



A systematic review of the views and experiences of subjects of community treatment orders



Deborah Corring*, Richard O'Reilly, Christina Sommerdyk

Department of Psychiatry, Faculty of Medicine and Dentistry, Clinical Skills Building, Rm. 3700, Western University, London, ON, Canada

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ABSTRACT

Objective: CTOS have been the subject of many qualitative and quantitative research studies. Both research approaches add value to our understanding of CTOs. Qualitative studies provide an understanding of CTOs and the experience of being on a CTO that quantitative studies cannot provide. Many qualitative studies that have examined the views of subjects of CTOs have been published. However, authors of these studies continue to note that views and experiences of the subjects of these orders are not well known. This paper provides the results of a systematic review of qualitative studies focused on understanding the experiences of individuals who have been the subjects of CTOs.

Method: Relevant databases and grey literature were searched. To be included, a study had to have used a qualitative methodology for data collection and analysis, and focus on examining stakeholder perspectives on the lived experience of CTOs.

Results: After a rigorous review of the abstracts, we identified 22 papers that met the criteria. These papers were analysed in detail in order to examine the existence of common themes. The 22 papers represented the views of 581 participants from 7 countries around the world. Ten themes were found to be common among the research findings of the 22 papers. Three themes in particular were highlighted: feelings of coercion and control, medication seen as the main reason for a CTO and that the perception of CTOs as a safety net. Findings also highlight the ambivalence that subjects of CTOs experience, the importance of the therapeutic relationship for successful engagement of the subject of the CTO and the complex role of coercion.

Recommendations: We have made a number of recommendations about how clinicians might use the views of the subjects of CTOs achieve a more positive experience of a CTO.

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* Corresponding author at: 126 Chalet Crescent, London, ON N6K 3C6, Canada.
E-mail address: deb.corrington@rogers.com (D. Corring).

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1. Introduction

Community treatment orders (CTOs) are legal statutes that require a person, who suffers from a serious mental illness, to adhere to a plan of treatment and supervision while living in the community. In this article the term CTO is used to encompass various legal statutes, including court ordered outpatient committal in the US (OPC) and conditional leave provisions that can only be initiated while a person is a patient in an inpatient psychiatric unit. Mandatory treatment and supervision applicable when a patient with a mental illness has been charged with committing a criminal offence is excluded. Quantitative studies have produced only limited evidence to support the efficacy of CTO (Kisely & Campbell, 2014; Maughan, Molodynski, Rugksa, & Burns, 2013). There has been controversy about the interpretation of the findings of quantitative studies of CTOs (Kisely & O'Reilly, 2015), and scholars differ on whether the evidence from quantitative studies is strong enough to justify the use of CTOs (Burns et al., 2013; Swanson & Swartz, 2014). Qualitative studies provide information and understanding of phenomena that quantitative studies cannot provide as qualitative studies are able to explore in detail, with limited assumptions for the researcher, issues such the positive and negative experiences of people who are placed on CTOs and which aspects of being on a CTO are most helpful and which most problematic.

Several authors have suggested that the views and experiences of the subjects of CTOs are not well known (Atkinson, Garner, Gilmour, & Dyer, 2002; Canvin, Bartlett, & Pinfold, 2002; Stuen, Rugksa, Landheim, & Wynn, 2015) although many qualitative studies examining patient views of CTOs have been published. Recently, Francombe Pridham et al. (2014) reviewed both qualitative and quantitative

studies of patients' views of CTO. Their analysis focuses on coercion and its mitigation and therefore was not intended to analyse the qualitative literature on the broader perspective of patients' views of CTO. In the current article we report the findings of a systematic review of qualitative studies that have examined the broader views and experiences of individuals who have been the subjects of CTOs.

2. Methods

Qualitative systematic review, sometimes called qualitative evidence synthesis, is a method for integrating or comparing the findings from qualitative studies (Grant & Booth, 2009, pp. 99). The accumulated knowledge resulting from this process may lead to the development of new theory, an overarching narrative, a wider generalization or an interpretative translation. A qualitative systematic review looks for themes or constructs that lie in or across individual qualitative studies. The goal is not to add studies together but to broaden understanding of a particular phenomenon (Grant & Booth, 2009, pp. 99). The Cochrane Collaboration's Qualitative Research Methods Group promotes the use of 'qualitative evidence syntheses' as the terminology of choice. In Chapter 20 of the *Cochrane Collaboration's Handbook for Systematic Reviews of Interventions* (Noyes et al., 2008) it is noted that a synthesis of the evidence from qualitative research can explore questions such as how people experience illness, why an intervention does or does not work, and for whom and in what circumstances an intervention is likely to be effective?

We wanted to better understand what subjects of CTOs had to say about CTOs in their own words: in particular the elements which subjects found positive and negative and whether subjects approved of

Table 1
Studies included in the review.

