <p>I have started doing systematic literature searches to collect all relevant material so that to start the write-up of section A.</p>
December 2011	<p>I visited the AOTs to meet with the care coordinators of the 5 potential participants and promised they will come back to me. After two 2 weeks I received e-mails that all service users refused to participate. They mentioned that Christmas period might be one of the reasons why no one wanted to be involved. I have started developing good relationships with some care coordinators and I am hoping that in the first months of 2012 I will manage to conduct a few more interviews.</p> <p>Last week of the year and no more participants. At least I have 8 interviews, but only 5 of them provide a reasonable amount of information. A positive is that the sample consists of service users from a variety of ethnic backgrounds, which might increase the generalisability of the findings. I will be spending this Christmas working on course works and the Section A of the MRP. I hope next year I will be qualified and on holidays somewhere warm.</p>
January 2012	<p>I am getting worried about the time constraints and the lack of participants. I have conducted the external supervisor and asked her to help me with the recruitment. She said that she would circulate an e-mail to all relevant services in the Trust to request further participants. She is a well-known clinician so I hope I will have some good news soon.</p> <p>Since no interviews have been arranged I completed the transcription of all interviews which took a considerable amount of time. I have also completed the line-by-line coding of all 8 transcripts and asked a supervisor to code a part of a transcription to check how accurate my coding is. The feedback was that I need to stay closer to the data but not too close because I will end up paraphrasing the text.</p>
February 2012	<p>I have conducted 3 more interviews. My interview skills have improved since I manage to consistently ask open questions throughout and get richer data. Since I am not sure how many interviews I will manage to complete in the next few months, I am trying to elicit as much information as I can. Two of the</p>

	<p>interviewees did not attend the first arranged appointments so I had to rearrange new ones. I have been travelling long distances and have already wasted 5 days of my A/L.</p> <p>I have started conducting a more conceptual type of coding (axial). Surprisingly, I find this type of coding more enjoyable compared to the line-by-line coding. Some interesting new ideas emerged. It seems that some factors influencing participants' perceptions of their CTOs stand up out of the data. These are the following: past experiences of hospital, view of self in terms of mental health difficulties and need for treatment and view of current living arrangements. It seems that some service users have been moved in inappropriate accommodations. For example, two service users with drug and alcohol histories and another two with very unstable mental health lived in flats on their own. All of them perceived living without support as extremely challenging and preferred living in hospital where they received better quality of care and had restrictions in relation to their substance misuse problems.</p>
March 2012	<p>I have arranged to meet with my internal supervisor to update him about the progress of the MRP regarding recruitment, literature search and data analysis.</p> <p>I also attended a seminar on CTOs and met with some qualified clinical psychologists who I knew when they were trainees in Salomons. One of them was working in a AOT. By the end of the seminar she gave me her contact details and asked me to e-mail her regarding support with the recruitment.</p> <p>I have arranged a meeting with a research team in Oxford who is conducting a new RCT on CTO effectiveness. They gave an update about their trial and asked questions about mine. I managed to persuade one of them to help me with my literature search by giving me a list of the most recent studies relevant to my research project.</p> <p>No interviews have been planned for this month.</p>
April 2012	<p>The psychologist I met in that seminar last month contacted me and said that she had some eligible service users. I subsequently attended a meeting of her team and met with care coordinators. After two weeks I received an e-mail that 4 CTO recipients were willing to participate. These were great news because they meant that by the end of next month I would have 15 participants.</p> <p>I have started transcribing/analysing each new interview before moving to the next one. Not many new themes emerged which is reassuring since I might be closer to reach data saturation. Four different CTO perceptions have been identified so far and these are: for, against, neutral about CTO but also 'CTO as a safety net'. Some participants perceived CTOs as offering protection but it seemed as it was a different category compared to CTOs as beneficial'. However, I can't see a model emerging yet. I will probably need to have a meeting with the supervisors to discuss my findings and the already identified conceptual categories.</p>
May 2012	<p>I just handed in the last course works. I had two referrals and two new pieces of work to prepare for the end of April plus all the work I had to do for the MRP.</p>

