COMMUNITY TREATMENT ORDERS: OVERVIEW AND RECOMMENDATIONS

TABLE OF CONTENTS

INTRODUCTION

THE ISSUE UNDERLYING THE CALL FOR CTOs:
- Untreated Mentally Ill Individuals in the Community Who Are Not Engaged in Treatment

OUTCOMES OF PRIOR EFFORTS TO ADDRESS THE ISSUE

ASSESSMENT OF PAST POLICY PERFORMANCE

ADDRESSING THE ISSUE
- The Policy Need
- Literature Review on CTOs

REVIEW OF POLICY POSITIONS OF RELEVANT STAKEHOLDER ORGANIZATIONS
- CAMH Medical Advisory Committee (MAC)
- Queen Street Patients' Council
- Canadian Mental Health Association (CMHA) Ontario Division
- Ontario Medical Association (OMA) Psychiatry sub-section
- Schizophrenia Society of Ontario
- CMHA, BC Division
- CMHA, National
- Mental Health Legal Committee (MHLC)
- Family Mental Health Alliance (FMHA)
- Mood Disorders Association (MDA)
- National Association for the Mentally Ill (NAMI)
- Summary

EXPERIENCE OF OTHER JURISDICTIONS
- New Brunswick Report on CTOs Consultation Day, 1999
- Saskatchewan
- Australia

A HOLISTIC APPROACH FOR ADDRESSING THE ISSUE

BEST ADVICE' ON CTOS
- Treatment System and Supports
- Scope and Nature of CTO Legislation
- Process for Introducing CTOs
- Research/Evaluation

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 its stakeholders.

THE ISSUE UNDERLYING THE CALL FOR CTOS: Untreated Mentally Ill Individuals in the Community Who Are Not Engaged in Treatment

Public concern about the apparently increasing number of mentally ill in the community who are not engaged in treatment is raising questions about alternative mechanisms, such as CTOs, which may be used to aid clients in becoming more treatment compliant.

This group of people actually represents two distinct groups:

- those individuals who come into contact with the mental health system and for various reasons do not engage in the treatment that is offered
- those individuals with virtually no contact with the mental health system who are living in the community, who are visibly mentally ill, many of whom are homeless

It is important to distinguish the two groups because it is the first group for whom CTOs have been designed in other jurisdictions.

An assumption made by proponents of CTOs is that the orders are a viable mechanism for linking this group of individuals with the treatment system. Opponents argue that there are better approaches to the problem of how to engage the 'hard to treat' and that the evidence is thin regarding the effectiveness of CTOs. It should be noted that there is also a group of clients who actively seek help but experience difficulty in accessing services and whose conditions may worsen as a result.

Adding complexity to the issue is the fact that there are many stakeholder groups with very different perspectives on the issue's causes and solutions. From a **provider** perspective the issue represents a failure of the system to engage those requiring mental health services with the full range of available psychiatric services and peer support. **Physicians**, in particular, tend to believe it is their medical responsibility to do everything possible to assist the individual in accepting treatment. The **societal** perspective focuses on the risk to members of the public by individuals whose untreated illnesses may cause them to become violent or unable to care for themselves adequately. Homelessness exacerbates these concerns. **Governments** view the issue as one of finding the right balance between safeguarding individual and collective rights in order to provide for the needs of the individual while at the same time protecting society.

The **individuals** in question may have a number of reasons for not seeking treatment including: the right not to seek treatment, the view that treatment is harmful or at least not very helpful, or they may be incapacitated to a point where it is not possible for them to understand the need for treatment. Some **family members** view this as a failure of the mental health system to face the reality that a small subpopulation consistently refuse treatment or have extreme and predictable difficulty in following through with it. Therefore, families feel that the system needs a more robust mechanism than what is currently available to engage these individuals in treatment.

Critics of the mental health system, along with many who work in it, claim that the system lacks continuity of care and integration, is under-resourced and is not client-centred. For these and other reasons many people end up 'falling through the cracks.' Finally, there are those who believe that the issue is about something that cannot be changed, in other words, they believe that there will always be people, no matter how perfect the system is, who will refuse treatment, and that the onus is on society to accept this and learn to live with it.