Country	Authors	Focus	Number of participants	Methods
Australia	Brophy & Ring, 2004	Efficacy of CTOs in Australia	30	Focus groups
	University of Sydney, 2013, Light et al., 2014	Lived experience of involuntary treatment in Australia	5	Interviews
Canada	Dreezer & Dreezer, 2005	Mandated Legislative review	47	Interviews
	O'Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006	Impact of Legislation	11	Interviews
	Mfoafo-McCarthy, 2010	CTOs with Minorities	24	Interviews
	Corring et al., 2010	Quality of Life and CTOs	8	Interviews
	Schwartz et al., 2010	Lived experience of CTOs	6	Interviews
	Malatest and Associates, 2012	Mandated Legislative review	60	Focus Groups
England	Canvin et al., 2002; Canvin, Bartlett, & Pinfold, 2005	Views on Compulsory Treatment	12	Interviews
	Patkas, 2012	Male perceptions of CTOs	15	Interviews
	Jobling, 2013	Policy & Practice issues	18	Interviews
	Rawala & Gupta, 2014	Use of CTOs in inner London	6	Focus Group
	Canvin, Rugksa, Sinclair, & Burns, 2014	Experiences with CTOs	26	Interviews
	Stroud, Banks, & Doughty, 2015	CTO user experiences	21	Interviews
	Banks, Stroud, & Doughty, 2015	Lived experience on CTOs	21	Interviews
New Zealand	Gibbs et al., 2004; Gibbs, Dawson, Ansley, & Mullen, 2005; Gibbs, Dawson, & Mullen, 2006, Gibbs, 2010	User views of CTOs in New Zealand	42	Interviews
Norway	Riley, Hoyer, & Lore, 2014	OP Commitment experiences	11	Interviews
	Stensrud, Hoyer, Granerud, & Landheim, 2015	Patient experiences with OP Commitment	16	Interviews
	Stuen et al., 2015	Patient experiences of CTOs on an ACT team	15	Interviews
Scotland	Atkinson et al., 2002	Impact of changes to the MH Act	64	Interviews
	Ridley & Hunter, 2013	Impact of Legislation	49	Interviews
USA	Scheid-Cook, 1993	OP Commitment in North Carolina	68	Interviews
	Steadman et al., 2001	NY City Involuntary OP Commitment Pilot	12	Focus groups

^a Papers that reported on the same study were combined as follows: (Gibbs et al., 2004, 2005, 2006; Gibbs, 2010; University of Sydney, 2013; Light et al., 2014; Canvin et al., 2002; Canvin et al., 2005; Stroud et al., 2015; Banks et al., 2015).

the use of CTOs. To do so we analysed all the published qualitative research and the grey literature relevant to this objective. To be included in the review a study had to have used a qualitative methodology (such as, phenomenology or ethnography) to examine stakeholder perspectives and/or their lived experience of CTOs.

On October 2, 2015 a search of PsycINFO-OVID (1967 to 2015), PubMed (1966 to 2015), EMBASE-OVID (1980 to 2015), and CINAHL-EBSCO (1981 to 2015) data base was completed using the terms in Appendix 1, which were adapted from Churchill, Owen, Singh, & Hotopf, 2005. In addition the grey literature was also searched (see Appendix 1 for a complete list of search terms).

All of the generated abstracts were read by one of the authors (CS). If the abstract contained any indication that the paper used qualitative methods to examine stakeholder perspectives about CTOs, the article was retrieved and read in full by all three authors. A decision on whether inclusion criteria were met was made by consensus. Studies that merged stakeholder perspectives so that it was not possible to distinguish the perspectives of subjects of CTO from the perspectives of other stakeholders were also excluded (Brophy & McDermott, 2013; Owens & Brophy, 2013; Nova Scotia Health Research Foundation). Articles that were commentary only as opposed to research studies were also eliminated at this stage.

The number of study participants, methods, focus of the inquiry, country of origin and themes were recorded and then compared and contrasted to determine consistencies and inconsistencies.

3. Results

We retrieved 152 abstracts of published papers from the databases and an additional 15 from the grey literature. Seventy-eight (78) articles were excluded after reading the abstract and an additional 46 after reading the full paper. This left 43 articles that described the views about CTOs of various stakeholders. A number of papers were duplicates or analysis of a subgroup of subjects from an original study. All of these reports were read and the findings subsumed under the original report. See footnote A, Table 1 for specifics.

Twenty-two of these studies – 20 published articles and formal reviews from 2 Canadian provinces – were determined to distinctly report the perspectives of subjects of CTOs and therefore were included in the current systematic review as illustrated in Table 1 above.

Together these studies incorporated the views of 581 participants from 7 countries around the world. The studies had a number of different focuses. They explored subjects' overall experience of being on a CTO, the impact of changes to legislation, the experience of patients on assertive community treatment teams who were also subject to a CTO, the experience of specific ethnic groups, the impact of CTOs on relationships, views of CTOs by subjects of different gender and the impact of CTOs on the subjects' quality of life.

