

Community Treatment Orders (CTOs): Alternatives

From its early drawing board outline to actual implementation, Bill 68 has been a major battleground between doctors, police officers, social workers, families and mental health groups.

Bill 68 is also known as Brian's Law, in reference to the Ottawa sportscaster Brian Smith, who was killed in 1995 by a man diagnosed as 'paranoid schizophrenic.' Due to this incident and a few other high profile incidents involving the mentally ill, Bill 68 has been successfully sold as a way of protecting public safety.

Five years ago, Bill-68 was introduced by the Ontario government with the intention of having a balance between patient rights and community safety. To name the law after a homicide victim, however, is unfair towards the larger population of individuals who suffer from mental disorders.

"Unfortunately, our whole group has been painted...the very name of the law suggests that we are violent."¹ It is important to note that those who suffer from severe mental disorders are more often victims of violence rather than perpetrators of it. According to a Health Canada sponsored study, "there is no compelling scientific evidence to suggest that mental illness causes violence."² Some American studies have argued that at most, 4 percent of all violent incidents have any connection to mental illnesses.³

There are some notable problems with CTOs. Public misperceptions of a propensity for violence involving people with mental disorders are just the beginning. What about the drugs that are being forced on people? Evidence about the dangers and side-effects of medications have been documented for several years.^{4,5,6,7,8,9,10,11} In particular, about 25 percent of patients who use neuroleptic drugs suffer from **akathisia** (internal restlessness or agitation). As a side-effect, akathisia has been linked to violent behaviour.^{12, 13}

"Each example of modern pharmacologic treatment is heralded as state-of-the-art and well through out, even as yesterday's remedies are relegated to generic graves. With hindsight several years hence, that certainty in drug choice may seem a little awkward," according to Chaimowitz. "From today's perspective, refusing high dosage haloperidol injections doesn't seem so "psychotic."¹⁴

According to Vaughan and McConaghy, et al, "Increased delivery of prophylactic medications may not be the only mechanism that could allow CTOs to reduce hospitalizations. Remissions may be made more robust by encouraging patients to accept social skills training, psycho-education, family therapy, personal therapy, assertive training, stress management, or improved problem solving and other interventions that enhance recovery."¹⁵

Practically speaking, forcing people to receive treatment may be counter-productive. Some

Community Treatment Orders: Alternatives

studies show that coercive treatment creates ambivalence that can dissuade people from getting help when they need it later on. In addition, compelling people to undergo treatment prevents them from learning about their illness, discovering self-recovery techniques, and gaining a sense of control.¹⁶ Psychotropic drugs are probably here to stay, so they must be contextualized in the overall approach. They should not be oversold and over-relied upon as they so often are today. Non-physicians tend to accept their use far too uncritically because of the authority of M.D.s. To place them in proper context, non-M.D. community mental health workers must know both their value and limitations. They must know how to ask questions that call the prescribing practices of M.D.'s into question.¹⁷

Having good information about the use, abuse and toxic potential of the various classes of psychotropic drugs must be made available and used by clients and staff. Lack of such information is irresponsible and dangerous.¹⁸

Section 33.9 of the Ontario Mental Health Act requires that a legislated review of CTOs be conducted every five years. The report to be made, consisting of qualitative, quantitative and literary reviews by the chief consultants of Dreezer and Dreezer Inc.¹⁹ has not yet been released to the public. In their conclusions, they may find that persons being subject to renewable CTOs might suffer stigma, as they are singled out in their communities as being less capable and deserving of exercising autonomy.

A review done by Swartz and Swanson (2004) is notable. They identified all English-language Studies of CTOs and related procedures available in Medline and other bibliographic search services. Their conclusions: "Outpatient commitment will continue to be a controversial treatment intervention, regardless of empirical findings about its effectiveness or lack thereof. Advocates and opponents of CTOs sometimes selectively use data about CTO benefits or detriments as a "straw man" to argue strongly held views about autonomy and paternalism in mental health treatment. Many opponents of CTOs believe that it may serve as a barrier to improving services because policy-makers will seize upon it as a quick and inexpensive remedy for a lack of community-based services. However, current data suggest that, if CTOs are effective, they can only be so when more intensive services are provided, obviating its use as an inexpensive remedy..."²⁰