	<p>The last few months had been quite anxiety provoking but I am pleased I managed to complete everything on time. For the next two and a half months I can focus on the project.</p> <p>I managed to complete all four interviews, so now I have 15 transcripts. I work almost everyday trying to catch up. The aim is to finish with the transcribing by the end of this month in order to spend the whole June analysing the data and develop a theory.</p> <p>I am writing my Section A (literature review) having met with my internal supervisor and agreed a structure and broadly what will be included.</p> <p>I had a meeting with the internal supervisor regarding the data analysis. We went through my coding and I explained what I had done and he thought it was ok. However, there were some queries about the axial coding and thought that some of the identified categories and subcategories needed shifting around. He also thought that some of the labels I used to describe categories/subcategories did not accurately reflect the relevant concepts and coding. I was helpful to get a different perspective on the data analysis.</p> <p>I have sent a draft of my section A to both research supervisors and they were both pleased with the end result. They warned me that the data analysis might be time-consuming and we arranged meetings for next month to discuss the findings. The aim is to send them a copy of Section B by the 15th of June.</p>
June 2012	<p>The analysis of the data has revealed some really interesting findings. Four different CTO perceptions have been identified along with four different perceptions of self and mental health. Each CTO perception seems to be linked with a different 'view of self'. I have also come across an interesting adult attachment theory which might be relevant to the emerging findings.</p> <p>I arranged a meeting with the external supervisor to discuss the data analysis and receive some guidance on the write-up of Section B. She found the findings interesting and added that they made sense. Section B is proving to be a lot more involved and time-consuming than I thought.</p> <p>I had a meeting with the internal supervisor who is an expert in grounded theory. I presented my results along with my hypotheses. He praised my efforts but said that I needed to make some minor changes. Creating the model took a lot of time and managing the vast amount of data is exhausting. I also am concerned about the word limitations of Section B (I have written 15, 000 and the limit is 8, 500).</p> <p>I have managed to get a draft of my Section B a week later than I had planned. Trying to work on Section C and Appendices until I receive feedback for Section B.</p>
July 2012	<p>I have received final feedback for the Section B from both supervisors. They seemed pleased with the content but I still have to make minor amendments. Section B which was long and quite difficult to write considering my limited experience in qualitative research. I am still writing Section C at the moment.</p>

This section seems easier to write but due to my exhaustion it takes more time than I have anticipated. I continue gathering Section D appendix materials as there is quite a lot to include in that.

I am making final changes in Section A/B and waiting for feedback about Section C. I hope I finish a few days before the deadline in order to focus on the details.

I finalised all sections two days before the deadline. The last day before the deadline I will print the work and get it bound.

Job done! I have finished my thesis! I can't think straight at the moment. I need a break to reflect on how I feel. I am definitely glad it's over.

Appendix 9: Table of categories, subcategories and supporting quotes

Category	Subcategory	Supporting quotes
Experience of hospitalisation	Restricting freedom	“You lose your liberty, don’t you? You lose your freedom”. (Vinnie)
		“...because some of them they just don’t care, they lock you up in a small room where you can’t do nothing, you can’t go out, don’t eat food, you can’t go out for months, even for years, get stuck in a little place, that’s what it’s like” (Marlon)
	Beneficial under specific conditions	“I can understand it if people are danger, they are dangerous, they are gonna harm other people, or they are gonna harm themselves, I can understand that, may be it’s good for them...” (Marvin)
	Having adverse effects on health	“The last time I went one of the staff members, he tried to struggle me, he put his hands around my throat and tried to struggle me and then he tried to break my arm, so not a very good experience overall” (Vinnie)
	Contributing to stable mental health	“It was alright, I got on ok in hospital, I had friends, I stopped taking drugs in hospital as well, I was taking medication and I finally got better, that’s all I could do” (Mark)
	Safety net	“It was good in hospital, they take care of you, when you are alone in the environment, in the community, you don’t have any of this...” (Bob)
	Step backwards	“I find it a hindrance. I find it gets in my way and slows me down...” (George)
Experience of living arrangements in community	Better alternative to hospitalisation	“My life now, I mean now I feel free; when I was in the hospital I was trying, I was trying to get out of the hospital, and go on, I didn’t feel happy being in the hospital” (Bill)
	Sign of improvement	“My life is much happier, I’ve lost weight, I do my daily routines like cooking and eating, watch TV, listen to music, go out for a walk maybe, and also go to my job and smoke, and that’s it” (George)
	Providing opportunities for socialising	“The difference being in hospital and live out of the hospital is that you see more of your family and friends” (Mic)
	Helpful with medication adherence	“... they are helpful, staff come everyday and check whether or not I take my medication” (Miles)
	Not providing structure	“It gets me a bit down sometimes...I am not doing a lot, there are some TV programmes I tune in when they are on” (Simon)
	Providing freedom	“When I want I can go out freely without asking anyone, I can come back any time, that is freedom for me” (Paul)
	Feeling neglected	“In a supported accommodation you don’t always have the chance to talk to staff about your problems...” (Bob)