Each author of this paper recorded the themes and sub-themes reported in the 22 papers independently using the constant comparative method to compare and contrast themes and identify themes and the relative prominence of the themes. The constant comparative method is a process in which any newly collected data is compared with previous data in a continuous ongoing procedure in order to confirm or discount themes. Several iterations of this comparative analysis were performed until there was consensus on the themes found in the literature and on the prominence or strength of one theme relative to another. In this way the important credibility strategies of triangulation and saturation were achieved. Triangulation was achieved given the multiple researchers, multiple data sources and multiple methods that were used to gather data. Saturation was achieved when it became clear that there were no new themes emerging from the results of the 22 studies. Additionally, despite the obvious ambivalence of many participants regarding the effectiveness of CTOs discussed later in the results section no negative cases were found. A "negative case" is one

in which respondents' experiences or viewpoints differ from the main body of evidence.

It should be noted that most of the researchers (85%) of the articles we reviewed highlighted sampling and recruitment concerns. Sixty-five percent of the studies used a purposive sampling strategy to attempt to achieve maximum variation in the sample but many authors still questioned sample representativeness due to issues such as the rigorous process of obtaining informed consent (Canvin et al., 2002), the subjects recent experience of compulsory care or degree of illness (Gibbs et al., 2004), likelihood that some subjects are more willing to volunteer than others (Mfoafo-McCarthy, 2010), and the subjects' fear of negative consequences should they participate (Gjesfeld & Kennedy, 2011). Other researchers made a definitive effort to recruit all subjects on a CTO in a defined area or at least representative sample (Gibbs et al., 2004; O'Reilly et al., 2006).

In the end 10 themes were identified. The results of the review will be provided in two parts. The first discusses the three themes that had the strongest presence in the identified articles and, which were labeled in a similar manner. The second discusses the remaining seven themes that after further analysis were grouped together into what we considered similar findings even though somewhat different labeling was used in the original papers.

A sample of quotes from the original research has been provided to illustrate the themes. We note that not all papers included direct quotes.

3.1. Feelings of being coerced and controlled

Many subjects of CTOs said they were compliant with a CTO once it was in place as they felt there was no choice but to do so. Examples of quotes from participants that illustrate this theme are noted below:

"Yes, it's forced follow up. I need a Trilafon injection every fortnight because the psychiatrist thinks I have a mental illness. I reckon I don't. I asked the doctor to stop Trilafon, but he wouldn't. So, I'll just have to continue. And then it is forced" (Stensrud et al., 2015).

"I'm a bit paranoid, but that's no reason for keeping me under detention for ten years. They want me in the system to have me under control" (Stuen et al., 2015).

"Just basically restricting [the compulsory treatment order] because I've got to keep to rules and regulations under it...I normally like to do things at my leisure... I don't like the emotional threat of 'you'll be re-called into hospital' if you don't". (Ridley & Hunter, 2013).

"I must do as they say, go to the doctor to get an injection, go to a psychiatrist to talk, go to a psychiatric nurse to talk. When I'm forced I feel it in my body. It's really tough. Just like tons of rocks being put on my back...I get pressed down... I have to live up to their expectations...the way I think they expect me to be." (Riley et al., 2014).

3.2. Medication adherence seen as the main reason for CTOs

Ensuring adherence to medications is frequently seen by patients as the primary reason for a CTO. For some this is a contest of wills while others indicated an awareness of medications keeping them well. Side effects, and relationships with physicians were often cited as reasons for acceptance or resistance to compliance with CTOs.

"...the real issue was about will, whose will was stronger, and who's not getting their way with the decision about taking the medication" (O'Reilly et al., 2006).

"I felt that part of my CTO and part of my injections were in conflict because I didn't feel in control of my injections. I was being told you've

got to have them. It felt like the responsibility had been taken out of my hands. It was in the hands of nurses and doctors and I thought well that's not fair...so I went up to the medical centre and they started doing it. I settled down a bit better." (Jobling, 2013).

"They just want me to take the medication but I think the mental health services rely too much on medication and not enough on other means of solving people's problems" (Canvin et al., 2014).

3.3. CTOs seen as providing a safety net

Seeing a CTO as a way to ensure safety was a frequent theme. Subjects of CTO felt assured that their care givers would catch warning signs of exacerbation of their illness before it resulted in need for a long period of re-hospitalization or other such negative outcomes.

"You get a lot of help. You're supervised in the community, so you don't get worn down and lose control of yourself. They can stop something serious from happening." (Canvin et al., 2002).

"They [staff] could automatically get you into hospital if you get ill and catch it in the bud." (Atkinson et al., 2002).

"I was pretty much into self-harm and attempting suicide. I don't think I would be here now if I wasn't on it." (Gibbs et al., 2005).