Moreover, there is concern that the use of CTOs in combination with ACT (Assertive Community Treatment) may be intrusive and very expensive to maintain, while missing a substantial portion of a given 'target population.' "Our understanding is that most clinicians and most community mental health agencies prefer to establish a therapeutic alliance with those who voluntarily seek their support and assistance."²¹

Community Treatment Orders: Alternatives

Legal Analysis

“Persons with serious mental illness and their families have long complained that it is difficult to obtain services and the ongoing involvement in their lives of physicians and service providers in the community. Certain provisions of Bill-68 may imply a form of “right to treatment” for CTO subjects that have not otherwise had a strong foundation in Canadian Law. It seems unlikely, however, that the individual client will be in a position to enforce this “right.” Compliance with these obligations will largely be a matter of professional ethics and program management.”²² It is noted that society has a “*parens patriae*” obligation to care for citizens who cannot care for themselves.

In the paper by Carver, “the legal analysis presented...suggests that the benefits of CTOs are likely to be limited at best. The essential task remains to improve the quality and availability of therapeutic and support services in the community. This is important to the success of CTOs. The irony is that improved community services would encourage voluntary compliance with treatment programs and make CTOs largely unnecessary.”²³

“The implications for the CTO scheme in Ontario are problematic. In effect, any person who is treatment competent must “consent to be ordered” to comply with a treatment plan. This suggests that the CTO is not an “order” in the usual legal sense, and has limited compulsory force...in what way will the CTO contribute to reducing the problem of non-compliance with psychiatric treatment by persons living in the community? The short answer is that it compels compliance. But is this true? As noted, in Ontario the issuing of a CTO depends on consent. Beyond this, however, is the issue of sanction. Most “orders” with legal force are backed by sanctions for non-compliance. It is not at all clear that this is the case with CTOs.”²⁴

“One usual means of enforcing an order, the contempt power of the superior courts, is not available. CTOs are issued by physicians, not by courts. The penal nature of a contempt recourse would, in any event, seem wholly inappropriate to a therapeutic measure like the CTO.

It might be thought that non-compliance with a CTO would be sanctioned by involuntary committal to hospital. However, neither the Saskatchewan or Ontario statutes go so far. Arguably, as a matter of principle, they could not go that far. Hospital committal depends on a person’s meeting committal criteria related to mental condition and therapeutic need. It should not be available for failure to comply with an order, regardless of whether a person meets committal criteria. That could amount to arbitrary detention, contrary to the *Charter*.”²⁵

“Several provinces, including Manitoba and B.C. have enhanced statutory leave provisions to permit psychiatric facilities to gradually reintroduce involuntary patients into the community while remaining subject to committal and the authority of the facility. Leaves of absence are granted on conditions, often including compliance with a treatment plan. If a patient ceases to comply, or starts to decompensate, they can be brought back to hospital under the continuing involuntary status. The leave of absence approach has advantages over the more complex CTO.

Community Treatment Orders: Alternatives

The starting place is hospital and in-patient treatment, rather than an effort to enforce compliance on an individual living in the community who may not meet standard committal criteria.”²⁶ The Ontario Mental Health Act contains a “leave agreement” (section 27) that works very much like a CTO.

“A dilemma is expressed by the question, in what way is a CTO a “less restrictive” alternative to hospitalization? In order to be so, it would seem to need to be an alternative to hospitalization that is available. This is somewhat inconsistent if the purpose of the legislation is to require treatment in the community at a point earlier than when detention in hospital is considered necessary. If committal criteria are relaxed in order to make hospital and community true alternatives, does this represent an expansion of the coerciveness of mental health laws, as opposed to creating a less restrictive alternative to hospitalization?”²⁷

Recommendations

It is expected that a Canadian Mental Health Commission will be established in accordance with the rationale put forth by the Standing Senate Committee on Social Affairs, Science and Technology. The federal government, along with all provincial and territorial governments, has accepted the Committee’s proposal.

This is a significant milestone, considering that the Uniform Mental Health Act of 1987 was not successfully implemented in each province and territory. Over the years, as more and more individuals receive care and treatment in community settings, the expansion of independent advocacy services into the community is needed to ensure equal access to advocacy and rights protection services. Investment in community-based mental health services **must include investment in independent advocacy and rights protection services**. Case managers may advocate on behalf of their clients, but it is not independent, may be “best interest” based and not necessarily what clients are seeking. Case management may become inflexible.