	Anxiety provoking	“It is a frightening place, depending on how socially adequate you are, how socially catered you are...” (Mark)
	Contributing to better quality of life	“I can paint, I can play music for the whole night, smoke cigarettes, meet with my mates...actually a life a great leisure” (Art)
	Contributing to stable mental health	“I think the CTO has helped, there is no doubt about that, categorically it has helped me, now I am feeling better mentally” (Art)
	Feeling indifferent	“It’s alright, I’ve lived in places like that for so many years, nothing special” (Mic)
View of self as vulnerable	Vulnerable due to unstable mental health	“I have my ups and downs, but I still have the voices and my paranoia, sometimes it’s very scary man...” (Simon)
	Vulnerable due to lack of support systems	“It gets me a bit down sometimes being on my own. There are days that I am alright being indoors and there are other days that I am out and I feel I am on my own” (Simon)
	Feeling vulnerable due to medication side effects	“... it doesn’t feel comfortable, it can be problem in your mouth, it can be no phlegm in your mouth, not phlegm but saliva, you wake up in the mornings your eyes, your eyes run water, sometimes I can’t move my legs, my body shakes” (Marlon)
	Feeling vulnerable due to stigma	“I hate it, the way people look at me, they probably think I am crazy” (Simon)
	Feeling vulnerable due to demands of living on the community	“The discipline, I mean the rigors of every day...I don’t dislike it, but it’s like a fear” (Mark).
View of self as moving towards recovery	Managing difficulties well with current treatment and living arrangements	“Not too bad. Not as bad as I was, I feel better mentally, every day i feel I get better. Now that I have my own place as well, yeah, I am doing well” (Art)
	Feeling stable due to natural process	“I think it’s a natural process, I think over the years with my illness being paranoid schizophrenia it has taken, it’s taken different kinds of, different feelings, different kinds of emotions, I think it’s a natural healing process” (Keith)
View of self as not needing treatment anymore	Having recovered due to self-determination	“I am well now, I overcame my problems, I think it’s down to the individual” (Mic)
	Having recovered due to natural process	“Things progress towards better and better, it’s part of a natural process, like with my mental illness” (Manny)
View of self as never had mental health difficulties	Always have been mentally well	“I don’t believe I have a mental illness, I have never had mental problems” (Paul)
	Having difficulties of a different nature	“I don’t have any mental health difficulties. But when I was on that 9 month binge 11 years ago, when I was taking a lot of Class A drugs, Class B, Class C... that caused me to have audio and visual hallucinations, which

		they then diagnosed paranoid schizophrenia” (Vinnie)
View of medication	Involving harmful side effects	“Some of them are known to make you really fat, some of them are known to make you really lazy... they really mess me up, they really screw me up” (Vinnie)
	Means of social control	“...the clozapine, it is a very strong sedative...I don’t know why people want other people to be somatised or subdued in such a way, you know easier to control, easier to fit in line” (Paul)
	Ineffective	“...the drugs haven’t solved my issues, I still have these issues” (John)
	Necessary to avoid relapse	“It’s helpful, the medication is very helpful, for example, for depression every morning I will take one pill and is helping me all day, when I go to bed I will take another pill, I need to take it to stay well” (Bob)
	Contributing to stable mental health	“I enjoy taking medication, it does help people with illness, for people like me, I need to take medication, because if I didn’t take medication, I would be like, I would relapse...it’s very important to take medication” (Miles)
View of psychiatrist	Understanding	“He is a nice person, he listens to me, he helps me with my problems, he is helping me...” (Art)
	Helpful with hospital discharge	“...we get on along very well; he helped to get into the CTO in the first place. Otherwise I would still be in hospital now” (George)
	Not empathetic enough	“...you go and see a doctor for 15 minutes, a consultant, and they make their assumptions about you, about what you said, why you said it, the way you speak, and they make their assessments in those ways...” (Keith)
	Hiding information from service users	“That’s why I am telling you, they are hiding something; he said he wasn’t my psychiatrist when I last saw him” (Simon).
	Neutral view	“I find him alright; I just have to see him every 3 months. It’s like you go to his office, you see him, and you have a chat, you say that you take your medication, and that’s about it” (Mic)
View of care coordinator (CC) and psychologists	CC as helpful with practical tasks	“We discuss things face to face and he helps me with my accommodation...because sometimes there are things that I don’t know what to do and he helps me do, like doing things, with housing, with freedom pass, with anything...he has been very helpful” (Bob)
	CC as not understanding	“He doesn’t seem to understand, or currently doesn’t understand...cause I suffer from paranoia, I don’t really like the idea of getting involved with too many things, I’d just rather be, living a quiet life.” (Keith)
	CC as main source of support	“...when he’s coming every week, it’s good, I can talk about my problems, what I am thinking inside” (Bob)
	Neutral view of CC	“I don’t have a problem with her, she is just doing her job” (Mic)

