



Ontario Psychiatric Association

344 Lakeshore Road East, Suite B
Oakville, Ontario L6J 1J6

December 15, 2007

Honorable George Smitherman
Minister of Health and Long Term Care
Minister's Office
Hepburn Block
80 Grosvenor St., 10th Floor
Toronto, Ontario
M7A 2C4

Re; The Report on the Legislated Review of Community Treatment Orders

Dear Minister Smitherman,

Enclosed is the Ontario Psychiatric Association's response to the Report on the Legislated Review of Community Treatment Orders.

Thank you for providing us with the opportunity to submit this response. We hope it proves helpful.

Sincerely,

Dr. Richard O'Reilly
President
Ontario Psychiatric Association

Ontario Psychiatric Association's Report on the Legislated Review Of Community Treatment Orders.

Background

Bill 68 was proclaimed in December 2000 amending both the Mental Health Act and the Health Care Consent Act. The most significant amendments were the introduction of community treatment orders (CTOs) and the addition of a broadened committal criterion. The Ontario Psychiatric Association (OPA) had pressed the government of the day to introduce these amendments. It had become clear to psychiatrists working in a variety of settings that community based care was not working for some individuals where severe mental illness impaired their ability to appreciate the need for treatment. The OPA has consistently spoken of the need to provide *both* sufficient levels of community services and appropriate mental health legislation to safely manage individuals with severe mental illness in community settings.

The OPA has over 700 members including our members-in-training. Members of the Association work with individuals with severe mental illness both in hospital and community settings and the OPA is thus in a unique position to provide feedback on the operation of amendments introduced in Bill 68.

We are pleased to see the long-awaited report prepared by Dreezer & Dreezer Inc. Since the OPA strongly supported the introduction of CTOs we are pleased with the overall positive findings of the report on the use of CTOs in Ontario. We accept most of the conclusions and recommendations made by the report's authors. However, there are a number of areas where an alternative view or approach to problems identified in the report should be considered.

Recommendation 1:

The MOHLTC should review the process by which community mental health service resource allocation decisions are taken, with a view to making the changes necessary to ensure that these decisions do not affect the choice by psychiatrists and other health professionals as to which treatment modalities should be made available to a client requiring community mental health services.

The OPA suggests caution in interpreting this recommendation. Psychiatrists and other mental health providers correctly wish to do the best for the patients they serve. Currently there are insufficient services suitable for assisting severely ill individuals to live in the community. If the problem is insufficient services the solution is improved levels of service. It would be of concern if individuals who did not meet the criteria for a CTO were being placed on a CTO. However, if one consideration of placing a person on a CTO (where that person meets all the criteria necessary to be placed on a CTO and has benefit of all the rights protections) is the availability of a specific service that accompanies the CTO this

is actually consistent with general clinical practice, which considers all consequences of a clinical decision.

Recommendation 2:

The MOHLTC should explore strategies to provide continuity of care for clients when their CTOs come to an end. Except in exceptional circumstances, the objectives should be to avoid transfer to different workers or different agencies, and especially to avoid a hiatus in service due to the presence of waiting lists.

We agree with this recommendation and would go further and state that “continuity of caregiver” is a concept that has not received sufficient consideration in system design of mental health services.

Recommendation 3:

The MOHLTC should explore the possibility of refining ministry policies and monitoring them, so that they do not inadvertently encourage discharge of CTO candidates from inpatient care before the groundwork for a successful CTO is in place. Consideration might be given, for example, to replacing length of stay measurements with total inpatient days over a one or two year period in the case of individuals suffering from serious mental illness.

Once again we agree with the recommendation but suggest that the problem Dreezer and associates have identified – inordinate pressure to discharge patients from psychiatric inpatient units before they have been adequately stabilized or before sensible discharge arrangements have been made - is widespread in Ontario affecting many more patients than those who might be the subject of a CTO. The solution to this problem is surely not one of “...refining ministry policies and monitoring them...” rather it is the provision of adequate numbers of inpatient beds!

Recommendation 4:

MOHLTC experts in legal and mental health process design, as well as experts in forms design, should be assigned to re-engineer the form, data reporting and paper flow requirements for CTOs with the goal of simplifying the process and eliminating or combining forms. This process, however, should not attempt to eliminate the necessary steps of community treatment plan formulation, the provision of rights advice, consent to the plan, and issuance of the order.