OUTCOMES OF PRIOR EFFORTS TO ADDRESS THE ISSUE

At the program level under Mental Health Reform, services for the seriously mentally ill are being developed that specifically address their needs of living in the community such as, Case Management, Assertive Community Treatment (ACT), Community Crisis Response Services and peer support. Services that are more specifically targeted at mentally ill people with tenuous connections to the mental health system (possible CTO candidates) are fewer in number and type, although some may argue that the above services can be adapted for this purpose. These individuals can be identified by: their episodic use of emergency and inpatient services, (often under a certificate), and their high risk for relapse and other sequelae, including possible aggressive behaviour stemming from their lack of treatment. Complicated clinical profiles are common and include substance use problems and developmental handicaps. Often described as 'the hard to serve' they constitute a small but worrisome subset of the larger population suffering from mental disorders.

Examples of such programs are the CRCT/COTA Hostel Outreach Program (HOP) and 'Contact' at St. Michael's Hospital, an Assertive Community Treatment Team for clients with complex mental health problems who are 'hard to reach'. In another recent program development, Court Diversion Programs are being set up to keep the mentally ill out of the criminal justice system where there is no possible benefit to them or society. It remains to be seen how they will fare as a result of the service and if, in fact, court diversion assists them to engage in treatment.

What we learn from these custom-designed programs is that they are labor-intensive, and take a very long time to engage someone to the point where he/she will accept appropriate care and support. The HOP allows 10 to 11 months for the individual to accept services. The starting point for the program is to offer clients a service that they keenly want, e.g., housing. It is understood that an individual's primary needs must be met first before the client will begin to work on his/her health and mental health issues.

In an evaluation of the Community Rehabilitation Service, a CRCT case management service, it was found that registered clients only began to show improvement in functioning and quality of life after two or three years, which speaks again to the severity of the problems being addressed and the need for providers to realize that even with 'ideal' programs there is no quick or easy solution to the issue. Finally, staff in the Contact Program have actively debated whether CTOs would enhance treatment compliance. They have concluded that in the vast majority of cases CTOs would most likely have a deleterious effect on the therapeutic relationship but in a handful of exceptionally difficult cases they might be of some benefit.

Many who resist treatment end up being homeless, living either in hostels or on the street, hence housing is viewed as a lynchpin service. Dundas/ Osler, a collaborative housing program involving the Centre, offers flexible supports and has successfully housed people many thought would never be able to live in the community. There is some evidence showing that stable housing, on its own, can have a positive effect on an individual's adjustment to living in the community, and lower the symptom level for those not on medication. Experience, however, suggests that housing with appropriate supports is far more effective in helping people live successfully in the community and that housing by itself falls short of being the solution.

ASSESSMENT OF PAST POLICY PERFORMANCE

The province of Ontario is currently immersed in the Mental Health Reform (M.H.R.) policy environment. The plans for M.H.R. were announced in 1993 in a document called, 'Putting People First: The Reform of Mental Health Services in Ontario.' That document established a ten-year time period for the implementation of M.H.R. The document focused on the shift from hospital-based services to community-based care, setting an ambitious target for real-

locating institutional dollars to the community based on changing the funding ratio from 80/20 to 40/60.

In 1998, at the midpoint of the implementation, the Government ordered a consultative review, headed by MPP Dan Newman, to assess the status of the implementation of M.H.R. The review reported that the pre-eminent message to the government was for it to 'get on with it,' with the majority of stakeholders feeling that progress was too slow. There was little disagreement over the policy directions per se. To move ahead, the system would need to: inject more money at a faster rate into community-based services, provide transitional funds, and have more clearly defined roles for all the 'players' including the Ministry of Health (MoH).

In response to the review, the government released two documents: 'Making it Happen: Implementation Plan for Mental Health Reform,' and 'Making it Happen: Operational Framework for the Delivery of Mental Health Services.' The 'Operational Framework' describes in detail the underlying principles and the actual services to be delivered under M.H.R. It stresses the need for joint responsibility and improved collaboration between hospital and community programs (shared service agreements being one mechanism) in responding to the needs of the people requiring services. It also stresses the importance of adopting an individualized client-centred approach building on client strengths.

