

Community Treatment Orders and Nova Scotia — The Least Restrictive Alternative?

*Shelley Trueman**

Introduction

Community treatment order, community committal, involuntary outpatient commitment, mandatory outpatient treatment, leave certificates: these are all similar terms used to define a legal tool or mechanism currently used in mental health reform legislation. Generally, a community treatment order [hereinafter CTO] is issued by a medical practitioner where there is legislative authority with the binding force of a court order. It compels a person with a serious mental disorder to comply with a treatment program in the community as an alternative to involuntary hospitalization. CTO terms are usually for a set period (i.e. 90 or 180 days) and can be renewed upon review.

CTOs are the latest trend of legislation following the de-institutionalization movement of the 1970s and are premised on the transfer of treatment of persons with mental illness from the institution to the community. CTOs were first provided for in Saskatchewan in 1995.¹ Ontario has most recently legislated for CTOs in 2001.² Other provinces that have adopted such measures in the form of leave certificates include Manitoba³, British Columbia⁴ [hereinafter B.C.], Prince Edward Island⁵ [hereinafter P.E.I.], and Alberta.⁶ Nova Scotia currently remains without any kind of CTO provisions in its mental health legislation, the *Hospitals Act*.⁷

Nova Scotia, though, is undergoing a process to update its mental health legislation and system of care. The process has already started with various institutions, professionals, providers, and consumers contributing their perspectives and recommendations to the Department of Health.⁸ The Law Reform Com-

* Shelley Trueman is an articling student at Coady Filliter, Halifax, Nova Scotia. This paper was originally written in 2002 as a requirement for the Mental Disability Law course offered at Dalhousie Law School. The author would like to thank Professor H. Archibald Kaiser for his comments, guidance and encouragement.

¹ *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1

² *Mental Health Act*, R.S.O. 1990, c. M-7.

³ *Mental Health Act*, C.C.S.M. c. M-110.

⁴ *Mental Health Act*, R.S.B.C. 1996, c.288.

⁵ *Mental Health Act*, S.P.E.I. 1994, c.39.

⁶ *Mental Health Act*, R.S.A. 2000, c. M-13.

⁷ R.S.N.S. 1989, c.208.

⁸ See Nova Scotia Department of Health, *Mental Health: A Time for Action* (Review Report) prepared by Roger Bland & Brian Dufton (Halifax: Department of Health, May 31, 2000), online: Nova Scotia Department of Health <www.gov.ns.ca/health/downloads/mh.pdf> (date accessed: 28 September 2003) [Bland & Dufton].

mission of Nova Scotia has also made recommendations for possible *Hospital Act* provisions and amendments. The Final Report on *Mental Health Provisions of the Hospitals Act* examines, among other issues, the use of community treatment orders already in place in provinces across Canada and recommends that Nova Scotia follow the model of "leave certificates."⁹

There is little Canadian case law and literature that has critiqued existing CTOs in Canada.¹⁰ This is no doubt due not only to the novelty of CTOs but also to the fact that there have been few opportunities to test the legislation in court. There has been ample opinion, though, of both the efficacy and arbitrariness of CTOs. The ongoing development of involuntary outpatient committal [hereinafter IOC] (the term more commonly used in the United States) has been even more hotly debated in the American community for the past 15-20 years.¹¹ As such, Canadians should carefully scrutinize the American experience and then decide on the wisdom of CTOs. Boudreau and Lambert note in the introduction of their survey of American IOC that

[a]s today's policy makers are bracing for the future and exploring new directions for mental health services... CCT's [compulsory community treatment] relevance as a key, critical, and controversial issue cannot be underestimated. Already adopted... in all American states... CCT requires close, informed, and critical examination before it is allowed to become an explicitly legislated part of the Canadian mental health landscape.¹²

This article takes the position that the adoption of CTO legislation in Nova Scotia would be controversial, problematic and unnecessary. Because CTO legislation is often vague and difficult to interpret and apply, mental health reform should focus more attention on constructive tools and less on coercive legislation. I will first review the American and Canadian experiences, their diversity of legislation, and various public policy arguments that have fuelled IOC/CTO implementation. This will be followed by discussion of specific issues within

⁹ Law Reform Commission of Nova Scotia, *Mental Health Provisions of the Hospitals Act* (Final Report) (Halifax: Law Reform Commission of Nova Scotia, February 2002) [Law Reform Commission of Nova Scotia]. Other provinces currently using "leave certificates" are Prince Edward Island, Manitoba, Alberta, and British Columbia.

¹⁰ See Françoise Boudreau & Philip Lambert, "Compulsory Community Treatment? I. Ontario Stakeholders' Responses to 'Helping those Who Won't Help Themselves'" & "Compulsory Community Treatment? II. The Collision of Views and Complexities Involved: Is It 'The Best Possible Alternative'?" (1993) 12 *Can. J. Community Mental Health* 57 & 79 [Boudreau & Lambert] for a significant Canadian study of the American IOC experience in anticipation of CTO legislation in Ontario. See also Naomi J. Fulop, "Involuntary Outpatient Civil Commitment: What Can Britain Learn from the U.S. Experience? A Civil Liberties Perspective" (1995) 18 *Int'l J. L. & Psych.* 291 [Fulop].

¹¹ See Gerry McCafferty & Jeanne Dooley, "Involuntary Outpatient Commitment: An Update" (1990) 14 *Mental & Physical Disability L. Rep.* 277 [McCafferty & Dooley] for trends taking place in state legislation in 1990s.

¹² Boudreau-Lambert, *supra* note 10 at 79.

community committal legislation. Then the difficulties and challenges of implementing *treatment* within a community order will be examined. Lastly, I will look outward and advocate for the “least restrictive alternative” in this context, in the form of a voluntary community support system.

The American and Canadian Experiences

For well over a century with the advent of social welfare in the 1800s, thousands of mentally ill persons in North America were placed in institutions or asylums.¹³ Institutionalization was premised on the belief that the mentally ill were incapable of looking after their own needs.¹⁴ The institution served not only a housing function, but also offered a treatment component. Once the 1950s were reached, research in the pharmacological field had advanced to the point of producing antipsychotic medication to control symptoms of some of the most treatment-resistant illnesses, most notably schizophrenia.¹⁵ This, coupled with the civil liberties movement in the 1960s, led many, including public administrators, to question the wisdom and costs of institutional care and the unnecessary detention of the mentally ill. Better care and treatment could be achieved in the community. The concept of reintegration was introduced into the lexicon of treating the mentally ill.¹⁶

The de-institutionalization movement followed in the 1960s and 1970s with the release of thousands of former inpatients to community care after the reduction of the standard of committal from paternalism to dangerousness.¹⁷ In retrospect, the community was not ready to handle the influx of so many former inpatients.

¹³ See Leonard D. Smith, *‘Cure, Comfort and Safe Custody’ — Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999) at 1-11 for a history of institutionalizing the mentally ill. See also Howard Zonana, “Mandated Outpatient Treatment: A Quick Fix for Random Violence? — Not Likely” (2000) 28 J. Am. Acad. Psych. L. 124 [Zonana]. See also Law Reform Commission of Nova Scotia, *supra* note 9 at 8-14 for the development of civil commitment in Nova Scotia.

¹⁴ See Steven J. Schwartz & Cathy E. Costanzo, “Compelling Treatment in the Community: Distorted Doctrines and Violated Values” (1986-87) 20 Loyola of Los Angeles L. Rev. 1329 [Schwartz & Costanzo], for an interesting discussion on the development of the “*parens patriae*” authority. They point out at 1339 that “the *parens patriae* doctrine established the king as no more than a temporary trustee over the property of people labelled mentally ill. Safeguarding their health — to say nothing of confining their persons — was unheard of.”

¹⁵ Rael Jean Isaac & Virginia C. Armat, *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (New York: The Free Press, 1990) at 20. See also Elizabeth Furlong, “Coercion in the Community: The Application of *Rogers* Guardianship to Outpatient Commitment” (1995) 21:2 New England Journal of Criminal and Civil Confinement 485 at 495-499 for a discussion of antipsychotic drugs and their effects in treatment.

¹⁶ Ted Frankel, “Exodus: 40 Years of Deinstitutionalization and the Failed Promise of Community-Based Care” (2003) 12 Dalhousie J. Legal Studies 1 at 2, 21 [Frankel].

¹⁷ John E.B. Myers, “Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change” (1983-84) 29 Vill. L. Rev. 367 at 388-400.

