

Fact or Fashion? Alberta Adopts the Community Treatment Order

Peter Carver

A decade ago I wrote an article titled “A New Direction in Mental Health Law.”¹ The article focused on “Brian’s Law,” the emotive name given by Ontario’s then Conservative government to a major revision of that province’s mental health laws. The thrust of *Brian’s Law* was to expand the bases for intervening in the lives of persons with mental illness, including through broadening the criteria for involuntary hospitalization. The particular issue addressed in the article, however, was the introduction into Canadian law of the “community treatment order” (CTO). While forms of CTO had become common among American states (known there as “outpatient committal”), *Brian’s Law* represented an innovation in Canadian mental health law and services.

Ten years later, Alberta has introduced the CTO into its legislation. It is the fifth province to do so.² What was an innovation just a few years ago now has a track record in several Canadian jurisdictions, as well as in other countries. What may seem surprising is that despite this widespread development, no consensus has emerged concerning how the CTO should be employed, nor whether it serves its intended purposes of maintaining individuals in the community and reducing involuntary admissions to psychiatric hospital facilities. In short, we have no ready answer to the question of whether in adopting the CTO Alberta has joined the vanguard in mental health legislation, or is merely the most recent victim of fashion.

Various criticisms have been made about the CTO mechanism over the years. This brief comment addresses

three such criticisms in the context of the specific CTO model adopted by Alberta:

1. CTOs are not effective for those persons for whom they are most intended – individuals who are non-compliant with treatment plans while living in the community.
2. The legislative obligations imposed on physicians and other service providers deter them from making use of the CTO mechanism.
3. CTOs serve more as an alternative to living freely in the community than as an alternative to involuntary hospitalization.

The first two points go to the efficacy of CTOs. The third goes to the balancing of potential benefits of the CTO with its impact on civil liberties of persons with mental illness.

Overview of the Community Treatment Order

The concept of the CTO is deceptively simple. It authorizes physicians to place a person under a legal order to follow a prescribed treatment plan, including the taking of medication, while living in the community. Previous to introduction of CTO provisions, Alberta’s law authorized treatment orders only for involuntary (“formal”) patients in psychiatric hospital facilities. Like the other CTO jurisdictions, Alberta had to address the issue of how to map the CTO onto existing hospital-based mental health legislation. The central features



of this legislation are the rules governing consent to treatment and the criteria for involuntary committal.

Alberta's CTO provisions track the province's position on consent to psychiatric treatment, with one exception. In Alberta, the refusal of treatment by a competent formal patient or by a substitute decision-maker for a formal patient may be overridden by order of a Review Panel under section 29 of the *Act*. This is unlike the situations in Ontario, which does not permit the overriding of competent refusals of treatment, or Saskatchewan, which does not permit involuntary hospitalization of

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treatment competent individuals. In Alberta, a CTO can be imposed over the objections of a competent patient. However, while hospitalized patients are subject to an override only by order of the Review Panel, the imposition of a CTO can occur on the basis of medical opinion alone.³

The committal criteria for CTOs in Alberta have both a qualitative and a quantitative aspect.⁴ The qualitative aspect of committal criteria are the substantive criteria going to the individual's current mental condition. As with the other jurisdictions, Alberta has set the CTO criteria at the same level as the criteria for involuntary hospitalization:

two physicians, after separate examinations of the person by each of them within the immediately preceding 72 hours, are both of the opinion that the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does

not receive continuing treatment or care while living in the community.⁵

All jurisdictions provide that once a person has been made subject to a CTO, they can be committed to a further CTO without the need for further or intervening hospital admissions.

Alberta has adopted a novel measure that arguably weakens the link between previous hospitalizations and CTOs. Section 9.1(1)(b)(iii) of the *Act* provides for issuance of a CTO where

in the opinion of the 2 physicians, the person has, while living in the community, exhibited a pattern of recurrent or repetitive behaviour that indicates that the person is likely to cause harm to the person or others or to suffer substantial mental or physical deterioration or serious physical impairment if the person does not receive continuing treatment or care while living in the community.

Here, the criteria for CTO committal are not previous hospitalizations, but "a pattern of recurrent or repetitive behaviour" in the community. For the first time, then, a Canadian legislature has made CTOs available for individuals based entirely on their conduct in the community.

A CTO remains in effect for six months (unless earlier withdrawn or revoked by Review Panel order), is renewable an indefinite number of times, and is subject to appeal to the Review Panel. As with other Canadian jurisdictions, the means of enforcing non-compliance by a patient with the terms of a CTO are by issuance of a warrant for apprehension of the person by peace officers, for purposes of bringing the patient to a psychiatric facility for assessment and possible committal to hospital pursuant to involuntary committal criteria.