The 'Implementation Plan' reflects a concern with streamlining access to services and enhancing service linkage to enable smooth transitions across the service delivery system. It defines the first priority population as being people with serious mental illnesses. It describes a comprehensive continuum of services that will encompass three levels of need: first-line (prevention, assessment and treatment for the population as a whole), intensive (assessment and treatment for the Seriously Mentally Ill) and specialized care (ACT Teams and specialized residential services for people with highly complex psychiatric conditions). Presumably, the population that has been described in need of CTO legislation is included in the latter two levels of need, especially the specialized level. Complementing the levels of need are services that cut across levels and are identified as: housing, income supports, self-help, family supports, consumer businesses, and social/recreational supports.

As confirmed in the Newman Review, progress toward M.H.R. has been slow. Some changes occurring have resulted in complaints about the lack of community supports and the increasing problems around access to inpatient services resulting from bed closures. Complexities surrounding the closure of Provincial Psychiatric Hospitals (PPH's) have delayed the process of transferring resources to Schedule 1's and community services even further. Concerns are expressed around the increasing fragmentation of services, contrary to the goals of greater integration and 'seamlessness.' There is a perception that more seriously ill people now reside in the community with fewer supports. This is coupled with the concern that many of these changes have had a detrimental effect on the mental health of this group.

On the other hand, M.H.R. has lead to the involvement and participation of families and clients in governance, program evaluation and other areas of mental health services. As a result of funding requirements, e.g., the Community Investment Fund, institutional and community services are working together to plan services along an integrated continuum. Planning for the closure of PPH's is involving detailed assessments of the level of functioning of clients, service level assessments and the design of appropriate supports before clients are discharged from hospital. In addition, funds for ACTs, enhanced crisis response and Intensive Case Management services have recently been released, which should lead to improvements in system capacity to deal with the seriously mentally ill, including the 'hard to serve.'

In summary, the system is in flux and it will be many years before it is seen whether M.H.R. policy is successful or not. Certainly it could be argued that the service needs of the people seen to be in need of CTOs are addressed in these documents, yet the services are, generally speaking, not yet in place in order to assess their effect. In the meantime, the reality of the untreated mentally ill in the community persists, possibly grows and continues to place pressure on government to act.

ADDRESSING THE ISSUE

The Policy Need

While the narrow focus is on CTOs, the issue of the untreated mentally ill in the community raises broader questions related to the current lack of capacity in the mental health system to engage the 'hard to treat' in services and supports. The Centre's response is to examine the CTO question within this larger context before addressing how, if CTOs are to be implemented, they should be structured in order to be most effective. In short, CTOs must not be seen as a panacea that will solve the problem of non-compliance on their own. Instead, the effectiveness of CTOs will be highly dependent on the availability of a range of other supports and services.

Literature Review On CTOs

It is important to recognize that there are different types of CTOs. Swartz (1995), identifies the following three:

- a form of conditional release for involuntarily hospitalized patients (this already exists in Ontario - Mental Health Act, Section 27)
- an alternative to hospitalization for patients who meet inpatient commitment criteria
- an alternative for patients not meeting criteria for inpatient commitment but at risk for severe decompensation1

It appears that the latter two are the most common with more emphasis on the third. It is with these two which this paper is concerned. The first, which is often treated as separate subject in the literature, is predicated on the patient having the ability to consent to the conditional discharge plan, whereas in the other two cases, consent is not mandatory.

CTOs have been in existence in some form for decades. While there is related research it is flawed in many respects. Confounding factors include: methodological problems around the lack of discrimination between treatment and non-treatment effects, variable criteria for the selection of patients, lack of clarity regarding for whom CTOs work, and unspecified or poorly measured outcomes (Swartz, 1999). McIvor (1998) adds that although studies point to reduced frequency and duration of hospitalization, it is difficult to determine if this is the outcome of the CTO or a result of some other factor, such as increased frequency of contact. This makes it difficult to have a definitive answer to the question, 'do CTOs work?'