"I haven't talked to them about personal stuff yet, but she [the psychiatrist] said it would take time to get to know each other and that it will not happen at once. They just take me as I am. The most important is that they pick up the phone when I call, and to know that they are accessible when I call. They have helped me with a lot of things." (Stuen et al., 2015).

As noted above the remaining 7 themes required additional examination using the constant comparative approach and discussion by researchers in order to agree on the meaning of the various results reported. To this end we carefully matched themes with one another even though slightly different wording was used by different authors. In addition, an analysis of the rationale provided by the authors regarding the themes they found in their study was used to identify the themes noted below. A sample of quotes from the originating research has been provided to illustrate the themes.

3.4. Positive relationships with clinicians help

Relationships with clinicians that were collaborative and recovery focused helped subjects of CTOs to accept the conditions of a CTO and feel that they could regain some control over treatment decisions.

"It helps to have someone guide you and be your backup. I like being on a team." (Malatest & Associates, 2012).

"She's a good psychiatrist, she's changed my medication a few times. I've told her that my medication that I was on wasn't working for me and she's changed it about until she got the right combination." (Ridley & Hunter, 2013).

3.5. Difficult relationships with clinicians

In contrast, interactions with clinicians that subjects viewed as lacking understanding or sensitivity to the subjects' problems or associated with inflexible expectations, having a lack of appreciation for their thoughts regarding what they were presenting as difficulties and rigid expectations were problematic for subjects of CTOs.

"What worries me a bit is that there can easily be misunderstandings if it's very rigid. What if I'm really trying hard to stick to their rules and something happens beyond my control?" (Stensrud et al., 2015).

"I think it was a case of banging your head against a brick wall, it's really like what's the point, you know in the end ... you have to do it anyway." (Light et al., 2014).

3.6. Subjects' concerns that they lacked knowledge about CTO legislation and processes

"Did she explain the reasons? Yeah, poorly you know, with poor explanations, and poor misinterpreted information." (Schwartz et al., 2010).

"Yeah, it was a shock. It was definitely a shock being on a CTO, because I didn't understand what it meant, it was still a shock definitely. ..." (Light et al., 2014).

3.7. Subjects feeling that a lack of respect and dignity was sometimes present

"...mentalism is like racism... one incident when I was in hospital to be admitted, the nurse was so scared of me. She was talking about me like I wasn't even there. But I didn't talk. I should have said something, but I didn't." (Mfoafo-McCarthy, 2010).

"...like ask them what they think of the injection process, having to go to hospital every second week and have the injections and have student nurses watching over and all that process, it can be a bit humiliating." (Light et al., 2014).

"I think the patients ought to be listened to more often and they're allowed a say because it is concerning them, and no bigwig doing all the talking for us..." (Ridley & Hunter, 2013).

3.8. CTOs were valued because of services provided

"I'm on my own. I need someone like a social worker to come and drop off my medication, a doctor to come in every six months to see me, to make sure I'm alright. I've got no-one. People like me need thing like that [a CTO]." (Stroud et al., 2015).

"There are advantages and disadvantages of being on a CTO. One of the advantages is that you have a support system. They come in and they support you very well." (Mfoafo-McCarthy, 2010).

"It's [a CTO] to make sure you're given the best recovery, to make sure that you're taking medication, because obviously it keeps you well, and it helps you get on top of your life again..." (Light et al., 2014).

3.9. Ambivalence regarding balancing acceptance of enforced treatment with feelings of increased wellness

"I was put on a CTO to help, well I was explained to help bring things, to respect their help, get me help with housing and kids, court, get me back into perspective, work, and home. In some aspects it did help and in some aspects it hasn't. Mind you the CTO brought me back here. I'd probably be in my own, doing my own thing and it's not bad because I don't find myself at a complete loss. I'm able to sleep and function so it's very disruptive and it means that people can make decisions for you." (Mfoafo-McCarthy, 2010).

"I'm still taking Cisordinol which I guess I have accepted. I have inner peace...so it might work...I have accepted that I can live with that

medication...now we have agreed that she [the psychiatrist] will support me to regain my driving license...and also practically, they [the ACT team] helped me to clean up my apartment.” (Stuen et al., 2015).

3.10. Being on a CTO was viewed as preferable to being in hospital

“On the surface [the CTO] does seem freer...it was better than being on section [involuntarily detained in hospital] because you would end up in hospital being away from everybody.” (Canvin et al., 2014).

“you need to ... agree on the terms of the doctors and in turn you get your freedom instead of going in and out of hospital all the time, which takes time, a bit of a while to get used to the medication and understand that and realize that the medication helps. It takes a long time, a very long time, to understand that but I believe that everyone who wants to get on with their lives will see a community treatment order as a beneficial thing.” (Stroud et al., 2015).