1. Effectiveness with Non-Compliant Individuals

The Alberta Ministry of Health and Wellness has set modest goals for the new CTO mechanism:

CTOs are intended and designed for a unique and small number of patients with serious and persistent mental disorders who have demonstrated that without treatment and

intensive supports in the community, they relapse and require hospitalization, or those individuals who pose a risk to public safety if intensive case management is not provided.⁶

It is noteworthy that while the Ministry describes the target population as “unique and small,” it divides the population into two groups – those with a demonstrated history of relapse and hospitalization, and those who pose a risk to public safety. This reflects the fact that while the CTO is justified in therapeutic terms, the political motivation for its adoption is often as a response to a high-profile incident of violence. This was the case with *Brian’s Law* in Ontario.⁷ In Alberta, the triggering event was the 2004 shooting death of RCMP officer James Galloway by Martin Ostopovich. Mr. Ostopovich had been diagnosed as having paranoid delusions at the time of a brief hospitalization in 2002. The Provincial Court Judge who conducted the subsequent fatality inquiry recommended *inter alia* that the Government of Alberta adopt CTO legislation as a means of empowering physicians to require patients living in the community to take prescribed medications.⁸

However, serious questions persist about whether CTOs reach either group identified by the Alberta Ministry. In Mr. Ostopovich’s case, he appears to have had only one interaction with the mental health system. He could not have been made subject to a CTO on the basis of a history of hospitalizations. It also seems unrealistic to suggest that a CTO could or should have been issued on the “recurrent or repetitive behaviour” basis. A bare CTO, issued at the time of his 2002 hospitalization, would not likely have been sufficient to keep Mr. Ostopovich taking medications prescribed for him on that occasion (medications he ceased taking some time after his discharge).

Two things might have assisted Mr. Ostopovich and perhaps saved his and Constable Galloway’s life: (1) an intervention at the time of crisis that resulted in his being taken to hospital; (2) the availability of mental health services, including the kind of “intensive case management” that can support a community-based treatment program. The CTO is inappropriate in the absence of intensive support, and no more than secondary to compliance where such support is provided.

The only extensive empirical study yet conducted in Canada on CTO performance suggests this to be a valid

analysis. In a report written by an independent consulting group for the Ontario government and released in 2007, the authors noted:

Many participants told us that CTOs are an excellent way to serve many individuals suffering from serious mental disorders, but that they are not suitable for the neediest of clients. We heard for example, that they are not suitable for those who also suffer from serious drug abuse issues. We also heard that they are not ideal for those clients who are the most resistive to treatment or guidance.⁹

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These conclusions are not surprising. Common sense dictates that an order of compliance is most likely to be obeyed by persons able to, and inclined to, comply. The Alberta legislation in fact requires the committing physicians to state their opinion that the patient is “able to comply with the treatment or care requirements set out in the community treatment order.”¹¹ As noted below, physicians have strong incentives to commit only those individuals to a CTO who they believe will comply with its terms.

The Ontario Report showed mixed results. The authors reported satisfaction with the results of CTOs among



some CTO subjects, and even more among their family members. However, the report was unable to attribute this to the compulsory features of the CTO itself:

As we travelled the province we heard repeatedly that community treatment orders have profoundly changed many lives and even saved lives. However, it is less than totally clear which factors, or combination of factors, have led to this apparent success. It is difficult to know whether the key is the order itself and the legal control over the patient that it conveys, the services and the treatment team that is frequently assembled to support the patient, or some combination of these factors.¹²

This uncertainty has characterized studies carried out in jurisdictions outside Canada.¹³

2. Obligations on Service Providers

In “Community Treatment Orders in Saskatchewan: What Went Wrong?”¹⁴ Anita G. Wandzura provides a useful analysis of why CTOs across Canada, and particularly in Saskatchewan, appear to be used so infrequently. She traces the problem to several “design paradoxes” in the CTO legislation of Saskatchewan that deter psychiatrists from using the mechanism. The principal deterrent she notes are the additional obligations imposed by the CTO on issuing physicians and other treatment personnel.

The Alberta legislation imposes the following obligations. The issuing physician must set out the care and treatment required by the individual in the community, and state the opinion that each of these “exists in the community, is available to the person and will be provided to the person.”¹⁵ The order must “identify the person who is responsible for the supervision of the community treatment order and any reporting obligations in respect of the community treatment order.”¹⁶ Should a psychiatrist wish to issue a warrant of apprehension for a non-compliant patient, he or she must be satisfied that reasonable efforts have been made to assist the person to comply with the order, and that they have been notified of their non-compliance and the possibility of the warrant.

None of these requirements seem unreasonable in the context of the legal powers conferred by the CTO.