Inevitably, despite the drastic decline in the number of institutional beds¹⁸, many returned to psychiatric facilities, as adequate community services were not in place, such as medical and social supports including clinics, trained staff, proper housing, employment initiatives, and financial means and funding¹⁹. As well, once placed back into the general community, a person with mental illness continued to face the unavoidable stigma and marginalization associated with mental illness. Involuntary outpatient commitment developed in direct response to these revolving door patients who were slipping through the cracks of community care. It used as its premise a finding of deterioration after discontinuing treatment once in the community and decompensating.²⁰

In 1979, North Carolina led the development of the first generation of legislated IOC, providing for compulsory treatment in the community immediately following hospitalization.²¹ This type of treatment, often known as conditional release, is based on the premise that if a patient does not comply with the conditional order of treatment in the community, he or she can be returned to the psychiatric facility where he or she had been previously committed immediately prior to release. The second generation or type of IOC is based upon the least restrictive alternative principle in that a patient is still involuntarily committed but to an outpatient community treatment centre instead of an inpatient facility, where the right to liberty and freedom from detention is less restricted. The third generation or type of IOC is developed on the premise of prevention — catching the revolving door patients *prior* to the decompensation that marked a return to dangerousness and to involuntary civil commitment. This is the most controversial type of IOC and suggests a return to the asylum approach, using a paternalistic justification for the infringement of civil liberties. Most states have provided for either one,²² two²³ or all three²⁴ types

¹⁸ See Bland & Dufton, *supra* note 8 at 32, where the authors note that the Nova Scotia Hospital, a psychiatric facility once housed over 1000 patients but now has only 186 beds.

¹⁹ See Frankel, *supra* note 16, for a critique of both North America's and Nova Scotia's inadequate transition from institutional to community-based mental health care.

²⁰ Often, those who didn't return to a psychiatric institution were transinstitutionalized into nursing homes, prisons, and jails. See Jillane T. Hinds, "Involuntary Outpatient Commitment for the Chronically Mentally Ill" (1990) 69 Nebraska L. Rev. 346 at 349 [Hinds].

²¹ Robert D. Miller & Paul B. Fiddleman, "Outpatient Commitment: Treatment in the Least Restrictive Environment?" (1984) 35 Hospital & Community Psychiatry 147 at 148 [Miller & Fiddleman].

²² Bazelon Center for Mental Health Law, *Involuntary Outpatient Commitment: Summary of State Statutes* (April 2000), Bazelon Center for Mental Health Law, online: Bazelon Center for Mental Health Law <<http://www.bazelon.org/iocchartintro.html>> (last modified: 24 October, 2001) (date accessed: 28 September 2003) [Bazelon Center, *State Statutes Summary*]. Alaska, New Hampshire, and Tennessee are three states that allow IOC only on the basis of conditional release of an involuntary patient status, thus being retained on an inpatient basis while being treated in the community.

²³ *Ibid.* States that allow for conditional release and preventive commitment, either expressly or impliedly, include Alabama, Arizona, Idaho, Indiana, New York, North Carolina, and Oregon. States that allow for conditional release and involuntary outpatient commitment on a least restrictive alternative principle, either expressly or impliedly, include Arkansas, Colorado, Delaware, District of Columbia, Illinois, Iowa, Kentucky, Louisiana, Missouri, Nebraska, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Virginia, Washington, West Virginia, and Wyoming.

²⁴ *Ibid.* States that allow for conditional release and involuntary outpatient commitment on both a

of IOC legislation. Some states allow for IOC, others advocate for the least restrictive means of treatment thereby implying IOC, while others have express provisions specifically for IOC. Very few states, such as Massachusetts, have resisted legislating some form of IOC legislation, preferring to solve the problem of hard to treat patients by some other means.

Treatment plans are almost always included in IOC and are predicated on the need for continued medication as treatment. The means of compliance with the treatment varies with some legislation dependent on competency while other legislation require a determination of non-competency.²⁵ Committal into the community with a corresponding treatment plan may be dependent on the actual informed consent of the patient.²⁶ One state has experimented with community commitment by making the treatment component voluntary.²⁷

Many states have revised their legislation at least once or twice since implementation. The Bazelon Center for Mental Health Law reports that there has been renewed interest in IOC legislation with Massachusetts, Maryland and Connecticut considering but not legislating outpatient commitment while Pennsylvania and Iowa rejected expansion of the use of outpatient commitment in their legislation.²⁸ All in all, in spite of only three general categorizations, there is a bewildering array of legislation in the United States. As Schwartz and Costanzo have noted, “[o]utpatient commitment is not a unified concept with a commonly accepted definition or consequence.”²⁹ Hinds has also pointed out that “in most states, statutory provisions for outpatient commitment have not been widely used — undoubtedly due, in part, to the confusion and lack of knowledge about procedures and parameters of statutory authority.”³⁰

In Canada, the situation is analogous to the United States, but in a belated yet accelerated fashion. Canada followed the American lead and initiated its own de-institutionalization movement. Like many provinces, Nova Scotia had devel-

preventive basis or the least restrictive alternative principle, either expressly or impliedly, include Hawaii, Kansas, Michigan, Minnesota, Mississippi, Montana, North Dakota, Texas, and Vermont.

²⁵ *Ibid.* A finding of non-competency is the most common type of treatment compliance. Some states allow for treatment on the basis of a need for treatment without addressing the competency or consent issue within the legislation (e.g. Rhode Island, South Dakota).

²⁶ *Ibid.* Kansas, Kentucky, Virginia, Washington are among those states that require a patient’s consent to a IOC. There are some states that allow for treatment when the patient is competent but refuses to voluntarily accept (e.g. Colorado, Minnesota, Missouri, West Virginia).

²⁷ *Ibid.* Both North Carolina’s and Hawaii’s legislation depends on a person’s ability to make an informed decision to voluntarily seek or comply with treatment to be limited, while at the same time stating that no subject of an involuntary outpatient commitment order shall be forcibly forced to take medication or forcibly detained for treatment.

²⁸ *Ibid.* Although the state legislatures had explored and then rejected the possibility of implementing IOC, advocates’ campaigns were successful in opposing proponents of IOC from both initiating and expanding current legislation in the case of Maryland and Pennsylvania.

²⁹ Schwartz & Costanzo, *supra* note 14 at 1332.

³⁰ Hinds, *supra* note 20 at 355.

oped a dangerousness criteria for detaining mentally ill persons in the *Hospitals Act*, which came into effect in 1979.³¹ And like the United States, Canada is also in the process of trying to implement a new mental health system based on community services rather than institutionalization.

However, the first Canadian CTO legislation only came into effect in 1995 when Saskatchewan overhauled its mental health legislation and provided for CTOs.³² Provision was made for mandatory treatment in the community based on prior involuntary hospitalizations of potential CTO patients. Criteria included, whether within the previous two years, a patient had spent sixty or more days as an involuntary patient or had been involuntarily committed to a psychiatric facility three or more times. As importantly, the standard for commitment was relaxed from dangerousness to deterioration, based on the assessments of two physicians, including one psychiatrist.³³ Ontario followed suit with its CTO legislation (named "Brian's Law") coming into effect in January of 2001. This legislation was highly controversial as it set criteria on an even less stringent basis than any other province. A CTO can be ordered, on the basis of, whether within the previous *three* years, a patient had been detained thirty days or more in a psychiatric facility, or had *two* previous hospitalization periods.³⁴ Furthermore, the standard was not only dropped to patients who exhibited deterioration, but the legislation does not state that the necessary pre-committal hospitalizations must be involuntary.³⁵

Manitoba, P.E.I., Alberta and B.C. have all amended their mental health acts to include a conditional release type of CTOs in the form of leave certificates. Manitoba's criteria is identical to Saskatchewan, except that the leave is attached to an immediate prior period of hospitalization.³⁶ P.E.I., Alberta and B.C. also use leave certificates to return involuntary inpatients to the community to continue treatment. In these provinces, criteria for leave certificates are generally discretionary with no additional requirements beyond those for initial involuntary inpatient commitment. For B.C., the criteria is to prevent substantive mental or physical deterioration or the protection of the patient or others.³⁷ In P.E.I., the criteria is in

³¹ Law Reform Commission of Nova Scotia, *supra* note 9 at 14-16. Nova Scotia enacted the *Hospitals Act* that included the danger requirement for involuntary admission in 1977 which came into effect in 1979.

³² *Supra* note 1.

³³ *Ibid.*, s. 24.3(1).

³⁴ *Supra* note 2, ss. 33.1-33.9. Contrast 3 years and 2 stays of Ontario with 2 years and 3 stays of other provinces.

³⁵ *Ibid.* The implied voluntary nature of previous hospitalization is much broader than even American criteria and could prove to be very litigious. See Anita Szigeti, "Ontario's Community Treatment Orders: How Did We Get There and Where Do We Go Now? An Advocate's Perspective" (2001) 21 Health L. Can. 66.

³⁶ *Supra* note 3, ss. 46-48.