“Section 25 means care in the community for me, general support in the community but free time to do my own bits and pieces. Social life as well, without having to be totally dominated by being in this building 24 hours a day. More freedom, responsibilities, choices, decision making on my own rather than being told what to do all the time.” (Canvin et al., 2002).

4. Discussion

The study of subjects' experiences of CTOs is intrinsically difficult. Individuals placed on CTOs are usually individuals who are or have been uncooperative in following-up with mental health professionals and/or taking treatment. This uncooperativeness may extend to other areas such as taking part in research studies. Moreover, the individuals who are the most dissatisfied with CTOs may view research as associated with the treatment orders and be the least likely to enter a study. Refusal by a dissatisfied individual seems particularly likely when the initial invitation to take part in research is made by one of the potential subject's clinicians who may be imposing the mandated treatment. An initial approach by a patient's clinician is a requirement of many institutional review boards. Findings of qualitative studies may systematically recruit subjects with more positive views about being on a CTO. This caveat was noted by many authors of the individual studies and should be kept in mind when considering the results of this review.

As noted earlier, many researchers have suggested that the views and experiences of subjects of CTOs are not well known. For example Canvin et al. (2014) states that “current literature on personal experiences of CTOs is limited” and Stensrud et al. (2015) states that “there is little research about the content of outpatient commitment orders from a patient perspective”. This systematic review suggests that we actually know a lot about the views and experiences of subjects of CTOs. It also suggests some areas where we could “accent the positives” and “attenuate the negatives” of being on a CTO in order to improve the experiences of a being on a CTO for the subject of a CTO.

Subjects of CTOs identified both positive and negative factors that made a difference in their ability to accept CTOs. A factor that helped some subjects accept the conditions of a CTO, albeit with some ambivalence, was the relationships with and help provided by their clinicians. In contrast a negative factor for other subjects appears to be was insufficient information about CTOs, including the purpose of their CTO and their rights as a subject of a CTO. It is possible that a scrupulous approach to providing information in both verbal and written form with repeated presentations might help patients understand the reasons for being placed on a CTO and increase acceptance. Working with patients who lack appreciation of the need for treatment can be taxing on clinicians and requires that the clinician uses specific skills to maintain a respectful and caring relationship in the context of

coercion. The experiences of the subjects of CTOs suggest that some clinicians have not learned these skills.

Some jurisdictions have addressed these factors. For example, the England and Wales Mental Health Act Code of Practice (2015) outlines the expectations and responsibilities of clinicians and managers regarding what information should be provided to patients on CTOs and aspects of the relationship with the patient that are likely to be helpful. The code of practice recommends involving patients (and relatives) as much as possible in formulating the treatment plan as well as providing copious communication and ensuring that patients know their rights. The Mental Health Act of the province of Manitoba in Canada has similar provisions. Codes of practice are a way in to develop a standard approach to clinical care. We suggest that professional organizations, particularly medical authorities – because physicians are vested with the most authority and responsibility for implementing CTOs – consider the development of codes of practice similar to that which exists in England and Wales. We also recommend that services providing care under CTOs provide specific training to their staff on managing relationships with patients who are under legal coercion.

Many scholars have advocated the use of CTOs noting that, while CTOs require the person to take treatment and attend appointments in the community, they are less restrictive than being an involuntary inpatient (Segal & Burgess, 2006). Others question whether CTOs are truly a least restrictive alternative because patients who are placed on CTOs typically remain under coercion for a longer period of time (Trueman, 2003). The views of subjects of CTOs appear to support the position that CTOs are in reality less restricting. In many of the studies we reviewed subjects reported that “being on a CTO is better than being in hospital.” This is in keeping with the findings of a quantitative study by Swartz, Swanson, et al. (2003), who reported that persons with schizophrenia, who are potential subjects of CTO, rated the coerciveness of outpatient commitment as less problematic than other possible outcomes such as inpatient admission.

The subject of coercion and patient reactions to such practices has been discussed in the literature for more than three decades. Hiday (1996) in the second chapter of *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law* reviewed the literature on outpatient commitment and the subject of coercion from several perspectives including patient responses to coercion. These authors noted that patient attitudes towards coercion often begin with anger and resentment when coercion is first applied but that these negative feelings usually lessen with time and were replaced with an appreciation for the earlier need for coercion.

Francombe Pridham et al. (2014) exploring the perception of coercion among patients who had been subject to a CTO, reviewed 23 articles reporting on 14 qualitative and quantitative studies from seven countries. They recommended a number of approaches that may reduce the coercive elements of CTOs. These included increasing patient access to information, developing better working relationships between patients and service providers and more fully including the patient in the processes of the CTO. The findings from this study support these suggestions.