The recommendations of the Psychiatric Patient Advocate Office²⁸ are viewed as being advanced, exemplary and consistent with a population health approach in respect of broader psychosocial determinants of mental health, i.e. education, income support, housing, sense-of-belonging, alternative therapies. Having options and the power to make one’s own decisions are vital ingredients to good community programs. “A Treatment team providing services to a person without benefit of a CTO would seem as likely to become aware of deterioration in a person’s mental or physical condition requiring hospitalization as a team operating under a CTO. Having a person on a CTO might permit easier apprehension for the purpose of obtaining an examination and assessment; the difference may well be marginal.”²⁹

At the same time, progressive research on functional magnetic resonance imaging (fMRI) conducted at University of British Columbia appears to be quite promising. The application of real-time fMRI scanning along with cognitive therapy may be helpful, especially in the treatment of depression. Further research may prove to be helpful in understanding schizophrenia. Currently, at approximately \$400/hour, fMRI scanning is rather expensive.³⁰

Community Treatment Orders: Alternatives

Psychologists have the training and expertise to work collaboratively with consumers, healthcare professionals, and policy makers and can make a significant contribution to substantially reduce inappropriate use of physician-based services, emergency and inpatient services, police and criminal justice services and pharmaceuticals, and can increase the rate of early detection and treatment of mental health conditions while decreasing healthcare costs associated with such difficulties. Psychologists can also contribute significantly to the development, implementation, and evaluation of programs aimed at prevention and treatment of mental health problems.³¹

It is expected that the medical establishment might oppose reallocation of resources from treatment and rehabilitation to primary prevention. **However, it is arguable that spending money on more effective services** such as community support, early intervention and prevention will save money in the long term by reducing the incidence of severe and chronic disability. Based on this rationale, Australia has actually increased funding to community health by 55% and overall funding for the mental health system by 24%.³²

As for the future, it has been predicted that the role of the psychiatrist will increasingly become one of education, consultation, supervision, research and evaluation. Psychiatry needs to collaborate with community organizations, patient and advocacy groups as well as primary health care workers. If psychiatric specialists do not adopt this approach they may find themselves bypassed as others take over their roles.³³ Ongoing trends toward interdisciplinary and intersectoral collaboration, better mechanisms for exchanging information on best practices along with integration of mental health and primary care services, will likely reshape psychiatric practice. The almost unanimous disapproval from psychiatrists concerning the outcome of the case of Starson vs. Swayze merely shows that psychiatry needs to evolve. The principle of honouring an advance directive established by a patient or their substitute decision-maker remains central to a competent right to refuse treatment. Treatment must be openly defined to include more than psychotropic drugs (“medications”).

A revisiting of the results of the Soteria Project, program values, administrative and clinical principles for a “user friendly system” are recommended. The challenge is to organize and present an appropriate intentional social environment under the heading of effective community mental health.^{34, 35} A patient-centered model is recommended where mental health workers help individuals coordinate their lives on their own terms.

In closing, there is logic to the inspiring view that *recovery* must extend beyond personal process, to involve the “larger human struggle for liberation, social justice and humanity.”³⁶