³⁷ *Supra* note 4, ss. 22, 37. In B.C. the director of a designated facility holds the discretionary power to release a patient on leave, but can only release "providing appropriate support exists in the community to meet the conditions of the leave" (s. 37).

danger to oneself or others.³⁸ In Alberta, the criteria is danger to oneself or others.³⁹ It is unclear which province's leave certificate legislation the Law Reform Commission is advocating for Nova Scotia. The Commission seems to be adopting Manitoba's requirement of developing a treatment plan but the recommendation does not state a requirement for previous involuntary hospitalizations.⁴⁰

There are significant similarities and differences between Canadian CTO and American IOC legislative initiatives. Just as the American legislation faced considerable debate, Canada's endeavours in CTO legislation have also been highly contentious and controversial. Stakeholders including professional associations and institutes, family consortiums, advocacy groups and consumers themselves, have advocated various viewpoints and arguments. At least two and even three positions have emerged since problems with the de-institutionalization movement surfaced. Proponents argue for balancing the civil rights of the patients with their needs. This means curtailing some rights and freedom in the best interests of the patient to ensure they receive required treatment. This group advocates that the patients' rights include getting necessary treatment to ensure a better quality of life both for themselves and those around them.⁴¹ Compulsory treatment in a community setting is seen not only as less restrictive but also as a viable alternative to institutionalization. A second group advocates granting rights as much possible but concedes that there are a small group of patients who will not voluntarily seek desperately needed treatment. Compulsory treatment is a last resort, to be used when all other avenues are exhausted and the uncooperative patient cannot break the involuntary inpatient/discharge cycle. In those circumstances there is a reluctant but necessary infringement of some rights. Finally, a third group, often associated with civil libertarians, advocate that infringement of rights be restricted to only an involuntary inpatient commitment basis.⁴² Compulsory community treatment is seen not only as intrusive for a mental health consumer, but generally not effective in the long run and even damaging to the advancement and reform of mental health care in general.

In both Canada and the United States, widely divergent opinion based on misconceptions biases, and assumptions has often fuelled CTO/IOC legislation.

³⁸ *Supra* note 5, ss. 13-15, 25-26. In P.E.I., the attending psychiatrist applies his discretion "allowing the patient to live outside the psychiatric facility," with the leave certificate subject to "such conditions as may be specified in the certificate."

³⁹ *Supra* note 6, ss. 2, 20. In Alberta, the Board of a facility exercises discretion to grant leave of absence "on any terms and conditions prescribed by the board and ... may include a condition that the formal patient remain under the supervision and subject to the treatment of any person or persons designated by the board." For all four provinces providing for leave certificates, there is no prescribed term for the leave period and it is unclear whether it is for the remaining duration of the original civil commitment or for an additional set term or period.

⁴⁰ Law Reform Commission of Nova Scotia, *supra* note 9 at 78.

⁴¹ See Michael L. Perlin, *The Hidden Prejudice: Mental Disability on Trial* (Washington, D.C.: American Psychological Association, 2000) at 105 [Perlin *Hidden Prejudice*]. See also Schwartz & Costanzo, *supra* note 14 at 1333. See also Boudreau & Lambert, *supra* note 10 at 80.

⁴² Perlin *Hidden Prejudice*, *ibid.* at 105 See also Schwartz & Costanzo, *ibid.* at 1333 and Boudreau & Lambert, *ibid.* at 80.

One of the most common misconceptions is that treatment is seen as benevolent or beneficent, despite the continuing problems associated with medication and/or services. The other misconception is that untreated mentally ill people are prone to violence, and thus dangerous without treatment.

Interestingly, there has been surprisingly little research of the effectiveness of CTOs/IOC. In the United States, there has been some study. Earlier studies indicating some effectiveness were often relied upon by advocates for IOC legislation. However, these studies have now been limited due to weaknesses while two significant studies have been released in the past five years with stronger methodology.⁴³ It is worthwhile to examine these results and apply them to any proposed Canadian initiative.

Certainly the debate has had a major impact on how public policy has affected legislation and underlying legal issues. To be sure, there are significant differences of philosophies between the Canadian and the American approaches.⁴⁴ Canada's socially-oriented health care system guarantees basic care for all, while the American system does not have universal access. At the same time, Canadian constitutionally guaranteed rights do not mirror American rights.⁴⁵ Mental health legislation jurisprudence in general has been nominally developed in Canada. On the other hand, mental health legislation jurisprudence in the United States is voluminous with considerable IOC litigation anticipated in the future.⁴⁶ Furthermore, both procedural and substantive mental health law is weaker in Canada than in the United States where there are constitutional requirements for mental health treatment.⁴⁷

⁴³ See Policy Research Associates, *Final Report: Research Study of the New York City Involuntary Outpatient Commitment Pilot Program, (at Bellevue Hospital)* (Delmar, N.Y.: Policy Research Associates, December 4, 1998) [Policy Research Associates, *New York Study*] for the first study. See also Marvin S. Swartz *et al.*, "Can Involuntary Commitment Reduce Hospital Recidivism? Findings From a Randomized Trial with Severely Mentally Ill Individuals" (1999) 156:12 *Am. J. Psych.* 1968 [Swartz *et al.*, *Randomized Trial*] for the second study, conducted in North Carolina by Duke University researchers. These studies will be discussed in the last part of this paper, although it is beyond the scope of this paper to critically analyse the findings. See generally Boudreau & Lambert, *supra* note 10 at 89, where the authors note that while effectiveness of IOC studies generally find lower hospital recidivism rates, they "tell us very little about how individual needs were met... They tell us absolutely nothing about individual satisfaction and quality of life."

⁴⁴ See Boudreau & Lambert, *supra* note 10 at 84 for a good discussion on the differing political and social cultures of the United States and Canada as it relates to mental health legislation and practice.

⁴⁵ See Isabel Grant, "Mental Health Law and the Courts" (1991) 29 *Osgoode Hall L.J.* 747 [Grant] where Grant points that there is less reliance on the police power in Canada than there is in the United States as criminal law and health care belong to different jurisdictions whereas a State has the power to enact mental health law with criminal sanction.

⁴⁶ See Michael L. Perlin, *Mental Disability Law: Civil and Criminal*, 2d ed. vol.1 (Charlottesville, Va: LEXIS Law Pub., 1998) at 498-99 [Perlin "Mental Disability Law"].

⁴⁷ Grant, *supra* note 45. Grant discusses that such underdevelopment may be due to Canada lagging behind the United States both in terms of constitutional rights development and mental health care legislation. At 759-64 Grant points out that since the arrival of *Canadian Charter of Rights and Freedoms* in 1982, there has been some litigious activity in defining Charter rights, particularly s. 7 right to life, liberty and security of person and s. 9 right not to be arbitrarily detained and more currently s. 15

The United States Supreme Court set the precedent in *Re Gault*⁴⁸ for rejecting a *parens patriae* basis to detain a person and required the much stricter state police power with appropriate safeguards to use as a basis for detaining in a rehabilitation institute. This decision was reinforced in the civil commitment context with *Lessard v. Schmidt*⁴⁹ which emphasized that a detainee requires sufficient measures and time for an opportunity to respond to a commitment decision. *O'Connor v. Davidson*,⁵⁰ another United States Supreme Court decision, found that involuntary commitment is a deprivation of liberty and as such requires safeguards within the due process of law. *Addington v. Texas* cemented the necessity of due process of law in civil commitment hearings with the requirement that the standard of evidence for committing be “clear and convincing proof.”⁵¹ Finally, the United States Supreme Court has held in *Olmstead v. L.C.*⁵² that the segregation and isolation of individuals with diverse mental illnesses in institutional settings constitutes discrimination under the *Americans with Disabilities Act of 1990*.⁵³ The Court also recognized that the state must guarantee and maintain a minimum range of facilities for the care and treatment of the mentally ill within the community.⁵⁴

In contrast, Canadian courts reviewing civil commitment decisions have retained a paternalistic mode when civil commitment decisions are made even though a dangerousness standard was adopted in post-de-institutionalization legislation. The psychiatric profession is usually given deference in the initial decision to commit.⁵⁵ Nevertheless, a successful *Canadian Charter of Rights and Freedoms* s. 9(1) right not to be arbitrarily detained challenge was made in *Lussa v. Health Science Centre*⁵⁶ where it was held that the plaintiff did not exhibit any danger to herself or others and was given no opportunity to challenge her detention. *Thwaites v. Health Sciences Centre Psychiatric Facility*⁵⁷ was another successful s. 9 challenge where the Manitoba Court of Appeal found broad committal criteria with unclear objectives violated a right not to be arbitrarily detained. However, a s. 7 right to liberty challenge to involuntary commitment was denied in the B.C.

anti-discrimination rights. However, there are fewer procedural safeguards put in place for Canadian legislation than American. For example, a court hearing is not needed to initially place a person on a CTO or leave certificate in Canada while a court hearing is required for an IOC order placement in many states.

⁴⁸ 387 U.S. 1, 18 L. Ed. 2d 527 (1967).

⁴⁹ 349 F. Supp. 1078 (E.D. Wis., 1972).

⁵⁰ 422 U.S. 563, 45 L. Ed. 2d 396 (1975).