One of the important questions concerning CTOs relates to the clinical characteristics of the populations responding well to them. The results of a recent study by Swartz et al. (1999), showed that:

- CTOs had little impact on the number of hospital admissions for people with mood disorders
- CTOs of greater than 180 days duration reduced the number of hospital admissions significantly for those with psychotic disorders

He also found that patients receiving intensive treatment (3+ service events/month), and on CTOs for more than 180 days, had significantly fewer cumulative days in hospital than those receiving the same amount of service and either not on a CTO, or on one for a shorter period of time.

This research suggests that length of time on a CTO makes a difference, that different sub-populations respond differently to CTOs, and that coupling CTOs with appropriate support services multiplies the effect.

The question raised by the research of differential client response to CTOs is pertinent because a criticism related to their application is that the clinical characteristics of the population to be served by CTOs are poorly understood. Torrey (1995) supports the need for more research into the characteristics of those who would potentially benefit. In the absence of refined, replicated research related to clinical response/effects, various groups have developed criteria or guidelines for their use. These are intended as a safeguard against the indiscriminate use of this tool.

Geller (1990), specifies 10 criteria that must be met including: capacity to understand and comply with the CTO, demonstrated efficacy of treatment being recommended, system capacity to monitor the CTO and availability of inpatient care. The guidelines assume a history of chronic mental illness and previous dangerousness to self or others. Saskatchewan has six criteria (see Experience of Other Jurisdictions), each of which must be met, and some of which are similar to Geller's. Unfortunately, there is little research associated with Saskatchewan's experience although it is known that 95% of those placed on a CTO in Saskatchewan have a psychotic illness.

In the Bellevue study (Steadman et al. 1999), 142 inpatient subjects were randomly assigned to one of two groups: outpatient commitment or discharge to the community. Both groups received enhanced community services and were matched for number of involuntary hospitalization and history of non-compliance with decompensation. At the conclusion of the study no significant differences were found concerning re-hospitalization rates, arrest, or quality of life.

Torrey and Kaplan (1995), reporting on the results of a U.S. national survey on the use of outpatient commitment, found that of 35 states with legislation, only 12 reported its use as 'common' or 'very common.' A wide range of reasons were given for not using it and included:

- concerns about civil liberties and practitioner liability
- lack of information/interest
- lack of enforceable standards for non-compliance
- lack of consequences attached to CTO non-compliance
- overly restrictive criteria
- fear of increased 'fiscal burden' resulting from the need to hire more staff to monitor the orders and to provide more inpatient treatment

The survey also uncovered a range of formal and informal alternatives used by practitioners to help individuals achieve compliance such as: conservatorship-guardianship, conditional release, intensive case management, close collaboration with the courts and other service providers. This research clearly illustrates the need for 'groundwork' to be done in order to support this legislation otherwise it will not be used.

REVIEW OF POLICY POSITIONS OF RELEVANT STAKEHOLDER ORGANIZATIONS

To place the Centre's 'Best Advice' in context, a brief review of internal and external policy positions will illustrate that the field has adopted different positions based on differing values, assumptions and analyses of the issue.

CAMH Medical Advisory Committee (MAC)

MAC reviewed the literature, described the limitations of current legislation and discussed the arguments for and against CTOs. It views CTOs as a specific mechanism to compel severely mentally ill people, who do not appreciate their need for treatment, to take medication to both prevent relapse and a return to dangerous behaviour. It assumes that CTOs would only apply to those individuals who had previously demonstrated a favourable response to medication. The individuals likely to be considered for CTOs have the following characteristics: repeated relapses, risk of violent and/or suicidal behaviour, non-compliance with treatment, ongoing incapacity to consent to treatment even as an outpatient, and frequent hospitalizations.