Where psychiatrists are the end-users of forms, such as mental health legislation forms, they should provide input into the development of these forms. The OPA offered to assist the ministry with form development prior to the 2000 amendments. The OPA remains committed to working with the ministry to develop a process that is efficient and meets the needs of all stakeholders.

Recommendation 6:

The MOHLTC should require that all CTO coordinators be located in a Schedule 1 facility, but be employed by and report to a non-hospital community entity.

This recommendation appears to be based on a perception that hospital and community services are and should be divided. General hospitals are in fact a community service. Admitting patients, treating their illnesses and discharging them back to their communities is a service designed to allow these individuals to continue to live in their community. Indeed, hospitals provide more than just inpatient beds. The psychiatrists working in hospitals and other clinicians often provide follow-up services for patients who are discharged on a CTO. There are locations, such as in London, where most of the CTOs issued by the local hospitals are followed by clinicians from these hospitals. In such situations, it would make no sense to have the CTO coordinator employed by and report to an outside agency.

Recommendation 7:

The MOHLTC should assign CTO coordinators an enhanced quality assurance role. Consideration should be given to designating them under the regulations as persons who may review community treatment order documents to ensure compliance with the act. They could be prescribed the additional duties of verifying and documenting on the face of the CTO whether or not:

- **consent was informed and voluntary**
- **a primary purpose of the CTO was to obtain services for the client**
- **less restrictive alternatives were considered for the client**
- **the client and the substitute decision-maker (if any) was involved in the development of the community treatment plan**
- **the community treatment plan includes initiatives to facilitate wellness such as employment, suitable housing, involvement in consumer initiatives, etc., and**
- **a plan is in place for continuity of services once that CTO comes to an end.**

The OPA cannot support this recommendation. The physician who signs the CTO takes the ultimate responsibility, not only for ensuring that the conditions of the order are met, but also ensures the validity of consent and considers the alternative treatments etc. Assigning an ambiguous role of verifying these and other complex clinical matters to a person not part of the treatment team is fraught with practical and legal issues.

Recommendation 8:

MOHLTC consideration should be given to the appointment of a small number of aboriginal CTO coordinators, with one in Northwestern Ontario

and others in identified areas of the province. These coordinators should work in conjunction with the coordinators already in place.

There may be some merit in this suggestion, however the OPA urges caution to avoid instituting a two-tier system. Discussions with aboriginal communities would be essential before implementing this recommendation.

Recommendation 12:

The MOHLTC, in conjunction with the Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General, explore the possibility and advisability of using CTOs as part of the strategy for diverting those with serious and persistent mental illness from the justice system to the health system.

We agree that too many people suffering from severe mental illness end up in jails because of crimes (often minor) caused by their illness. A variety of strategies are required to remedy this problem. The use of CTOs to divert individuals from the justice system is worth considering. However, we also note that CTOs would be very helpful for some inmates with severe mental illness who are being released from prisons and who lack insight into their need for ongoing psychiatric treatment and supervision. In most cases these individuals cannot benefit from being placed on a CTO because they do not meet the prior hospital days requirement. See recommendation 27.

Recommendation 13:

MOHLTC consideration should be given to the establishment and funding of a family and caregiver advocacy service to provide advocacy and summary legal advice to family members, substitute decision-makers, and other informal caregivers of those suffering from serious and persistent mental illness.

Family members are often burdened with the responsibility of trying to get services for their ill relatives in an under-resourced system. We strongly support the proposal of funding a family and caregiver advocacy service.

Recommendation 15: The MOHLTC should:

- **ensure that the process of appointing and reappointing Consent and Capacity Board members results in consistent and high quality decision-making with regards to CTOs and related matters.**
- **explore the possibility of establishing a properly funded mechanism to provide physicians with the following:**
 - **telephone summary legal advice on demand**
 - **legal representation before the Consent and Capacity Board in appropriate cases**
 - **guaranteed legal representation with regards to CTO appeals from the Consent and Capacity Board.**

The availability of legal advice and especially representation at Consent and Capacity Board hearings is an important issue for psychiatrists. Some hospitals provide excellent legal services for psychiatrists working with these patients while others provide no legal assistance for their physicians. Psychiatrists who work in office based practice must fund their own legal counsel. When CTOs were initially introduced the Canadian Medical Protective Association provided legal counsel to some psychiatrists. However, it is clearly inappropriate for psychiatrists to have to use their malpractice insurance to fund aspects of regular clinical work.