Qualitative studies highlight the significance patients on CTOs place on positive and negative aspects of relationships with their relatives and with clinicians. The relationship between clinicians and a patient on a CTO is a complex one that requires the clinician to ensure that the patient adheres to a plan of treatment to which the patient has not given consent. Maintaining an approach that is respectful of the patient's dignity requires specific skills and some clinicians working in community settings may require special training to master those skills. Many hospitals have implemented recovery oriented education for their clinicians as one way to enhance the development of positive, supportive therapeutic relationships. It is important that these hospitals consider how clinicians can best work with patients under compulsion, whether in an inpatient or outpatient setting.

Coercion is intrinsic to CTO. While it cannot be totally avoided we should try to attenuate it as much as possible. Research shows that

involuntarily hospitalized patients value procedural justice (Lidz et al., 1995) and anger at hospitalisation is muted when patients feel that their views have been heard (Galon & Wineman, 2010). The qualitative literature indicates that patients who are subject to CTOs complain that they are unaware of their obligations and rights. Patients' views suggest that CTO legislation should include provisions to ensure that subjects of CTOs, and any formal substitute decision makers, receive the information necessary to understand the CTO and also to have an opportunity to influence the development of the treatment plan. Legislative options to support these objectives may include provisions such as, a requirement to deliver rights advice to the patient and substitute decision maker (Ontario, *Mental Health Act* 33.1(8)), or a requirement that a substitute decision maker take into consideration an incapable patient's values and incapable wishes when making treatment decisions (Ontario, *Health Care Consent Act* 21.2(a) & (b)). Importantly, hospitals and clinicians can commit to the principle by going beyond the minimal requirements of legislation to a "best effort" to ensure that patients and substitute decision makers understand the process and contribute to the treatment planning as much as possible.

Subjects of CTOs regularly complain that appealing to a review board is futile. Studies suggest that there are low rates of revocation of CTOs by review boards (Malatest & Associates, 2012). This may occur because clinicians are careful to ensure that patient placed on a CTO meet the legislated criteria. When courts and review boards consider CTOs they often confine their judgement to the question of whether the legal criteria for issuing a CTO are met, deferring to medical expertise on the actual content of the treatment plan. Some jurisdictions require a physician to consider obtaining a second opinion for patients who are on CTO if the patient requests one (British Columbia, *Mental Health Act*, S.31(2)). The views of subjects of CTO suggest that, at a minimum, legislation should provide for a second opinion at the request of the patient.

Treatment plans associated with CTOs primarily require patients to attend clinical appointments and to take prescribed medication (O'Reilly, Dawson, & Burns, 2012). Thus, it is not surprising that subjects of CTOs report that it is "all about taking medication." One approach to "attenuate" the negativity of this perception is to ensure that patients on CTOs are offered additional needed services. It is clear from this review and O'Reilly, Corring, Richard, Plyley, and Pallaveshi (2016) that access to intensive services is valued by subjects on CTOs.

We hope that the views of individuals who have received mental health services while subject to a CTO presented in this systematic review can inform policy makers and clinicians so that the design and implementation of legislation attains its objective while minimizing the sense of coercion and other negative effects on those subject to compulsory community treatment.

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The corresponding author confirms that none of the authors have any conflicts of interests.

Appendix 1. Search terms

1.1. Databases

"CTO" OR "community treatment order" OR "community treatment orders" OR "mandatory outpatient" OR mandatory outpatient treatment OR mandatory outpatient release OR mandatory outpatient commitment OR "involuntary outpatient" OR "IOT" OR involuntary outpatient treatment OR involuntary outpatient release OR involuntary outpatient commitment OR "outpatient commitment" OR "OPC" OR "involuntary commitment" OR "assisted outpatient treatment" OR "AOT" OR conjunction of civil commitment OR "OPC" OR "outpatient commitment"

OR "conditional release" AND qualitative OR "lived experience" OR "lived experiences" OR "client perspective" OR "client perspectives" OR "stakeholder view" OR "OR" stakeholder views" OR "qualitative review" OR "qualitative reviews" OR "qualitative study" OR "qualitative studies" OR "qualitative investigation" OR "qualitative research" OR ethnography OR ethnology OR "narrative therapy" OR "philosophical inquiry" OR "grounded theory" OR "participant action" OR "phenomenology" OR experience OR experiences OR perception OR perceptions OR interview OR interviews.

1.2. Grey literature

Google search using the terms: "Community Treatment Orders and qualitative research" which produced 25,300,000 hits. Given the large number of hits the research assistant then searched until 2 consecutive pages included links that were no longer relevant to the topic, for example if page 3 and 4 of the Google search were all irrelevant, then any pages after that were not searched.