Community Treatment Orders: Alternatives

References

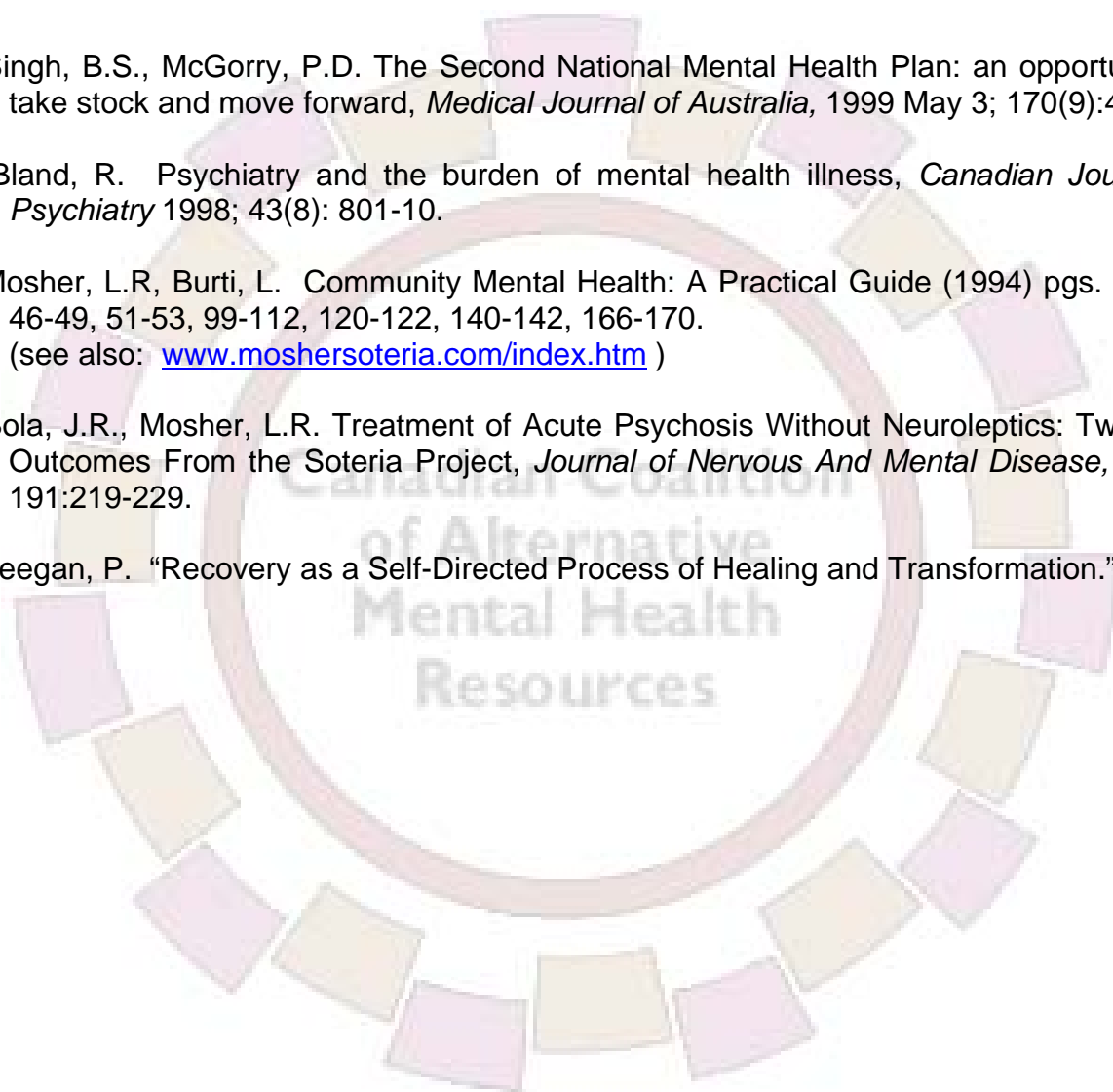
1. Artuso, A. *Toronto Sun*, interview with Erick Fabris of the No Force Coalition, June 22, 2000.
2. Arboleda-Florez, J., Holley, H.L., Crisanti, A. *Mental Illness and Violence: Proof or Stereotype*, Health Canada, 1996, p. x.
3. Simmie, S. *Out of Mind: An Investigation into Mental Health* (Toronto: Atkinson Charitable Foundation, 1999) p. 65
4. Whitaker, R. *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* (2002), pgs. 162-4
5. Silvestri, S. Increased Dopamine D₂ Receptor Binding After Long-term Treatment with Antipsychotics in Humans: A Clinical Pet Study, *Psychopharmacology* 152 (2000): 174-180.
6. Huston, P. Redundancy, Disaggregation, and the Integrity of Medical Research, *Lancet* 348 (1996): 1398.
7. Conley, R. Adverse Effects Related to Olanzapine, *Journal of Clinical Psychiatry* 61, supplement 8 (2000):26-30
8. Knable, M. Extrapyramidal Side Effects with Risperidone and Haloperidol at Comparable D₂ Receptor Levels. *Psychiatry Research: Neuroimaging Section* 75 (1997): 91-101
9. Roseblush, P. Neurologic Side Effects in Neuroleptic-Naïve Patients Treated with Haloperidol or Risperidone, *Neurology* 52 (1999): 782-5
10. Leong, G.B., Silva, J.A. Neuroleptic-Induced Akathisia and Violence: A Review, *Journal of Forensic Science*, 48:(1), 187-9
11. Angell, M. The Truth About the Drug Companies: How they Deceive Us and What to do About It (2004) p.111-115.
12. Crowner, M.L., Douyon, R., et al, Akathisia and Violence, *Psychopharmacology Bulletin* 1990; 26(1):115-117.
13. Nelson, D.E. Akathisia – A Brief Review, *Scottish Medical Journal* 2001; 46: 133-4
14. Chaimowitz, G.A. Community Treatment Orders: An Uncertain Step, *Canadian Journal of Psychiatry*. Guest Editorial, September 2004