⁵¹ 441 U.S. 418, 60 L. Ed. 323 at 331 (1979).

⁵² 119 U.S. 581, 119 S.Ct. 2176 (1999).

⁵³ 42 U.S.C. § 12101 (1990).

⁵⁴ But see Frankel, *supra* note 16 at 6-7 where he discusses the American Congress initiative under President John F. Kennedy's term in office to provide funding for community mental health centers under the *Mental Retardation and Community Health Centers Construction Act*. He notes that by 1989, despite government support and promises, fewer than the 700 of the 2,500 planned CMHCs had actually been constructed.

⁵⁵ Grant, *supra* note 45.

⁵⁶ (1983), 9 C.R.R. 350 (Man. Q.B.).

⁵⁷ [1988] 3 W.W.R. 217 (Man. C.A.).

Supreme Court case *McCorkell v. Riverview Hospital*⁵⁸ where it was found that dangerousness is not the only criteria that an individual can be civilly committed under in accordance with the principles of fundamental justice. Also, in contrast to American case law, *Re Azhar and Anderson* established that the standard of proof required in a hearing has been left on a balance of probabilities civil standard where the court stated that the standard is not pivotal in the process of protecting and balancing the rights of individuals and that the word likely in the provincial civil commitment legislation meant just probable and not highly probable.⁵⁹ Few civil commitment process cases have made it to the Supreme Court of Canada.

Various issues with CTO legislation and its corresponding components of community committal and treatment will be discussed and critiqued in the next two sections.

Issues in Community Committal

The main difficulty with CTO legislation is that it has been conceptualized and presented within the context of civil commitment legislation based on inpatient committal to a psychiatric facility. With civil commitment legislation, the committal and treatment components are often treated separately. Usually, commitment is established before treatment is even considered. One can be involuntarily committed without necessarily being treated. If an inpatient is determined to be competent, then there is a further issue of whether treatment can be given with or without informed consent. There must be a finding of non-competency or some other mechanism to get past a lack of consent if treatment is to be administered. In contrast, with CTO/IOC legislation, treatment is intrinsically linked with committal.⁶⁰ In some states and provinces, such as Saskatchewan,⁶¹ there must be a finding of non-competency before a CTO/IOC order is given. In other states and provinces, such as Manitoba,⁶² a patient must consent to a treatment plan prior to a CTO, or, in some cases, consent can be overridden and a patient is subject to the treatment nevertheless, as is the case in Alberta.⁶³ In almost all cases, however, if there is no treatment, there can be no CTO. This has invariably led to confusion in structuring and interpreting CTO legislation.

CTOs and IOC have developed on the basis of two premises. First, there would be a natural transition towards much of mental health treatment being provided in the community instead of the institution. The second premise was that

⁵⁸ [1993] B.C.J. No. 1518. (S.C.)(Q.L.).

⁵⁹ (25 June 1985), (Ont. Dist. Ct.) [unreported], 33 A.C.W.S. (2d) 521.

⁶⁰ But see Bazelon Center. *State Statutes Summary*, *supra* note 22, where in North Carolina and Hawaii legislation a patient can be given a right to refuse treatment and still remain in community committal.

⁶¹ *Supra* note 1, s. 24.3(1)(a)(v).

⁶² *Supra* note 3, s. 46(3)(b).

⁶³ *Supra* note 6, s. 29(1), but subject to a review panel decision.

the main focus of treatment in the community would be much the same as in the inpatient facility, *e.g.* medication.⁶⁴

Difficulties have emerged in the translation of the inpatient setting to a community setting because of the above premises. One such difficulty is the implication of using the dangerousness standard as a deterioration standard in *preventive commitment*. This includes the impact of defining imminent and preventive within the interpretation of deterioration and dangerousness. Another difficulty is the contradiction of *conditional release* in terms of restricting a patient's freedom or liberty when hospitalization is no longer required. A final difficulty is the confusing and inconsistent principle of the *least restrictive alternative* within the community itself. Treatment and consent issues will be discussed more fully in the following section.

(i) Preventive Commitment

Many of the first IOC orders in the United States did not initially rely on a finding of deterioration. However, it became apparent that determining dangerous was ambiguous and difficult. Ideally, the standard was to recognize and *anticipate* the occurrence of any real harm through actual dangerous behaviour. The standard was thus designed to detain persons and prevent them from doing any harmful acts. As such, the problem with the dangerous standard was determining at what point a mentally ill person would become dangerous and would require detention to prevent them from doing something harmful either to themselves or to others.⁶⁵

Early jurisprudence in the United States initially interpreted the dangerous standard as requiring an imminent state of dangerousness including overt action before detention could occur. A key case was *Lessard v. Schmidt*, where the court found that proof of "a recent overt act, attempt, or threat to do substantial harm to oneself or another" was constitutionally necessary.⁶⁶ *State v. Krol*⁶⁷ agreed by delivering a comprehensive definition of dangerousness. In contrast, although provincial legislation require dangerousness to commit, Canadian courts have not upheld a clear and stringent standard for dangerousness. For example, in a 1984 finding by the P.E.I. Supreme Court in *References Re Procedures and the Mental*

⁶⁴ See Susan Stefan, "Preventive Commitment: The Concept and Its Pitfalls" (1987) 11 *Mental & Physical Disability L. Rep.* 288 at 294 [Stefan] where Stefan states "[i]n practice, the core of outpatient treatment is forced medication."

⁶⁵ See Stefan, *ibid.* at 289 for an interesting discussion on the danger standard where she states that:
[t]his objective probably falls short of the conditions necessary to assert the state's police power because the individual by definition is not dangerous, much less imminently dangerous. Moreover, since civil commitment is itself a form of preventive detention, to the extent that a person is detained not because of what he has done but for what he will predictably do, preventive commitment is actually preventive treatment to avoid preventive detention.

⁶⁶ *Supra* note 49 at 1093.

⁶⁷ 344 A.2d 289, 301-02 (N.J. 1975).

Health Act, the Court deferred to medical opinion and defined safety as going beyond mere protection against physical injury. This was done by stretching the meaning to include the “alleviation of distressing physical, mental or psychiatric symptoms.”⁶⁸ Furthermore, in a criminal law context, the Supreme Court of Canada held in *Winko v. British Columbia (Forensic Psychiatric Institute)*⁶⁹ that the definition of danger for committal of or disposition of an accused offender with mental disorder, “significant threat to the safety of the public,” stated in the *Criminal Code of Canada*⁷⁰ was not unconstitutionally vague or imprecise under a s. 7 right and that it did give sufficient guidance for committal/disposition without any further definition.

Eventually courts in the United States started requiring less tangible action and relying more on the ability of the psychiatric assessor to determine the point of imminent danger, as evidenced by the 1984 case of *State v. Robb* where the Court rejected dangerousness defined as a “recent overt act, attempt or threat” as it would place an “unnecessarily heavy burden on the State.”⁷¹ Legislators soon followed suit by also abandoning the “dangerous act” as a prerequisite.⁷² This represents a backwards slide in the “dangerousness” standard. No doubt, it is better to interpret dangerous *before* harm actually happens, provided that it is obvious that harm is about to happen. However, research indicates that the psychiatric profession, although very proficient at recognizing mental illness have not developed any realistic or true indicators of “dangerousness.”⁷³ As well, there is a public myth that dangerous means people with mental illness are violent,⁷⁴ an image that is often encouraged by the media. This misconception is embedded within some IOC legislation.⁷⁵ More recently, public pressure has been put on government to legislate an answer to situations of violence where a person with mental illness has been involved.⁷⁶ As a result legislators have often responded to political expediency

⁶⁸ (1984), 5 D.L.R. (4th) 577 (P.E.I. S.C.) at 589 [*References Re Procedures*].

⁶⁹ [1999] 2 S.C.R. 625, S.C.J. No. 31 [*Winko*].

⁷⁰ R.S.C. 1985, c. C-46, s. 672.54.

⁷¹ 484 A.2d 1130, 1134 (N.H. 1984).

⁷² Perlin *Hidden Prejudice*, *supra* note 41 at 83.

⁷³ “The American Psychiatric Association...openly admitted that psychiatrists are wrong two-thirds of the time in predicting which of their patients truly present a danger. Studies indicate that psychiatrists, well aware of their fallibility, seriously overpredict” Carla McKague, “Involuntary Hospitalization: Are New Mental Health Laws Necessary? A Patient’s Rights Perspective” (1988) 9 Health L. Can. 15 at 15-16 [McKague].

⁷⁴ *Ibid.* at 15 where McKague states that “there appears to be little, if any, correlation between mental disorder and violence. The most frequent outcome of studies trying to correlate the two is that the level of violence among people with mental disorders is the same, or less than, the level of violence in the general public.”