References

- Atkinson, J., Garner, H., Gilmour, W., & Dyer, J. (2002). Change to leave of absence in Scotland: The views of patients. *The Journal of Forensic Psychiatry*, 13(2), 315–328.
- Banks, L. C., Stroud, J., & Doughty, K. (2015). Community treatment orders: Exploring the paradox of personalisation under compulsion. *Health and Social Care in the Community*. <http://dx.doi.org/10.1111/hsc.12268>.
- British Columbia, *Mental Health Act* (1996). RSBC, S.31(2).
- Brophy, L., & McDermott, F. (2013). Using social work theory and values to investigate the implementation of community treatment orders. *Australian Social Work*, 66(1), 72–85.
- Brophy, L., & Ring, D. (2004). The efficacy of involuntary treatment in the community: Consumer & service provider perspectives. *Social Work Approaches in Health and Mental Health*, 2(2/3), 157–194.
- Burns, T., Rugkasa, J., Moldynski, A., Dawson, J., Yeeles, K., Vaquez-Montes, M., ... Preibe, S. (2013). Community treatment orders for patients with psychosis (OCTET): A randomized controlled trial. *Lancet*, 381, 1627–1633.
- Canvin, K., Bartlett, A., & Pinfold, V. (2002). A 'bittersweet pill to swallow': Learning from mental health service users' responses to compulsory community care in England. *Health and Social Care in the Community*, 10(5), 361–369.
- Canvin, K., Bartlett, A., & Pinfold, V. (2005). Acceptability of compulsory powers in the community: The ethical considerations of mental health service users on supervised discharge and guardianship. *Journal of Medical Ethics*, 31, 457–462.
- Canvin, K., Rugkasa, J., Sinclair, J., & Burns, T. (2014). Patient, psychiatrist and family caregiver experiences of community treatment orders: Qualitative study. *Social Psychiatry and Psychiatric Epidemiology*, 49, 1873–1882.
- Churchill, R., Owen, G., Singh, S., & Hotopf, M. (2005). International experiences of using community treatment orders. psychrights.org/research/Digest/OutPtCmntmnt/UKRptnCTO.pdf
- Corring, D., Anders, K., Bateman, L., Harshaw, S., Shlomovitz, E., Diaz, K., & Peer, I. (2010). Perspectives on quality of life provided by persons with serious mental illnesses who are on a community treatment order: A naturalistic enquiry involving critical case sampling. *Research Insights - Regional Mental Health Care London & St. Thomas*, 7(2), 1–16.
- Dreezer, & Dreezer (2005). *Report of the legislated review of community treatment orders required under section 33.9 of the Mental Health Act*. Toronto, ON: Ontario Ministry of Health and Long Term Care.
- Francombe Pridham, K. M., Berntson, A., Simpson, A. I. F., Law, S. F., Stergiopoulos, V., & Nakhost, A. (2014). Perception of coercion among patients with a psychiatric community treatment order: A literature review. *Psychiatric Services in Advance*, 1–13. <http://dx.doi.org/10.1176/appi.ps.201400538>.
- Galon, P. A., & Wineman, N. M. (2010). Coercion and procedural justice in psychiatric care: State of the science and implications for nursing. *Archives of Psychiatric Nursing*, 24(5), 307–316.
- Gibbs, A. (2010). Coping with compulsion: Women's views of being on a community treatment order. *Australian Social Work*, 63(2), 223–233.
- Gibbs, A., Dawson, J., Ansley, C., & Mullen, R. (2005). How patients in New Zealand view community treatment orders. *Journal of Mental Health*, 14(4), 357–368.
- Gibbs, A., Dawson, J., Forsyth, H., Mullen, R., & Te Oranga Tonu Tanga (2004). *Australian & New Zealand Journal of Psychiatry*, 38, 830–835.
- 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.
- Gjesfeld, C., & Kennedy, M. (2011). Outpatient commitment on the ground: Listening to consumers and providers. *Advances in Social Work*, 12(2), 152–163.
- Grant, M., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information and Libraries Journal*, 26, 91–108.
- Hiday, V. (1996). Outpatient commitment: Official coercion in the community. In Dennis, & Monaghan (Eds.), *Coercion and aggressive community treatment: A new frontier in mental health law*. New York and London: Premium Press.