MAC stresses the need for the appropriate community services to be in place to support the implementation of CTOs and believes that CTOs cannot be seen as a solution to the problems associated with homelessness, unemployment, stigma and social isolation. The MAC concludes that:

- CTOs should become part of a continuum of supports/options available to clients and service providers
- CTOs may reduce impairment and dysfunction
- clinicians should accept responsibility to provide treatment without direct consent of the client under special circumstances where substitute consent is provided and the client is incapable of making treatment decisions
- only a small number of clients would be candidates for CTOs
- the implementation of CTOs should include their systematic evaluation from the individual and system perspectives

Queen Street Patient's Council

The Council opposes CTOs and advocates for affordable housing, more supports, liveable levels of income support, jobs and accountability of services to those receiving them.

To view the QSPC's entire position, visit their website at www.icomm.ca/patientsco/council/positions/ctopcpos.html.

CMHA Ontario Division

The position of CMHA/Ontario Division is that the Mental Health Act should not be amended to include CTOs, since the current legislation, including the Health Care Consent Act and the Substitute Decisions Act, permits treatment where the person is incapable of consent. CMHA supports the development of a comprehensive community mental health system that includes attention to quality of life issues, housing, income and work. It supports the idea of service agreements for clients being discharged as a mechanism for outlining the expectations of the client and provider and for identifying clients who may represent a danger to themselves and others.

OMA Psychiatry sub-section

The OMA Psychiatry sub-section position on CTOs is as follows:

- CTOs are a necessary tool to ensure appropriate treatment for a small group of patients only, namely the 'hard to treat' who lack capacity and who are likely to become a risk to themselves or others or are at imminent risk of serious physical impairment
- current legislation has no viable alternatives in Advanced Directives, Guardianship and Leaves of Absence
- deinstitutionalization is driving the movement and it is important to be able to guarantee appropriate treatment in the community
- CTOs must be integrated with a comprehensive package of community-based treatment and support services
- CTOs must be accompanied by procedures for monitoring and appeal similar to involuntary inpatients, such as a mandatory Review Board

Schizophrenia Society of Ontario

The Schizophrenia Society stresses that too many untreated mentally ill are ending up in the criminal justice system and on the streets rather than getting the treatment they need. In their analysis of the issue, the Mental Health Act is too limited to address the full scope of the problem because it only applies to psychiatric facilities and it is too narrow in terms of criteria for involuntary hospitalization. They propose it be amended as follows:

- the phrase 'imminent and serious physical impairment of the person' should be changed to read: 'serious physical or mental deterioration or impairment of the person'
- the leave-of-absence provision should be changed to extend to those people whom the physician does not anticipate will return to hospital
- amend the Mental Health Act to provide for outpatient committal and to have it serve as an alternative to hospital, with hospitalization as the consequence for non-compliance

In addition to changes in the Mental Health Act, the Society states there is consensus around crucial issues pertaining to mental illness and treatment. They argue for a better coordinated system that extends to the community, more outreach to those not receiving treatment, a comprehensive system of housing and employment options, a system that 'minimizes' the need for involuntary hospitalization and a lessening of the 'factionalization' within the mental health community. The ethical principles identified as essential guidelines for the assessment of mental health policy are:

- compassion for those with schizophrenia
- mental capacity, i.e., anyone capable of making decisions should do so and those incapable should 'not be denied treatment'
- liberty, which means the individual should have the right to challenge the decision before an arbiter
- public safety, i.e., fear from harm

CMHA, BC Division

CMHA, BC Division recommends against CTOs. It identifies the PACT model as an approach which shows results superior to those of CTOs. It also views treatment compliance as only one of several factors contributing to relapse in addition to social and system factors, medication efficacy and lack of client education. It holds that CTOs may prevent people from learning about the consequences of their

illness. They conclude that the system needs more accountability and more services in line with what clients say they want. They have voted in favour of 'non-coercive' solutions for the 'most difficult to treat' such as court diversion programs, assertive community treatment, 'no reject care,' better strategies for early intervention, better crisis intervention and finally, an accountable system that places high expectations for recovery on those in need.