⁷⁵ See Bazelon Center, *State Statute Summary*, *supra* note 22 where Georgia, Nebraska, New York, Ohio and Rhode Island all include “violence” or “violent behaviour” within their commitment criteria. Compare with Illinois’ criteria, which includes “unable to guard himself or herself [committed person] from serious harm.”

⁷⁶ See *e.g.* Ken Kress, “An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa” (2000) 85 Iowa L. Rev. 1269. Mentally ill are more often victims rather than perpetrators, but have committed violent and harmful acts upon

rather than examining the full issue of danger, violence and the implications thereof.⁷⁷

Eventually, a split developed within civil commitment with outpatient commitment requiring a less strict dangerous standard in order to prevent a return to the hospital, justified on the basis of a *parens patriae* power.⁷⁸ This is a direct contradiction of the whole impetus of the de-institutionalization movement, that of not detaining people for any reason except in the most critical of dangerous situations. Schwartz and Costanzo have a stinging commentary on the acceptance of the prevention standard:

[r]egardless of allegedly humane motivations, outpatient commitment proposals which sanction the involuntary treatment of competent persons who do not pose any immediate risk to their own physical safety solely to improve their mental health, face substantial constitutional and theoretical difficulties. They simply are not consistent with the legal foundation on which they purport to rest. On the contrary, they represent a significant distortion of the historical purpose and benign motivation of the *parens patriae* principle.⁷⁹

At present, Nova Scotia's *Hospitals Act* for criteria for civil commitment is based on a danger standard in that a patient "requires care that cannot be adequately provided outside the facility because he is a danger to his own safety or the safety of others."⁸⁰ The Law Reform Commission of Nova Scotia is advocating a standard of "serious harm to self or others" for its recommendation of leave certificates⁸¹ as well as for the standard of formal admission to a facility, noting that "[s]erious harm' is a term that is easily understandable, *flexible in its application*, acceptable under the *Charter*...[and] would take into account not only events about to happen immediately, but in addition, consequences which occur more gradually ..."[emphasis added].⁸² The Commission states that a serious harm standard would then preclude a deterioration standard. Although the Commission thinks otherwise, serious harm in actuality would not preclude deterioration, and would, indeed, be flexible enough to be misinterpreted as a preventive standard.

In spite of the American constitutional guarantee, later U.S. courts and legislators have broadened the definition of danger to include deterioration, and,

which legislative initiatives have been based, such in New York with "Kendra's Law" and Ontario with "Brian's Law". Both Kendra and Brian were portrayed as victims of the violently mentally ill.

⁷⁷ Zonana, *supra* note 13.

⁷⁸ Bazelon Center, *State Statutes Summary*, *supra* note 22. Of seventeen states that allow for preventive commitment, five use the same standard for both inpatient and outpatient status (Arizona, Michigan, North Dakota, Oregon, and Vermont).

⁷⁹ Schwartz & Costanzo, *supra* note 14 at 1349.

⁸⁰ *Supra* note 7, s. 36(2)(ii).

⁸¹ *Supra* note 9 at 77.

⁸² *Ibid.* at 41.

as explained earlier, where a statute definition does not state preventive or deterioration, courts have stretched the definition of dangerousness to include situations where the interpretation of danger is less clearly defined. If Canadian legislators wanted a strict interpretation of dangerousness, they have not had the benefit of a Canadian court to reinforce such interpretation as clearly pointed out by the elastic decisions of *References Re Procedures* and *Winko*. The Commission's definition of serious harm in all likelihood could and would be interpreted and upheld as a preventive or deterioration standard by Nova Scotia physicians and courts alike.

(ii) Conditional Release

Conditional release is seen as a graduated type of treatment, where one is still subjected to treatment conditions but in less restrictive environs than a psychiatric hospital. Manitoba, Alberta, Prince Edward Island, and British Columbia leave certificates are a form of conditional release. Sometimes the criteria for leave certificates is similar to other types of CTO legislation where there must be a previous history of hospitalization. At other times the only criteria is to be presently involuntary committed to an institution. There is an internal contradiction when an inpatient has been committed on a dangerous standard and that same standard is then used as criteria to be conditionally released. How can a patient be dangerous enough to be in need of hospitalization but still be safe enough to be conditionally released? If a patient is dangerous and needs supervision in an inpatient setting, then conditionally releasing them will make supervision all that more difficult if a patient is still considered dangerous or capable of causing serious harm. On the other hand, if a patient is conditionally released based on a non-danger finding (versus a danger finding used for inpatient civil commitment in the first place), then it is difficult to understand why the patient is subjected to a continuing form of detention (including restriction of movement, and compulsory appointments and treatment) instead of being unconditionally released. Dawson points to the incongruity of conditional release:

[w]hen a decision has been made ... that a committed patient is fit to be granted leave, has not a decision been made, in effect that their 'detention' is no longer necessary? If their detention *was* necessary why would they be granted leave? At the very moment the patient departs on leave they should be discharged instead.⁸³

The Law Reform Commission of Nova Scotia, like other jurisdictions, recommends use of leave certificates with a collaborative treatment plan to which the patient consents.⁸⁴ However, if an inpatient can gain release from a civil commitment only by consenting to treatment in the community, then there is no true consent. To consent to treatment through means of a trade or promise is not

⁸³ John Dawson, "Community Treatment Orders" (1991) 7 Otago L. Rev. 410 at 416.

⁸⁴ *Supra* note 9 at 78.

true consent, but rather involuntary or coercive.⁸⁵ Thus, conditional releases that are dependent on the consent of a treatment plan are not truly a release, a patient has not truly agreed to the conditions and is still being detained with his rights being infringed. Releasing a patient conditionally from an inpatient setting is not inappropriate. Attaching legal consequences to those conditions is coercion and thus not appropriate.

Finally, conditional release is analogous to parole in that if there is non-compliance with treatment (whether or not true consent is obtained), then the patient will have his or her release status revoked and be returned to facility for at least a reassessment and possible re-hospitalization. American courts have made this analogy of parole to mental health law in their jurisprudence. Oklahoma Federal District Court in *Lewis v. Donahue*,⁸⁶ a mental health decision, adopted the United States Supreme Court criminal parole decision of *Morrissey v. Brewer*⁸⁷ and confirmed that deprivation of liberty upon revocation of conditional release also demands due process. Yet, Canadian courts continue to reject the parole and criminal law analogy in mental health law, and allow for minimal procedural requirements, basing it on a paternalistic mode.⁸⁸ As such, courts will often defer to professional opinion rather than proceed with its own decision making when liberty is deprived or threatened.

Presently, the *Hospitals Act* does not provide for the conditional release of formal inpatients in the form of leave certificates or otherwise. However, the Law Reform Commission of Nova Scotia comments and readily uses the analogy of parole in its recommendation of adopting leave certificates.⁸⁹ This is a contradiction of the rejection of the analogy by Canadian courts. At the same time, even though retaining the possibility of a court or tribunal order for examination and admission as provided for in s. 37 or for review of status as in s. 47 of the *Hospitals Act*, the Commission is of the view that courts or tribunals should not be used to determine whether a person is to be involuntarily admitted to a facility as a patient. Instead, it submits the view that there is a need to rely predominantly on medical evidence.⁹⁰ This is confusing — the Commission admits that use of leave certificates is analogous to parole yet at the same time would deny use of courts or tribunals to ensure procedural requirements and would defer almost all decision making to medical authority. It is resorting to the criminal analogy when convenient, to justify an end, but not accepting any of its implications.

⁸⁵ See H. Archibald Kaiser, "Mental Disability Law" in Jocelyn G. Downie & Timothy A. Caulfield, eds., *Canadian Health Law and Policy* (Markham, Ont: Butterworths, 1999) 217 at 252 where Kaiser stresses that "[a]ny consent to treatment must be voluntary in several senses. There must be no coercion, fear of reprisal or promise of reward." See also *Arndt v. Smith*, [1997] 2 S.C.R. 539.

⁸⁶ 437 F. Supp. 112 (W.D. Okla. 1977).

⁸⁷ 408 U.S. 471 (1972) which held that there must be procedural protection when parole is revoked upon a deprivation of liberty.

⁸⁸ Grant, *supra* note 45 at 788-89.

⁸⁹ *Supra* note 9 at 73.

⁹⁰ *Ibid.* at 28-32.