Recommendation 20:

The MOHLTC should monitor national and international research findings and commission scientifically rigorous Ontario-based research into:

- **the importance or lack thereof of the legal component of CTOs**
- **defining the profile of individuals likely to benefit or not benefit from the legal component of CTOs.**

Further research examining outcomes of individuals treated under CTOs and attempts to define the types of individuals most and least likely to benefit from CTOs could be very helpful. As models of mandatory treatment in the community vary significantly between jurisdictions, it is entirely possible that the Ontario model will produce different outcomes from those used in other jurisdictions. Thus, the OPA is very supportive of the recommendation to conduct research in Ontario.

However, we must caution that this is a particularly problematic area of research. There have already been two small studies completed in Ontario using a mirror image design (comparing the same patient before and after the introduction of a CTO) that showed positive benefits of a CTO. But as noted by Dreezer and associates, the gold standard in this type of research is the randomized trial. Unfortunately, randomizing individuals to receive, or not receive treatment, on a CTO raises major ethical and legal issues. Even in the two jurisdictions where this research was carried out, the research methods and generalizability of the results have been criticized. In view of these difficulties and the contentious nature of the subject, the government may wish to consider commissioning an international team of researchers to conduct this research if the decision is to proceed.

Recommendation 21:

The MOHLTC should delay the introduction of recommendations for legislative amendment until the conclusion of the research, so that they can be introduced at the same time as any amendments flowing from the research itself. If a decision is made not to proceed with the research, these amendments should be put before the legislature as soon as is practicable.

Because of the considerations outlined in our response to Recommendation 20, we believe that it is highly unlikely that there will be conclusive findings from research in this area. To plan, implement, conduct and analyze the results of a randomized control trial that addressed the many issues raised in this report would take a minimum of five years and probably closer to ten years. As the results of the two completed randomized control trials are indecisive, we recommend that amendments should not be delayed until we know the findings of a new research programme. There is considerable international research addressing many of these issues which, while not definitive, can be combined with expert opinion to inform legislative change.

Recommendation 22:

The CTO criteria should be amended in order to require that less invasive treatment modalities be ruled out before a CTO is considered.

This recommendation is problematic. Firstly, a CTO can only be issued if the person meets the criteria for inpatient committal. Dreezer and associates do not define what they mean by “less invasive” nor are we aware of any definition in law. Presumably, inpatient committal would be seen as “less invasive” than outpatient committal. Moreover, it is always possible for society to choose a less restrictive alternative but this is not always the best choice for citizens. We argue that when proposing “least restrictive alternatives” or indeed “least invasive alternatives” the more accurate goal is to search for the least restrictive or invasive alternative “that is appropriate to the circumstances.” We believe that this is a clinical rather than a legal decision. Moreover, it is important to remember that when a CTO is used consent is provided by the patient if capable or by the substitute decision maker if he/she is not.

Recommendation 24:

The wording in the legislation should be clarified to ensure that use of a Form 47 does not nullify the CTO.

The OPA strongly supports this recommendation. The nullification of a CTO when a Form 47 is issued is unnecessary, is a major addition to the administrative burden of using a CTO and ultimately discourages their use for individuals who would benefit from being on a CTO.

Recommendation 26:

The act should be amended to provide that a CTO client apprehended on the authority of a Form 47 may be brought to either the responsible physician or designate or to the closest Schedule 1 facility that would then be required to liaise with the responsible physician or designate.

The OPA would support such an amendment.

Recommendation 27:

The act should be amended so that periods of voluntary hospitalization are not included in the qualifying period for a CTO.

The OPA recommends that the requirement for *any* periods of hospitalization is removed. We believe the requirement for prior hospitalization is unnecessary as a CTO can only be issued if the person meets the criteria for inpatient committal. Thus, a CTO diverts the person for inpatient care (as most are issued from hospital they presumably shorten the period of involuntary inpatient care). It can be argued that requiring prior hospitalization forces some patients to spend unnecessary time committed to an inpatient unit. Moreover, as noted in our response to Recommendation 12 the prior hospitalization requirement often prevents the possibility of using a CTO for people with severe mental illness who are being released from prisons. As Dreezer and associates note, most international jurisdictions do not require previous hospitalization.