However, clinicians may wonder how these new obligations balance against what the CTO is able to achieve. This is particularly so with the requirement to name, or serve as, the person responsible for supervising and reporting on CTO performance. This role may ultimately be intended for “CTO coordinators,” as is the case in Ontario – that is, management officials affiliated with community mental health services. Nevertheless, by specifying the supervisory role and its importance to the scheme, the statute may effectively expand the duty of care owed by physicians to both patients and community members at large. In this regard, Wandzura notes that several provinces have incorporated provisions in their CTO statutes relieving physicians and other treatment personnel of liability for actions taken in good faith in carrying out CTO duties. Alberta has chosen not to do so. While Canadian courts have been cautious about finding physicians liable for civil committal decisions with respect to individuals who pose a risk to themselves or others, they have recognized this as a potential source for liability. There is little reason to think this risk would not also attach to decisions to impose or not impose a CTO, or to opt for a CTO in place of hospitalization.

The bottom line is that physicians will be, and should be, reluctant to issue CTOs where they do not have confidence that adequate treatment resources, including intensive case management, are available for patients living in the community. The services must come first. Where community mental health services are adequately funded, CTOs may be added to the mix as a form of legal back-up. Without the services, CTOs will either not be used or will fail.

3. A Less Intrusive Alternative?

Wandzura believes that the Alberta CTO model can serve as a means of assisting individuals who are experiencing a first “psychotic break,” and who have never been hospitalized. Viewed in this light, the CTO would be a middle ground intervention that would allow a person to remain in the community such that they never get into a cycle of repeat hospitalizations.

This is an optimistic view, but perhaps not a realistic one. First, it is questionable whether a first psychotic episode would provide the basis for the recurrent behaviour required by the statute. Beyond that, however, section 9.1(1)(b)(iii) represents an undermining of the idea that the CTO is only an alternative to the more restrictive



alternative of involuntary hospitalization. While repeating the harm criteria that serve as criteria for hospital committal, the section goes on to make the CTO available where the physician is of the opinion that these risks can be avoided by treatment in the community. This means that CTOs reach persons who may not otherwise be committable to hospital.

Section 9.1(1)(b)(iii) embodies a paradox. If its terms are strictly applied, then it will almost never be invoked – how else does one assess a person’s condition as being “likely” to render him or her committable to hospital without having a record of recent hospitalizations? Should the section be more routinely invoked, this will almost certainly be occurring in circumstances that would not have resulted in hospitalization.

This kind of conundrum characterizes the CTO as a whole: the CTO will either be used so infrequently that it plays no significant role in community mental health (as appears to be the case in Saskatchewan), or it will be applied to many individuals who could be maintained in the community without compulsion. Everyone who has written about CTOs, including the authors of the Ontario Report, agrees that the key to a successful CTO is the kind of “intensive case management” mentioned by the Alberta Ministry. There is good reason to believe that intensive case management – involving frequent contact with psychiatric nurses and social workers, and good access to psychiatrists – is equally effective whether or not accompanied by a CTO. The CTO is an unnecessary add-on to the arrangement.

Does this matter? Patient advocates have argued that the coercive nature of the CTO adds to the stigma that already marginalizes the seriously mentally ill. CTOs might be able to be managed discretely so as to minimize that kind of effect. Nevertheless, the coercive power of law should generally be limited to those circumstances where it is necessary, and effective. Coercion will continue to have a role in mental health services. Persons with serious illness must sometimes be hospitalized. They require the safety, supervision, time away from harmful environments, and close monitoring of a medication regime that can be provided on an in-patient basis. The force of law is often required to support the custodial basis of treatment. It is much less clear that law meets standards of necessity and effectiveness when dealing with non-custodial, community treatment.

Conclusion

As a *legal* device, the community treatment order is suspect. It holds out a promise of compulsion where compulsion is largely unnecessary, impractical or illusory.

This does not necessarily mean that CTOs serve no purpose in mental health services. As the Ontario Report finds, and as Wandzura and others report, there is considerable anecdotal evidence from clinicians, patients and their families that CTOs contribute to improved mental health outcomes. For one thing, the CTO serves a useful purpose in facilitating apprehension

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and assessment of CTO patients. Families frequently report that it is difficult to obtain intervention by police or mental health personnel when they observe early signs of deterioration in their relatives’ mental condition. The enforcement mechanism or “penalty” for non-compliance with a CTO is apprehension for assessment. This does allow for earlier intervention in some cases than would otherwise be the case.

An intriguing point, however, is that the reported success of CTOs is due more to perceived shifts in the relationship between patients and treating personnel than any legal reality. Among several reasons given to explain this phenomenon, two are worth noting here. First, Dawson *et al.* report the phenomenon of CTO patients who experience an added sense of security by being made subject to an order to comply with their treatment plan, even where they have every intention to do so in the first place.¹⁷ Second, the CTO is seen by some participants as a form of contract between the patient and service providers, in which the latter are committed to the patient’s care and maintenance. The



Ontario Report noted that CTOs were being used by some clinicians as a means of creating a priority for CTO patients in accessing community services. In this way the CTO takes on the aspect of a “right to treatment” that otherwise does not exist.