(iii) Least Restrictive Alternative Principle

The least restrictive alternative principle is becoming the cornerstone of most mental health legislation, particularly CTOs/IOC. It was first articulated in earlier mental health law in *Lake v. Cameron*⁹¹ a civil commitment and detention case. The Court determined that civil commitment should only be used as a last resort and that there was a duty upon the state to direct an appropriate inquiry into "other alternative courses of treatment" and that "[d]eprivations of liberty solely because of the dangers to the ill persons themselves should not go beyond what is necessary for their protection."⁹² This principle figured in the constitutional case *Lessard v. Schmidt*.⁹³ Schwartz and Costanzo elaborate that the

least drastic means [restrictive alternative] principle creates no independent legal rights, but instead is an interpretive guideline for assessing whether an established constitutional precept has been infringed. It imposes an additional burden on the state to legitimize actions which impinge on otherwise protected privilege of citizenship.⁹⁴

This principle had great impact in mental health legislation. In 1978, the U.S. President's Commission on Mental Health Report adopted this doctrine as "the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment *or receives services*" [emphasis added].⁹⁵

The least restrictive alternative underlies conditional release, preventive commitment or stands on its own as a substitute to civil commitment. Some states explicitly express IOC as the least restrictive alternative to civil commitment while others imply that IOC is a least restrictive alternative.⁹⁶ In Canada, Prince Edward Island provides for certificates of leave as being "less restrictive and less intrusive" than being detained in a psychiatric facility.⁹⁷ Ontario states in its purposes for the provision for a community treatment order that it "is less restrictive than being detained in a psychiatric facility."⁹⁸ Manitoba legislation states that a leave certificate is to "provide the patient with psychiatric treatment that is less restrictive and

⁹¹ 364 F.2d 657 (D.C. Circ. 1966).

⁹² *Ibid.* at 660.

⁹³ *Supra* note 49.

⁹⁴ *Supra* note 14 at 1349.

⁹⁵ The President's Commission on Mental Health, *1 Report to the President from the President's Commission on Mental Health 44* (1978), as quoted by Hinds, *supra* note 20 at 347, n. 7.

⁹⁶ Bazelon Center, *State Statutes Summary*, *supra* note 22. At least twenty-one states have expressly legislated that involuntary outpatient commitment be a less restrictive alternative and at least another seven states have implied involuntary outpatient commitment as a lesser restrictive alternative to hospitalization. These numbers do not include those states that use conditional release as a lesser restrictive alternative to hospitalization.

⁹⁷ *Supra* note 54, s. 25(1).

⁹⁸ *Supra* note 2, s. 33.1(3).

less intrusive to the patient than being detained in a facility.”⁹⁹ Alberta legislation provides for consideration of “whether the treatment is the least restrictive and least intrusive.”¹⁰⁰ Neither British Columbia nor Saskatchewan state the principle of least restrictive alternative within its CTO or leave certificate legislation.

However, the least restrictive alternative is difficult to apply. When first enunciated, the least restrictive alternative was used to interpret the district’s mental health service as going beyond civil commitment (which was considered too drastic under the circumstances) and including “the entire spectrum of services...including outpatient treatment, foster care halfway houses, day hospitals, nursing homes, etc.”¹⁰¹ *Lessard v. Schmidt* later broadened the less restrictive alternative to include: “(1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable.”¹⁰²

This points to an ambiguity. Is CTO/IOC legislation to be considered as *the* least restrictive alternative to civil commitment to a psychiatric facility rather than *a* least restrictive alternative? The fact that less rather than least is used in Manitoba, Ontario, and P.E.I. legislation suggests that other possibilities may be open but the legislation does not provide for further exploration.¹⁰³ It is also unclear whether it is incumbent on the person advocating for commitment to prove there is no least restrictive alternative or on the person advocating non-committal that there is another least restrictive alternative. Does least restrictive alternative mean proving that CTO treatment is available (*e.g.* all the required support and services not only for treatment but residing in the community are fully available)? Most statutes require that services be available in the community but many do not give guidelines as to what services and their level of adequacy.¹⁰⁴ Who decides that the least restrictive alternative is a CTO or something other — patient, physician, board or court?¹⁰⁵ Does least restrictive alternative take into consideration the circumstances of the patient (*e.g.* no readily available housing

⁹⁹ *Supra* note 3, s. 46(1).

¹⁰⁰ *Supra* note 6, s. 28(4)(d).

¹⁰¹ *Supra* note 91 at 659-60.

¹⁰² *Supra* note 49 at 1096.

¹⁰³ Contrast this with state legislation that outlines the need for exploration of lesser restrictive alternatives. See Bazelon Center, *State Statute Summary*, *supra* note 22 where Mississippi’s legislation states that the “court shall commit the patient for treatment in the least restrictive treatment facility” which “may include, but shall not be limited to: voluntary or court-ordered outpatient commitment for treatment with specific reference to a treatment regimen, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative or the provision of home health services.” On the other hand, some state legislation is quite vague as to what constitutes as an alternative to hospitalization. District of Columbia states that the court may order “any other alternative course of treatment which the court believes will be in the best interests of the person or of the public.”

¹⁰⁴ See *e.g.* Manitoba legislation, *supra* note 3, s. 46(5)(d).

¹⁰⁵ See *e.g.* West Virginia legislation, Bazelon Center, *State Statutes Summary*, *supra* note 22, where the burden of proof of the lack of a less restrictive alternative is placed on those seeking the commitment of the individual.

or family in the community)?¹⁰⁶ Issues of homelessness, inadequate supervision, and abandonment are also direct or indirect implications of least restrictive alternatives. The state may take it upon itself to order and administer the treatment in a community setting, but will the state accept the additional responsibility of ensuring that the patient also has shelter, food and clothing so that the patient can and will focus on treatment. If an involuntary patient is released to the community under a CTO, what checks and balances are in place to guarantee that a patient can coordinate all aspects of treatment and community life without running into serious difficulties resulting in either injury or abandonment?

Is the perspective of the patient accorded the least restrictive alternative? It could be that it is easier just to receive treatment in the psychiatric facility than grappling with other issues associated with supervised community treatment. It is possible that a competent patient would rather be civilly committed and not treated than subjected to a least restrictive alternative of enforced community treatment. Boudreau and Lambert note that in some contexts, a CTO

may be even more restrictive than inpatient civil commitment...[as it] denies such right [to refuse treatment] and holds the potential to monitor and control a patient's entire life; place of residence, presence in day clinics, the consumption of alcohol, the acceptance of case management, etc.¹⁰⁷

There are other ambiguities including whether a least restrictive alternative would be less effective than civil commitment. For example, whether the state is allowed to use an alternative that does not have the same effectiveness as IOC, whether the state must use the *least* or just *lesser* alternative (no matter what the effectiveness), and whether the state must use the least expensive option (whether IOC or an alternative).¹⁰⁸ Should determination of costs of one alternative over another be a factor?

Considerable debate exists as to whether the principle should be viewed in the context of mandatory treatment or rather in the context of the right of not to be interfered with or detained. Proponents claim that it is less restrictive in terms of where involuntary treatment is to be situated, in a facility or in the community.

¹⁰⁶ See *e.g.* Pennsylvania legislation, *ibid.*, which includes consideration of the person's relationship to community and family, employment possibilities, all community resources, and guardianship services when investigating alternatives.

¹⁰⁷ Boudreau & Lambert, *supra* note 10 at 82. See also McCafferty & Dooley, *supra* note 11 at 278 where they note that IOC nature is illusory and that "IOC respondents' right to refuse medication and treatment is unclear. By its very nature, treatment orders issued by the court can override the individual's right to refuse treatment. In fact, persons committed to inpatient care may have a stronger right to refuse antipsychotic medication than persons committed for outpatient care."

¹⁰⁸ Perlin *Mental Disability Law*, *supra* note 46 at 423.

However, the least restrictive alternative principle should be properly referred to in terms of as little detention as possible. That may or *may not* include treatment.¹⁰⁹

Schwartz and Costanzo offer a compelling argument as to how the principle of least restrictive alternative has been misconstrued from being a doctrine that guided least restrictive infringement of a person's liberty and freedom from detention to a doctrine that dictates what is the least restrictive alternative for involuntary treatment. They suggest that, because the alternative services and types of treatment (i.e. non-medication) were often unavailable and the community system was vastly underdeveloped, the doctrine could not be implemented as it was intended. At that point, the medical profession, frustrated with the system, then used the doctrine to justify forced medication, the only type of treatment that was often truly available and effective in the eyes of the professional community, basing it on a *parens patriae* authority. Many courts subsequently endorsed this use of the doctrine and upheld psychiatric decisions.¹¹⁰ Schwartz and Costanzo then point out situations where the *parens patriae* authority has been limited in court decisions thus reflecting the true intention of the doctrine. They state that in these decisions

[L]iberty could be measured in several dimensions but physical freedom and the fundamental right to control one's own body were clearly the most relevant criteria. The least restrictive alternative doctrine was then properly a measure of the extent of freedom restricted by state action. Coerced psychiatric treatment, no matter where compelled, implied a 'massive curtailment of liberty.' Conversely, truly voluntary care was undoubtedly the least restrictive means for offering help. The ability to choose, not the geographic location of forcibly imposed treatment, was the proper determinant of the doctrine.¹¹¹

Any legislation dealing with the aspect of rights curtailment in the least restrictive alternative should consider what Schwartz and Costanzo have repeatedly stated: "[f]or the principle of the least restrictive alternative to retain its vitality in the commitment context, it should adhere to its original moorings in the substantive guarantee of liberty and be limited to a simple measurement of coerced versus voluntary care."¹¹² The authors then point out that Massachusetts and Connecticut are two states that have used the principle as constitutionally intended and have searched for alternatives other than involuntary community treatment. At the same time, those states' courts have upheld the principle by applying it properly to the most basic right of liberty as affected by civil commitment.¹¹³

¹⁰⁹ *Supra* note 103. Mississippi also has included different options within its legislation to consider least restrictive alternatives.

