

INTRODUCTION

A CTO is a legal tool or mechanism, issued by a medical practitioner, which defines the conditions under which a person with a mental illness may live in the community (CMHA/Ontario Division). The consequence to the individual of failing to follow the order is return to a psychiatric facility for assessment, but not hospitalization. Other terms commonly used in place of CTO are: coercive community treatment; compulsory community treatment; involuntary outpatient commitment and community committal.

The issue giving rise to discussions at the public policy level about the need for CTOs is the apparent increasing number of mentally ill in the community who are not engaged in treatment. Accounting for this are the shifting emphasis toward more community care, the shift away from institutionally-based care, and inadequate resources and strategies for maintaining people in care after discharge to the community.

The Centre for Addiction and Mental Health initiated a review of the issue of CTOs, involving clients, families, advocacy groups, clinical and medical staffs and stakeholders, in order to encompass the broadest range of perspectives.

The utility of CTOs is a complex and controversial issue, which is reflected in the divergence of opinion within the Centre and among stakeholders.

A HOLISTIC FRAMEWORK FOR ADDRESSING THE ISSUE

Given the current state of development of the mental health system there is no way of knowing whether the call for CTOs is a symptom of the current inadequacies of the system or has some merit in its own right. The debate is clearly 'non-scientific' at this time, because there is limited supporting evidence to say CTOs work or, in fact, that they do not work. The research and experience of other jurisdictions do not lend strong support to either side of the debate.

Therefore, discussion frequently divides along ethical, clinical, and legal lines.

That being said, much can be learned from Saskatchewan's approach to introducing CTOs and the framing of their legislation. The province saw the need for a broad-based consultation process and took two years to complete it. It also assumed that the infrastructure of a comprehensive mental health system needed to be in place before any changes to the Mental Health Act were made. Thirdly, the legislation included strict criteria for issuing a CTO so as to limit the application to the very small number of people for whom it might be beneficial.

The Centre assumes, along with virtually every other stakeholder group, that a well-funded, comprehensive community-based treatment and support system is fundamental to the well-being of clients and families in any case and will likely diminish the need for CTOs. It is equally important to acknowledge the wide range of reasons/causes behind 'treatment noncompliance' and to define 'treatment' in terms broader than the acceptance of medication. Only by adopting a multi-dimensional view of the issue will the mental health system be able to address it effectively.

Under all circumstances, CTOs should be viewed as a last resort in the community to be used after all else has failed. Preference should be given to utilizing strategies along the continuum of non-coercive interventions such as specialized programs for this population, and better collaboration among clients, families and providers.

'BEST ADVICE' ON CTO LEGISLATION

This 'Best Advice' addresses the four critical areas of this complex issue: the needs of the mental health system; the scope and criteria of CTOs, the need for process around the introduction of CTOs, and the need to evaluate their effectiveness.

Treatment System and Supports

The first priority for the mental health system must be to continue to work toward establishing the services and supports necessary to provide a continuum of coordinated and accountable care. The following outlines the essential elements of an improved mental health system:

- comprehensive, responsive, accessible, client-centred services and supports
- an appropriate balance between community and institutional treatment and supports
- available supports to improve quality of life including housing, employment, income and social supports
- specialized programs tailored to meet the differential needs of the 'hard to treat' building on current service delivery models
- better methods for facilitating communication regarding treatment preferences among clients, families and providers
- a range of supports for clients and families, and client/family involvement in decision-making around this issue

The consultation concluded that an adequate, comprehensive system of care would likely minimize the need for CTOs.

Scope and Nature of CTO Legislation

In reviewing the literature, the experience in other jurisdictions and the policy positions of other organizations, it is clear that the scope of CTO legislation must be clearly and narrowly defined in order to target it appropriately and avoid its indiscriminate use. Even proponents of CTO legislation argue for its limited scope. In addition, it must be recognized that the necessary mental health services and supports must be in place to support the implementation of CTOs, otherwise they will fall into disuse, Torrey (1995).

The following criteria, based on Saskatchewan and Geller's work (1990), are designed to effect the above:

- CTO legislation must apply only to a small subset of those with mental illness, defined broadly as the 'hard to treat,' who meet all the following criteria:
 - have previously received inpatient involuntary treatment for 60 or more days, have been in an inpatient facility on three or more occasions in the last two years, or have previously been the subject of a CTO
 - have previously responded to treatment (including medication, but not limited to it)
 - are incapable of consent to treatment, even as outpatients
 - have the capacity to understand and comply with the CTO¹
 - are at risk to themselves/others
 - have a high rate of relapse
- must only be implemented where services exist in the community and are available
- services must be willing and able to monitor treatment and enforce compliance

¹ Capacity to consent to treatment suggests an ability and to understand and appreciate the nature of the illness, the nature of the proposed benefits and risks of the treatment and its alternatives, as well as the consequences of giving or withholding consent. This goes far beyond the simple act of agreeing to have and cooperate with a treatment. Most patients who are legally incapable of consent to treatment are still behaviourally able and willing to participate in treatment, whether as an inpatient or an outpatient; on inpatient basis this may only occur when there is informed substitute consent.

- determining eligibility for CTOs must be a clinical decision
- CTO legislation must have safeguards, including an appeal process

Process for Introducing CTOs

It is important to recognize the contentious nature of CTO legislation and its potential to create divisions among stakeholder groups. Steps will need to be taken by the government to forge alliances and understanding around this issue such as:

- the province should engage in a consultation process similar to that of Saskatchewan to receive input into the design and implementation of CTOs
- the appropriate community services must be in place before CTO legislation is introduced, since the viability of CTOs is dependent upon the system being capable of monitoring the individuals under them and enforcing the CTO. The government should consider delaying proclamation until programs are in place.
- any changes in legislation should be accompanied by a broad educational component for clients, families and providers to ensure the optimal use of all mental health legislation.

Research/Evaluation

There is much that needs to be learned about the effectiveness of CTOs and to this end the Centre strongly recommends that:

- CTO initiatives in Ontario have qualitative and quantitative evaluation components attached to them. Evaluation should extend beyond the standard measures of numbers of hospital re-admissions, days in hospital and medication compliance to include quality of life improvements and client/family satisfaction measures. Parallel research into the effectiveness of alternatives

such as conditional release and guardianship would be useful.

- a sunset clause based on evaluation results should be incorporated into the legislation. In the event that CTOs are shown to be ineffective in achieving higher rates of treatment compliance, they should be discontinued. There should be an explicit time frame for making this decision.

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