Alberta has now joined the coterie of Canadian jurisdictions that have embraced a form of CTO. To answer the question posed at the outset, this is more likely a statement of fashion than a breakthrough in mental health service delivery. To mix metaphors, it is still too early to say that the emperor has no clothes.¹⁸ The emperor may indeed be clothed – but more in rags than raiments.

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Endnotes

- 1 Peter Carver, “A New Direction in Mental Health Law: Brian’s Law and the Problematic Implications of Community Treatment Orders” in Timothy A. Caulfield & Barbara von Tigerstrom, eds., *Health Care Reform and the Law in Canada: Meeting the Challenge* (Edmonton: University of Alberta Press, 2002)187.
- 2 In addition to Ontario, the other three Canadian provinces to adopt a CTO mechanism are Saskatchewan (*Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1), Newfoundland and Labrador (*Mental Health Care and Treatment Act*, S.N.L. 2006, c. M-9.1), and Nova Scotia (*Involuntary Psychiatric Treatment Act*, S.N.S. 2005, c. 42). Note that at least two other provinces, B.C. and Manitoba, opted in recent years to revise the extended leave from hospital provisions of their mental health statutes rather than move to a CTO scheme.
- 3 *Mental Health Act*, R.S.A. 2000, c. M-13, s. 9.1(1)(f)(ii), as am. by *Mental Health Amendment Act*, 2007, S.A. 2007, c. 35, s. 8.
- 4 Along with Ontario, this is the most relaxed such threshold in Canada.
- 5 *Supra* note 3, s. 9.1(1)(c) [emphasis added]. The replacement of “dangerousness” with the “substantial deterioration” standard is the other major change to the *Mental Health Act* effected by the recent amendments.
- 6 “Mental Health Amendment Act – A Summary of Changes,” online: Alberta Health Services <<http://www.albertahealthservices.ca/788.asp>>.
- 7 *Brian’s Law* was enacted in response to the 1995 shooting death of well-known Ottawa sportscaster Brian Smith (after whom the statute was named) by an individual with mental illness.
- 8 P. Ayotte, *Report to the Attorney General – Public Inquiry into the death of Corporal James Galloway and Martin Ostopovich* (Edmonton: Justice and Attorney General, 2006), online: Justice and Attorney General <http://justice.alberta.ca/programs_services/fatality/Documents/fatality_inquiry_report_galloway_2006_11_21.pdf> .
- 9 Stephen Dreezer, Michael Bay & David Hoff, *Report on the Legislated Review of Community Treatment Orders Required Under Section 33.9 of the Mental Health Act* (Toronto: Ontario Ministry of Health and Long-Term Care, 2005), online: Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/public/pub/ministry_reports/dreezer/dreezer.html> at 105 [Ontario Report]. When it introduced the CTO into Ontario’s mental health law in 2000, the provincial legislature mandated that a performance review of CTOs be conducted every five years. This first Report was completed in December 2005, although not released to the public by the Government of Ontario until almost two years later.
- 10 *Ibid.* at 115.
- 11 *Supra* note 3, s. 9.1(1)(e).
- 12 *Supra* note 9 at 124.
- 13 For a particularly useful summary of studies through to 2003, see John Dawson *et al.*, “Ambivalence about community treatment orders” (2003) 26 *Int’l J.L. & Psychiatry* 243. See also Ann-Marie A. O’Brien & Susan J. Farrell, “Community Treatment Orders: Profile of a Canadian Experience” (2005) 50 *Canadian Journal of Psychiatry* 27, and Richard L. O’Reilly *et al.*, “A quantitative analysis of the use of community treatment orders in Saskatchewan” (2006) 29 *Int’l J.L. & Psychiatry* 516.
- 14 (2008) 71 *Sask. L. Rev.* 269.
- 15 *Supra* note 3, s. 9.1(1)(d).
- 16 *Ibid.*, s. 9.1(2)(f).
- 17 Dawson *et al.* note the difficulty this poses for explaining what is going on with respect to our notions of freedom and compulsion:



This situation illustrates the complexities of freedom and choice and the problem of defining patient liberty in compulsory community care. It is clear from our interviews that some patients do not view complete discharge from the CommTO as the least restrictive option for them. They value being held metaphorically in a system of protection and support.

Supra note 13 at 252.

- 18 The use of the metaphor in this context is borrowed from a 2006 exchange in the Canadian Journal of Psychiatry concerning the state of research findings on CTO efficacy. See Stephen Kisely & Leslie Anne Campbell, "Community treatment orders for psychiatric patients: the emperor has no clothes", (2006) 51 Can J Psych 683, and Richard L. O'Reilly, "Community treatment orders: this emperor is fully dressed!" (2006) 51 J Psychiatry 691.