¹¹⁰ Schwartz & Costanzo, *supra* note 14 at 1357 where they suggest that a "guideline for constitutional analysis would become a prescription for psychiatric intrusion, with medical standards of improvement becoming the measure of the full implementation of the principle."

¹¹¹ *Ibid.* at 1356-57.

¹¹² *Ibid.* at 1358.

¹¹³ *Ibid.* at 1356-57.

In Canada, New Brunswick considered legislating community treatment orders and then decided against it, instead leaving civil commitment legislation in place as it was and not expanding legislation that would infringe on a person's liberty. In 1999, the Department of Health consulted various stakeholders in the mental health system, the consensus was that there were alternatives strategies to CTOs and that less restrictive alternatives that didn't rely on coercion within the community did and could exist.¹¹⁴ Interestingly, New Brunswick's *Mental Health Act*¹¹⁵ makes abundant use of the principle least restrictive and least intrusive in various elements of their legislation where there are involuntary hospitalization procedures, including commitment, treatment and consent.¹¹⁶ The factors include whether there are less restrictive alternatives to the procedure and whether these alternatives would be appropriate or inappropriate for the patient. There are no indicators of inappropriateness and this as well as lack of definition of alternatives can be misconstrued. However, it is a consideration used in the true sense of "alternative to restriction of liberty" that is specifically built into more provisions than most other provinces' legislation.

Currently, the *Hospitals Act* does not articulate a least restrictive alternative principle. The Law Reform Commission of Nova Scotia recommends that "[c]ommunity treatment should be the least intrusive option available."¹¹⁷ This is the only mention made of a least restrictive alternative in the report. It is not listed in any of its purposes or even in the guiding principles of the report. In what context is the Commission referring to when using the the least intrusive option? Commitment? Treatment? Compulsion? The Commission states that this option would be provided where relevant services are available, but does not discuss what these services are and how they would be relevant. The Commission has done little if any significant research as to what possible alternatives there could be to civil commitment other than community treatment (which is not presented in definitive terms) and does not supply any kind of framework as to determine what is least intrusive. The Commission should have advocated for a less restrictive alternative principle when presenting its recommendations of mental health treatment or services but has failed to do.

Issues in Treatment

Treatment is at the core of CTOs. Whereas civil commitment does not necessarily engage treatment, the CTO almost always requires that a patient comply with a medication component. This suggests an over-reliance on pharmacological methods for treatment. Psychiatric treatment has traditionally relied on medication

¹¹⁴New Brunswick Department of Health and Wellness, "Mental Health Services", *Health Services Review: Report of the Committee* (1998), online: New Brunswick Department of Health and Wellness <<http://www.gnb.ca/hw-sm/hw/pub/hsr/index.htm>> (date accessed: 7 October 2003).

¹¹⁵R.S.N.B. 1973, c. M-10.

¹¹⁶*Ibid.* at ss. 8-8.6, 12, 13.

¹¹⁷Law Reform Commission of Nova Scotia, *supra* note 9 at 77.

but also used other modes of treatment such as psychotherapy and behaviour therapy. However, medication is the type of treatment that has been regarded as most effective (and daresay most efficient) in an institution setting, particularly when treating symptoms rather than an unknown cause. Symptoms often include not only physical effects but also socially unacceptable behaviour. Thus treatment was often used to bring about more acceptable behaviour. With the breakthrough of antipsychotic drugs, medication became even more promising.¹¹⁸ There were also changing roles within psychiatry and psychology professions as psychiatrists took the lead in treatment, relying more on medication than other forms of treatment.

The transfer of treatment to an outpatient setting has not decreased reliance on medication. Whether it was intended that de-institutionalization would be much more than a transfer of medication-focused treatment is not clear. In retrospect, though, treatment as more than medication was required. Medication should not be the mainstay, but only one aspect of treatment. Unfortunately, many CTO statutes reflect a lack of choice and flexibility. Hinds points out that “[j]ust as definitions of outpatient commitment vary, treatment provided to committed outpatients lacks a standard definition.”¹¹⁹

Focus on pharmacological treatment continues as more effective drugs are developed. However, even with second and third generation atypical drugs, medication is still not dependable. Problems with side effects have made medication seem almost as bad as the illness itself.¹²⁰ There is still considerable experimentation in finding the right medication and dosage with the least amount of side effects. As such, patients often will not comply with a medication regime.¹²¹ This is not always a conscious decision. Sometimes the side effects themselves make it difficult to comply. In many cases, though, non-compliance becomes a rational decision when a patient chooses symptoms of an illness over a loss of function that medication often induces.

Certainly, even if a patient is granted freedom in the community, he or she is still subjected to variables in making the treatment work. As noted earlier, community implementation is multi-faceted. Costs, obtaining and scheduling of medication may become the responsibility of an outpatient. The patient will have to attend outside appointments, thus another demand on scheduling and transportation needs. And, most basic of all, an outpatient will have food, clothing and shelter to attend to, worries that are minimized in an institutional setting. An outpatient will require

¹¹⁸ Schwartz and Costanzo, *supra* note 14 at 1332.

¹¹⁹ Hinds, *supra* note 20 at 361.

¹²⁰ *Ibid.* at 372 where Hinds gives an inventory of the most common side effects.

¹²¹ *Ibid.* at 375 “Until more information is available regarding noncompliance and how well the goals of outpatient commitment are achieved in practice, we should defer to the right of a competent outpatient to refuse medication in the absence of an emergency.” There is a need for more research on *why* a patient is non-compliant and less reactive behaviour on the part of professionals when a patient does refuse medication.

a source of income whether in terms of employment or social assistance. These are just some considerations of complying with treatment in the community. A problem with any aspect of coordination could ultimately cause non-compliance with a possible return to a facility. For example, if treatment can only be scheduled during regular business hours and a patient has managed to find employment but has no choice of shifts or working hours to accommodate treatment, he or she must then decide between maintaining a job so that he or she can afford to live in the community (and thus minimizing stigmatization by not resorting to social assistance) or complying with treatment so that he or she will not be forced (back) into a psychiatric facility. Another example is if a CTO patient is ordered to take medication that interferes with his or her physical functioning (*e.g.* drowsiness or edginess), which may in turn interfere with his or her prospects of engaging in viable employment. Hinds correctly states that “[h]ospitalization should not be used as punishment for mentally ill patients who fail or refuse to comply with treatment.”¹²²

There is little agreement in state and provincial legislation as to the best way to effect a patient’s compliance, though. Some require a finding of non-competence before community treatment can be ordered.¹²³ Saskatchewan’s CTO legislation is such an example. It states that “as a result of the mental disorder, the person is unable to fully understand and to make an informed decision regarding his or her need for treatment or care and supervision”,¹²⁴ thus allowing for a CTO. A problem with this approach is whether the patient’s prior wishes when competent will be entirely overridden (best interests often decided from a medical professional perspective) or if any accommodation will be allowed as expressed by a substitute decision-maker. In *Guardianship of Roe*,¹²⁵ the Supreme Court of Massachusetts held that an incompetent non-institutionalized patient cannot be forcibly medicated if, on judicial review through substituted decision-making, it is determined that the individual would not have accepted medication if competent, regardless of best interests. A landmark Ontario Court of Appeal case came to a similar conclusion in *Fleming v. Reid*,¹²⁶ where it was held that provision for compulsory treatment of an involuntary incompetent patient without regard to prior competent expressed wishes violates s. 7 right to life, liberty and security of person. The Court noted, however, that Ontario legislators were in the process of overhauling the consent provisions of their mental health legislation that did allow for lack of consent to be overridden with appropriate procedural requirements.

Even though a finding of incompetence in one area of a patient’s life should not affect competence in another area, there is an assumption that a patient will be

¹²² *Ibid.* at 398-99. See also Fulop, *supra* note 10 at 299 where she notes that people who are well enough to cope in the community should retain the right to accept or refuse treatment.

¹²³ See *e.g.* Rhode Island, South Dakota, *supra* note 25.

¹²⁴ *Supra* note 1, s. 24.3(1)(a)(v). But see B.C. legislation, *supra* note 3, s. 31(1) where an involuntary patient is deemed to be consenting to treatment.

¹²⁵ 421 N.E.2d 40 (Mass. 1981).