	Psychology as providing space for discussion	“I think I just love speaking with a psychologist, just love speaking to a psychologist... the power of words” (George)
		“I suppose Ms X, the psychologist I see, she sits down and listens to me and maybe asks the odd question to provoke, to provoke some sort of continuation to the discussion I am having, eh, which is good...” (Miles)
	Psychology as ineffective	“I don’t feel that counselling has helped me too much, it’s helped a little bit, but I mean, it’s not really made any drastic returns into my way of feeling...” (Keith)
	Unsure about effectiveness of psychology	I am sure what a psychologist can do for me, I don’t think they can give answers to my problems” (Paul)
CTO as beneficial	Providing more freedom compared to hospitalisation	“I find it very helpful now that I am out of hospital, it’s much better for my freedom, I have more freedom here” (Miles)
	Providing opportunities for socialising	“Now that I am out of hospital I hang out with my mates, we smoke spliffs, listen to music, it’s much better” (George)
	Providing opportunities for leisure activities	“I can go out any time, meet friends, play pool, go out with girls, have fun if you know what I mean” (George)
	Providing accommodation in the community	“A CTO allows me to stay here, offers me a place so I can go back, straighten my life” (George)
	Contributing in stable mental health	“I feel better in the community, it’s good for me, CTO helps you get better I think” (Art)
	Providing a sense of normality	“The CTO is helpful, for example, now I am supporting myself, I started now supporting myself, I do some things with my colleagues and finally I become normal, because I live in more normal situations” (Miles)
	Increasing motivation	“Once you are on a CTO, you know you have a net there so you pursue work, relationships, things like these which are important in a pyramid of health” (Mani)
	Improving independent living skills	“I cook my food, I clean my room, I go shopping, I can do everything by myself” (George)
CTO as a safety net	Monitoring mental health in community	“You have people look after you, when I feel low, I can talk about my problems with my doctor, the nurses...” (Mani)
	Providing structure	“It made me become a bit more active, I am part of the community, instead of having a recluse type of life” (Mark)
	Keeping patients away from trouble	“Now I have to see them almost every day, I have to go there for my medication; they give me advice how to avoid the wrong people” (Simon)
Neutral about CTO	Staying out of hospital	“I don’t know much about my CTO, but it’s good that I am not in hospital anymore” (Mic)
	Set of rules to follow	“...you just stick to what they are asking you to do. They say, you must attend all appointments here, so I make

		sure I come all the time. There are certain things you have to do” (Marlon)
CTO as a burden	Restrictive	“I think it is an infringement of my personal liberties.” (Vinnie)
	Punishing	“It’s a bit like a punishment really, It feels like I’ve been punished for been ill, I was ill so, it just feels like you’ve been punished in one way or another” (Keith)
	Ineffective treatment	“It’s not helpful because they are not doing anything for us, there is nothing they are doing for us and they are claiming they are doing something for us, they are not” (Bill)
	Psychologically damaging	“I feel worse since I’ve been placed on a CTO, I feel low in mood” (Vinnie)
Family and intimate relationships	More frequent family contact since CTO	“I see my mum every day at work; I pop to her work and see her...” (Miles)
	Limited family contact due to difficult relationship or distance	I don’t see them very often; we never got on really well, especially with my mum... (Marvin)
	Lack of family contact due to difficult relationship or other reasons	“I mean, we never had a good communication with my family anyway, there has never been good communication, there has been a breakdown in communication, so that’s one of the reasons why we didn’t stay in contact so much...” (Keith)
	Improved relationship with partner since onset of CTO	“Yeah because before we were separated by the system, I was in hospital, she was here, since I got placed on a CTO we got together again, it improved our relationship” (Vinnie)
	Lack of intimate relationship due to stigma	“Maybe taboo of mental health, maybe the mental health services put you in a category in society whereby you know, girls are not attracted to you because you are thought in a certain way in society” (Manny)
Relationships with friends and local community	Lack of friends	“I have no friends, everybody is trying to use me, I got no friends at all, not even one, I am by myself” (Mark)
	Limited contact with friends	“I don’t have any friends, only one guy is coming and visiting me, other than that I have no friends” (Bob)
	Difficulty forming new friendships while on CTO	“You can’t make new friends when you are in that” (Marlon)
	More frequent contact with friends	“I could go out every day, meet friends... I get along with people better” (Miles)
	Lack of or limited close friendships	“I don’t have a lot of friends; my only friends are people I met in hospital. I used to know a lot of people before my illness” (Bob)
	Lack of contact with local community	“I speak sometimes to a neighbour, but I don’t know anyone around here” (Paul)
	Limited contact with local community	“They are some neighbours that are Somalians and we see each other sometimes, I know the Somalians” (Mic)