Community Treatment Orders: Alternatives

15. Vaughan, K., McConaghy, N., et al Community Treatment Orders: relationship to clinical care, medication compliance, behavioural disturbance and readmission, *Australian and New Zealand Journal of Psychiatry* 2000; 34:808.
16. Canadian Mental Health Association, *Community Committal* p.4 May 1998
17. Mosher, L., Burti, L. *Community Mental Health: A Practical Guide* 1994, pgs. 55-56.
18. Ibid. p.234
19. Dreezer, S., Bay, M., Hoff, D., Dreezer & Dreezer Inc., consultants for the Minister of Health and Long Term Care, Ontario (2005) www.ctoproject.ca
20. Swartz, M.S., Swanson, J.W. Review Paper: Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data? *Canadian Journal of Psychiatry* 2004; 49: 585-591.
21. Kehyayan, V. Submission regarding "The Next Steps": Consultation on Proposed Legislative Changes to the *Mental Health Act* and the *Health Care Consent Act*, Psychiatric Patient Advocate Office, April 13, 2000, pgs. 10-11.
22. Irvine, J.C., Sneiderman, B., Osborne, P.H. *Canadian Medical Law*, 3rd edition 2003 p. 289
23. Carver, P. A New Direction in Mental Health Law: Brian's Law and the Problematic Implications of Community Treatment Orders, *Health Care Reform and the law in Canada: Meeting the Challenge*, Caulfield, T.A., von Tigerstrom, B. editors 2002, p.214
24. Irvine, J.C., et al. *Canadian Medical Law*, 3rd edition 2003 p. 288.
25. Ibid. pgs. 288-9.
26. Ibid. pgs. 289-90
27. Carver, P. A New Direction in Mental Health Law, *Health Care Reform and the law in Canada*, Caulfield, T.A., von Tigerstrom, B. eds. 2002, p.200
28. Simpson, D. et al, Psychiatric Patient Advocacy Office, Ontario, *Covering Letter to Senator Kirby and Summary of Recommendations*, August 2005
29. Carver, P. A New Direction in Mental Health Law, *Health Care Reform and the law in Canada*, Caulfield, T.A., von Tigerstrom, B. eds. 2002, p.206

Community Treatment Orders: Alternatives

30. Wilson, P. Promising Work at UBC aims to help people alter bad thought patterns by seeing their brains think, *The Vancouver Sun* September 29 ,2005, Sec. (see also www.brain.ubc.ca)
31. McIlwraith, R.D., Dyck, K.G. Strengthening Rural Health: The Contribution of the Science and Practice of Psychology, University of Manitoba (2002) p.5.
32. Singh, B.S., McGorry, P.D. The Second National Mental Health Plan: an opportunity to take stock and move forward, *Medical Journal of Australia*, 1999 May 3; 170(9):452.
33. Bland, R. Psychiatry and the burden of mental health illness, *Canadian Journal of Psychiatry* 1998; 43(8): 801-10.
34. Mosher, L.R, Burti, L. Community Mental Health: A Practical Guide (1994) pgs. 40, 44, 46-49, 51-53, 99-112, 120-122, 140-142, 166-170. (see also: www.moshersoteria.com/index.htm)
35. Bola, J.R., Mosher, L.R. Treatment of Acute Psychosis Without Neuroleptics: Two-Year Outcomes From the Soteria Project, *Journal of Nervous And Mental Disease*, 2003; 191:219-229.
36. Deegan, P. "Recovery as a Self-Directed Process of Healing and Transformation." 2001.



Community Treatment Orders: Alternatives