CMHA National

CMHA National takes the position that, although the case for community committal has compelling arguments on both sides, rather than continuing the debate, it is preferable to shift the argument to positive alternatives on which there is agreement. In their draft policy statement they make three recommendations:

- support for development of a comprehensive community mental health system as the 'first line of defense'
- mental health systems must provide active support and consistent care based on consumer needs and which go beyond treatment to include quality of life factors
- more resources are needed for family and consumer organizations

Mental Health Legal Committee (MHLC)

The MHLC takes the position that the 'frustration' leading CTO advocates to recommend them is a result of a 'lack of appreciation for the existing ways in which informed consent to treatment on behalf of incapable persons can be obtained.' The problem as defined by them is the under, and inappropriate, use of current legislation.

They criticize the underfunded inpatient system, the inadequacy of community supports and believe the thrust should be towards consensual care based on therapeutic engagement of the client. Quality of life factors are seen as being crucial to the well being of mental health clients.

Family Mental Health Alliance (FMHA)

The FMHA has taken a position against CTOs on the grounds that it sees the entire issue as a symptom of a larger problem rather than a solution to the problem. They argue that, while there is a problem with untreated mentally ill in the community who are often aggressive, the underlying problem is the lack of resources available to 'all stakeholders.' The FMHA opposes CTOs because they represent an involuntary interference that does 'violence' to an individual. Also, they see the issue of non-compliance as multidimensional, with many of the reasons having to do with inadequacies in medications and the service system. The FMHA endorses a review of the MHA with a view to broadening the definition of harm, along with the creation of an adequate service base, possibly with mental health legislation.

Mood Disorders Association (MDA)

The MDA of Ontario and Toronto opposes CTOs and states that the real issue of concern is the 'failure of the MoH to build a comprehensive community-based system of care for those with mental illness while closing psychiatric treatment beds.' It contends that the MHA is robust enough to safeguard public safety and the rights of people with mental illness.

National Association for the Mentally Ill (NAMI)

NAMI's position is summarized as follows:

- availability of effective comprehensive community treatment will diminish the need for involuntary commitment (inpatient and outpatient)
- methods for facilitating communication regarding treatment preferences among clients, families, and providers should be adopted
- involuntary commitment decisions should be made expeditiously and simultaneously so individuals can receive treatment in a timely manner
- involuntary commitment should be used as a last resort
- independent review must be guaranteed in all involuntary commitment cases

Summary

There is no consensus among these organizations on whether CTOs are a good thing or not. Organizations opposing CTOs emphasize different aspects of the issue from those advocating for CTO legislation. The advocates appear to agree that CTOs are likely to benefit only a small number of people with psychiatric illnesses and that appropriate services are needed to ensure CTO effectiveness.

Regardless of the position taken on CTOs, all groups speak to the need for a comprehensive mental health service and support system. Some groups supporting CTOs see a comprehensive mental health system as a necessary condition for CTOs to be effective. This interdependency is well-described by Applebaum (1986):

"If states are more interested in discharging patients than in ascertaining what happens to them after discharge, if mental health centres are not willing to accept responsibility for these patients, and if most mental health professionals avoid involvement in monitoring compliance, then it (CTO) will not be effective."

EXPERIENCE OF OTHER JURISDICTIONS

New Brunswick Report on CTOs Consultation Day, 1999

Seventy people representing all perspectives in mental health from across the province were involved in a one-day consultation on CTOs. A consensus was reached that the province needed to pursue alternative strategies to CTOs. It was resolved that the Mental Health Division, in partnership with others, needed to develop solutions to issues around poverty, housing, work, social disconnection and medication/health cards. More education was needed around the application of the Mental Health Act. The system needed better coordination. They also agreed that the numbers impacted by this problem were small and that they should find out what can be done differently using a case profiling methodology.