Recommendation 29:

The act should be amended to change the requirement that the CTO candidate must meet the Form 1 criteria, to a requirement that the practitioner is of the opinion that the client is likely to reach a state wherein he or she will meet the criteria within a defined period of time unless he or she is maintained on the CTO.

This proposed amendment is sensible for the reasons outlined by Dreezer and associates. However, we recommend that rather than requiring that it is likely that the person will meet the criteria within a defined period that the requirement should be “a likelihood that the person will meet the criteria within a *reasonable* period.”

Recommendation 32:

If and only if the proposal for an initial mandatory hearing is adopted, consideration should be given to amending the requirement in the act for previous hospitalization so that the test may be met in any hospital, or in other custodial institutions where the person has been detained on the basis of a duly constituted legal authority and satisfactory evidence is available to indicate that the person would likely have met the hospitalization criteria of section 33.1 were he or she not to have been detained elsewhere.

The OPA cautions against the introduction of a mandatory hearing at the time the first CTO is written. A CTO is less restrictive than civil commitment to hospital. Therefore, we see no reason why the rights procedures should be greater than for inpatient committal. The down side of this proposal is that it would require significantly more of a physician’s time to initiate a CTO. As Dreezer and associates note, the administrative burden is one reason why physicians avoid

using CTO and thus, an initial mandatory hearing would likely result in fewer people who would benefit from a CTO being placed on one.

The OPA suggests that the protections and rights associated with CTO use should mirror, in as far as possible, protections and rights for civil commitment to hospital. Thus, we would not support the introduction of mandatory review at the time of initiation of a CTO. However, we would support an alternative amendment requiring a that a second physician support the initial CTO in the same way as two physicians must agree that initial commitment to hospital is necessary.

Recommendation 33:

The MOHLTC should remove all references to “Brian’s Law” from their communications and publications. Consideration should also be given to amending the act to remove the term and make other changes in terminology to make the wording more respectful of consumers and more suitable for use in a health care milieu.

We agree that references to the term “Brian’s Law” are unnecessary and potentially stigmatizing and consequently should be removed.

Recommendation 34:

The MOHLTC should consider taking steps to further minimize telephone rights advice for clients and for substitute decision-makers who are located within the province.

Although we agree that it is preferable that rights advice be given in person, we are aware of the difficulties for some substitute decision makers who may live in distant regions of the province. Caution is necessary not to place an extra burden unnecessarily on these individuals who are usually family members trying to do their best for their relative.

Recommendation 37:

The PPAO should stop its practice of commenting to physicians and coordinators on the legality or propriety of treatment plans.

It does appear inappropriate for the PPAO to provide legal advice to physicians and coordinators on the legality of treatment plans.

Recommendation 39:

The MOHLTC should consider amending the act in order to provide physicians with the same protection from liability that they enjoy with regards to CTOs.

We agree with this recommendation. We also agree with Dreezer and associates’ conclusion in the body of the report that the Leave of Absence provision introduced in the 2000 amendments is underutilized. Dreezer and

associates note that confusion about whether patients released from hospital on an administrative leave of absence are eligible for Ontario Disability Support Program benefits has been a factor limiting use in some areas of the province. This has been the experience of many of our members.

The use of administrative leaves of absence might be increased if it was possible to clarify their relationship to certificates of involuntary admission and renewal. For example, the legislation does not specify if a committal certificate which expires during an administrative leave of absence can be renewed (presuming the patient has been examined by the attending physician and meets criteria) or whether an administrative leave of absence can be renewed after the three month period designated in the legislation has expired.

Recommendation 40:

The MOHLTC should consider amending the act to require a community treatment plan for all LOAs over 30 days.

We do not agree with this recommendation. It is unnecessary as the legislation provides for terms and conditions of the leave of absence which are binding on both the patient and the physician. The most likely use of the administrative leave of absence is to facilitate reintegration to the community upon release from hospital. Its main advantage over a CTO is that it can be initiated easily and not delay the patients release from hospital confinement.

Recommendation 44:

The MOHLTC should expand the scope of the next review to deal with the related aspects of community mental health care and wellness.

The OPA would be pleased to see an expansion of the next mandated review of the legislated amendments. We would suggest that in addition to the items suggested by Dreezer and associates it would be informative to examine why patients are or are not being admitted to psychiatric units from emergency rooms. Specifically, whether a lack of inpatient beds is resulting in some patients, who meet committal criteria and would benefit from admission, not receiving inpatient care.