- Jobling, H. (2013). Using ethnography to explore causality in mental health policy and practice. *Qualitative Social Work*, 13(1), 49–68.
- Kisely, S. R., & Campbell, L. A. (2014). Compulsory community and involuntary outpatient treatment for people with severe mental disorders, Cochrane Database of Systematic Reviews 2014;12: Cd004408. *Cochrane Reviews* (http://www.cochrane.org/CD004408/SCHIZ_compulsory-community-and-involuntary-outpatient-treatment-for-people-with-severe-mental-disorders Accessed 29th September 2016).
- Kisely, S., & O'Reilly, R. (2015). Reappraising community treatment orders — Can there be consensus? *Medical Journal of Australia*, 202(8), 415–416.
- Lidz, C. W., Hoge, S. K., Gardner, W., Bennett, N. S., Monahan, J., Mulvey, E. P., & Roth, L. H. (1995). Perceived coercion in mental hospital admission. Pressures and process. *Archives of General Psychiatry*, 52(12), 1034–1039.
- Light, E., Robertson, M., Boyce, P., Carney, T., Rosen, A., Cleary, M., ... Kerridge, I. (2014). The lived experience of involuntary community treatment: A qualitative study of mental health consumers and carers. *Australasian Psychiatry*, 22(4), 345–351.
- Malatest & Associates (2012). *The legislated review of community treatment orders: Final report*. Toronto, ON: Ontario Ministry of Health and Long Term Care.
- Maughan, D., Molodynski, A., Rugksa, J., & Burns, T. (2013). A systematic review of the effect of community treatment orders on service use. *Social Psychiatry and Psychiatric Epidemiology*. <http://dx.doi.org/10.1007/s00127-013-0781-0>.
- Mfofo-McCarthy, M. (2010). *'Experience is the best teacher': Community treatment orders (CTOs) among ethno-racial minority communities in Toronto: A phenomenological study*. (Thesis submitted in partial fulfilment for Doctor of Philosophy) University of Toronto.
- Noyes, I., et al. (2008). Chapter 20: research and Cochrane reviews. *Cochrane collaboration's handbook for systematic reviews of interventions* Version 5.0.1 Available from: www.cochrane-handbook.org.
- Ontario Health Care Consent Act. (1996) (21 (2) (a) & (b)).
- Ontario Mental Health Act, RSO 1990 ((33.1(8))).
- O'Reilly, R., Corring, D., Richard, J., Plyley, C., & Pallaveshi, L. (2016). Do intensive services obviate the need for CTOs? *International Journal of Law and Psychiatry*, 47, 74–78.
- O'Reilly, R., Dawson, J., & Burns, T. (2012). Best practices in the use of involuntary outpatient treatment. *Psychiatric Services*, 63, 421–423.
- O'Reilly, R., Keegan, D., 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.
- Owens, N., & Brophy, L. (2013). Revocation of community treatment order in a mental health service network. *Australasian Psychiatry*, 21(1), 46–50.
- Patkas, J. (2012). *Service users' perceptions of community treatment orders and their impact on interpersonal relationships*. (Thesis submitted in partial fulfilment for Doctor of Clinical Psychology) Canterbury, UK: Salomons Canterbury Christ Church University.
- Rawala, M., & Gupta, S. (2014). Use of community treatment orders in an inner-London assertive outreach service. *Psychiatric Bulletin*, 38, 13–18.
- Ridley, J., & Hunter, S. (2013). Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003. *Health and Social Care in the Community*, 21(5), 509–518.
- Riley, H., Hoyer, G., & Lore, G. (2014). 'When coercion moves into your home': A qualitative study of patient experiences with outpatient commitment in Norway. *Health and Social Care in the Community*, 22(5), 506–514.
- Scheid-Cook, T. (1993). Controllers and controlled: An analysis of participant constructions of outpatient commitment. *Sociology of Health & Illness*, 15(2), 179–194.
- Schwartz, K., O'Brien, A., Morel, V., Armstrong, M., Fleming, C., & Moore, P. (2010). Community treatment orders: The service user speaks exploring the lived experience of community treatment orders. *International Journal of Psychosocial Rehabilitation*, 15(1), 39–50.
- Segal, S. P., & Burgess, P. M. (2006). Conditional release: A less restrictive alternative to hospitalization? *Psychiatric Services*, 57, 1600–1606.
- Steadman, H., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., et al. (2001). Assessing the New York City involuntary outpatient commitment pilot program. *Psychiatric Services*, 52(3), 330–336.
- Stensrud, B., Hoyer, G., Granerud, A., & Landheim, A. (2015). 'Life on hold': A qualitative study of patient experiences with outpatient commitment in two Norwegian counties. *Issues in Mental Health Nursing*, 36, 209–216.
- Stroud, J., Banks, L., & Doughty, K. (2015). Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. *Journal of Mental Health*, 24(2), 88–92.
- Stuenkel, H., Rugksa, J., Landheim, A., & Wynn, R. (2015, Sep 23). Increased influence and collaboration: A qualitative study of patients' experiences of community treatment orders within an assertive community treatment setting. *BMC Health Services Research*, 15(1), 409.
- Swanson, J. W., & Swartz, M. S. (2014). Why the evidence for outpatient commitment is good enough. *Psychiatric Services*, 65, 808–811.
- Swartz, M., Swanson, J., et al. (2003). Assessment of four stakeholder groups' preferences concerning outpatient commitment for persons with schizophrenia. *American Journal of Psychiatry*, 160, 1139–1146.
- Trueman, S. (2003). Community treatment orders and Nova Scotia — The least restrictive alternative? *Health Law Journal*, 11, 1–34.
- University of Sydney (2013). Community treatment orders: the lived experience of consumers and carers in NSW. *Centre for values, ethics and the law in medicine* (pp. 1–51).