Saskatchewan

In Saskatchewan, CTO legislation was introduced in response to family concerns regarding the need for more service system support, and following an overall enhancement of mental health services between 1986 and 1995. Between 1995 and 1999, the province shifted to a regional system of care, and prior to that had initiated a consultation on CTOs. The province recognized at the outset the need to balance civil rights with the obligation to provide care and treatment, to limit the criminalization of mental illness. The intended functions of CTOs were to provide support to families and to provide a streamlined mechanism to access hospital admission when an individual had a crisis in the community. The target population is those who cycle through hospital psychiatric units because of non-compliance with medication and other treatment program requirements. In Saskatchewan's provision for involuntary community commitment, six criteria must be met:

- treatment can be provided in the community
- the person has received inpatient involuntary treatment for 60 days or more, has been in an inpatient facility on three or more occasions in the last two years or has previously been the subject of a CTO
- the person may harm self or others or suffer from physical deterioration without care or supervision
- services must exist in the community and must be available
- the person is incapable to make an informed decision about the need for care and treatment
- the person is capable of complying with the requirements of a CTO

In the words of one spokesperson, the intent was to 'cast a small net, not a large one' and in fact only 63 CTOs have been issued over a three-year period for a total population of approximately six thousand people with serious mental illness. The order is in effect for a maximum of three months and requires the opinion of two physicians, one of whom must be a psychiatrist, to enact. An appeal process is outlined in the legislation.

Qualitative feedback on their success suggests that: families are more or less satisfied and the cycle of deterioration is broken sooner by lowering the threshold for having a person psychiatrically assessed. There has been no pressure to date to broaden or lessen the criteria. 62 percent of psychiatrists surveyed are pleased with the legislation and 95 percent of individuals placed on a CTO have had a diagnosis of schizophrenia. There is no available data on client satisfaction/ perception of CTOs.

Australia

In 1996, Western Australia introduced CTOs with the underlying principle being the need to "provide treatment in the least restrictive environment with due regard for patient safety and the safety of the general public," (McIvor, 1998). The act allows for the administration of medication against the person's will for up to 12 months and is intended for 'revolving door patients.' Concerns were raised at the time about the lack of clinical guidelines, putting nursing staff at risk, poorer clinical care resulting from CTOs, and the lack of comprehensive community supports. In a six-month follow-up study on the results of CTOs, clients were on higher levels of medication and had a significant drop in the duration of hospitalization when compared to the six-month period before the CTO. The authors of the study, however, did not demonstrate a clear connection between this latter effect and the effects of the CTO. McIvor suggests that higher rates of contact worker/client might also be a factor.

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 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 the availability of 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 non-compliance' 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 CTOs

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

After reviewing the literature, the experience in other jurisdictions and 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 days or more, 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 CTO2
  - 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
- 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.

February 2000

REFERENCES

Appelbaum, P.S. "Outpatient commitment: the problems and the promise." American Journal of Psychiatry, 1986, 143, 1270 – 1272.

Geller, J.L. "Clinical Guidelines for the Use of Involuntary Outpatient Treatment." Hospital and Community Psychiatry, 1990, 41(7), 749-755.

McIvor, R. "The Community Treatment Order: Clinical and Ethical Issues." Australian and New Zealand Journal of Psychiatry, 1998, 223-228.

Steadman, H.J., Gounis, K., Dennis, D.L., Roche, B. and Hopper, K. "Evaluation of the Bellevue Outpatient Commitment Pilot Program: Is it Enhanced Services or the Court Order that Makes a Difference?" XXIVth International Congress on Law and Mental Health, Toronto, Canada, June 1999.

Swartz, M.S., Burns, B.J., Hiday, V.A. George, L.K., Swanson, J., Wagner, H.R. "New Directions in Research on Involuntary Outpatient Commitment." Psychiatric Services, 1995, 46(4), 381-385.

Swartz, M.S., Swanson, J., Wagner, H.R., Burns, B.J., Hiday, V.A., Borum, R. "Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings From a Randomized Trial With Severely Mentally Ill Individuals." The American Journal of Psychiatry, 1999, 156 (12), 1968-1975.

Torrey, E.F. and Kaplan, R.J. "A National Survey of the Use of Outpatient Commitment." Psychiatric Services, 1995, 46(8), 778-784.

[1] This refers more specifically to those who have: previously required involuntary hospitalization; previously responded to treatment; who are incapable of consent to treatment even as outpatients.

[2] 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 behaviorally 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.