¹²⁶ (1991), 4 O.R. (3d) 74 (C.A.).

capable of complying with the treatment order without necessarily understanding that order. As well, there is also an assumption that non-compliance is indicative of lack of capacity.¹²⁷ Manitoba's legislation is dependent on the criteria of capability of compliance.¹²⁸ This can be a difficult criterion to determine and establish. Almost all variables and unknowns must be established before a CTO can be put into place. What if a service or support is withdrawn or other arrangements are made that are more difficult to work with? If a patient becomes non-compliant as a result of outside difficulties, must he or she then face consequences such as a possible return to psychiatric facility?

In other state and provincial legislation, before a CTO or IOC is put in place, the patient must be competent and must consent to the accompanying treatment plan.¹²⁹ Manitoba's leave certificates provide that a patient must be consulted and must consent to a plan (or have substituted consent in place if not competent).¹³⁰ Ontario's CTO legislation requires the patient or substitute decision-maker to be involved in developing a treatment plan, suggesting that this constitutes consent¹³¹. Because of the linking of treatment to community committal, there cannot be a CTO *unless* the patient submits to the treatment.¹³² If the other option is to return or remain in a psychiatric facility, it is not difficult to perceive this as coercion. Indeed, both active and reluctant proponents of CTOs acknowledge this as coercion, but term it justified coercion.¹³³ As with other aspects of CTOs, this is also seen as a least restrictive alternative. Once again, this is only a least restrictive alternative to involuntary treatment, and not necessarily to detention itself. Stefan discusses the lasting effect of justified coercion and notes that

[f]orcible treatment, however, in the absence of an adjudication of incompetence or committability under state standard for institutionalization invites a system with tiers of competence, in which persons who are not committable [as an inpatient under the criteria of 'dangerousness'] are held hostage indefinitely by their propensities or perceived propensities.¹³⁴

¹²⁷ See Boudreau & Lambert, *supra* note 10 at 84 where they expose this assumption in that "[i]ndividual reasons for non-compliance have been addressed in psychiatric terms as 'defect in insight,' 'intentional, involuntary behaviour' or 'volitional disability'" and that "despite the patient's obvious resistance to medication, the clinicians expressed little or no concern about the causes of this resistance."

¹²⁸ *Supra* note 3, s. 46(5)(c).

¹²⁹ *Supra* note 26.

¹³⁰ *Supra* note 3, s. 46(3)(b). See also P.E.I. legislation, *supra* note 5, s. 25(2).

¹³¹ *Supra* note 2, s. 33.1(4)(b).

¹³² See Hinds, *supra* note 20 at 369 where she states the converse in that "if a patient will unequivocally refuse outpatient treatment, he is not a suitable candidate for outpatient commitment."

¹³³ See Leonard I. Stein & Ronald J. Diamond, "Commentary: A 'Systems'-Based Alternative to Mandatory Outpatient Treatment" (2000) 28 J. Am. Acad. Psych. L. 159 at 160 where they succinctly state: "[T]he suggestion seems to be that coercion is ethically justified because it is effective... 'effectiveness' is measured only by decreasing hospital recidivism."

¹³⁴ *Supra* note 64 at 289.

In a CTO, if a patient is denied a right to refuse treatment (treatment as either consented to (coerced) or if another decision-maker makes the decision to consent to treatment (incompetence)), or is denied a right to self-autonomy, then the patient should be entitled to effective treatment in form of access to services and supports that will make it easier to comply with treatment. Indeed, the patient should have the right to receive treatment (beyond medication) in the form of supports. If the patient received the necessary supports in all aspects of treatment, there would be a corresponding lack of need for CTOs. This requires that community services themselves are fully supported and funded. With de-institutionalization, the idea was a transfer of treatment from the facility to the community, but there was no corresponding transfer of funding planned.¹³⁵ Since then, there has been historic unwillingness on the part of governments to offset hospital savings with community investments. As well, the general community's lack of awareness and understanding has reinforced and compounded governments' insufficient approach to investing in the community mental health system. Governments and courts are taking a leap of faith in assuming that the necessary community components are in place to facilitate treatment orders.

Finally, a necessary a degree of willingness between the patient and his or her care provider is not always present when supervision is dictated. This goes against both current consumer advocacy and service provider philosophy of the patient helping himself or herself. Ultimately, the therapeutic relationship between patient and care provider can be seriously compromised with ordered treatment.¹³⁶ Ordered treatment in this concept is hardly seen as the least restrictive alternative.

The *Hospitals Act* requires that, in general, no treatment be administered to a patient without the patient's informed consent. There is also a presumption of competency and capacity for consent until determined otherwise.¹³⁷ The Law Reform Commission of Nova Scotia upholds these provisions in its recommendations. The Commission also notes that for incapable patients who have no proxy decision-maker or advanced health directive, a review board would authorize compulsory treatment in certain situations. Interestingly, the Commission also states "the type of compulsory treatment contemplated here would take place within

¹³⁵ Edward Mattison, "Commentary: The Law of Unintended Consequences" (2000) 28 J. Am. Acad. Psych. L. 154 at 154 [Mattison] where Mattison states that most often a statute that allows for coerced treatment is often not used because "there has almost never been any appropriation of new funds to pay the costs of such intensive treatment" and as a result of no extra funding, the IOC treatment collapses from the demands placed on an already overloaded mental health system.

¹³⁶ Canadian Mental Health Association, National Organization, *Community Committal* (Policy Paper), online: Canadian Mental Health Association <http://www.cmha.ca/english/advocacy/policies/print_pol_17.htm>(date accessed: 28 September 2003) [CMHA *Community Committal*] where the authors report that some professionals "find that forced treatment destroys trust in the caregiver and in the system, reinforces passivity, and creates negative feelings. Without trust and a sense of mutual respect, it is difficult to form a dynamic therapeutic relationship. Chances for the person to acquire the power necessary to take steps to deal with the illness are greatly diminished."

¹³⁷ *Supra* note 7, ss. 54, 56.

a facility, to distinguish it from treatment taking place in the community.”¹³⁸ However, the Commission does not elaborate on how compulsory facility treatment is distinguished from compulsory community treatment, either in its “Consent to treatment and compulsory treatment” section 3., or its “Provision of compulsory mental health treatment in the community” section 7. If compulsory treatment (*e.g.* treatment to which is given an incompetent and incapable patient with no advance health care directive or proxy decision-maker) can only be given under very limited conditions within a facility, it is difficult to perceive how compulsory treatment can be facilitated within the community if the patient is competent and capable of consent (*e.g.* is involved with developing and consenting to a treatment plan).

The next section will examine the need for coerced treatment in the community versus the need for treatment and services in the community. The debate is whether it is the treatment or the community that is the key factor in achieving mental health. The intention of de-institutionalization was to transfer treatment to the community, thus giving freedom to those who were detained and whose rights constrained. The question then becomes why is it necessary to again deny the rights that de-institutionalization granted in order to achieve community treatment? Mattison offers a prosaic view when he states that “what happened was that our political support ran into a crucial American political limit: the impatience with problems that have no definitive solutions.”¹³⁹

Community Treatment Order v. Community Support System

Like American IOC legislation, there has been two generations of IOC effectiveness research. Earlier studies were conducted generally in the 1980s and early 1990s.¹⁴⁰ In 1990, Keilitz compiled nine of these empirical studies and critiqued the effectiveness of American CTO legislation.¹⁴¹ The conclusion he drew at that time suggested that, while the studies were not definitive, there was some measured success using hospital recidivism, program compliance and community functioning as indicators. At the same time, Keilitz noted that “the debate about IOC may have reached an impasse ... Now may be the time to look to empiricism for answers.”¹⁴² It has since been generally acknowledged that these earlier studies, although reporting generally positive results, were methodologically flawed.¹⁴³

¹³⁸ Law Reform Commission of Nova Scotia, *supra* note 9 at 60.

¹³⁹ Mattison, *supra* note 135 at 156.

¹⁴⁰ See McCafferty & Dooley, *supra* note 11 and Miller & Fiddleman, *supra* note 21. See also Virginia Adige-Hiday & Theresa L. Scheid-Cook, “The North Carolina Experience with Outpatient Commitment: A Critical Appraisal” (1987) 10 Int’l J. L. & Psych. 215 [Hiday & Scheid-Cook].

¹⁴¹ Ingo Keilitz, “Empirical Studies of Involuntary Outpatient Civil Commitment: Is It Working?” (1990) 14 Mental & Physical Disability L. Rep. 368 at 370. Keilitz finds that “[n]ot surprisingly, the results of the nine studies are mixed, given the diversity of IOC programs, the variations of statutory provisions and the number of different measures and standards used to assess IOC.”

¹⁴² *Ibid.* at 371.

¹⁴³ Bazelon Center for Mental Health Law, *Studies of Outpatient Commitment Are Misused* (July 2001), online: Bazelon Center for Mental Health Law <<http://www.bazelon.org/issues/commitment/ioc/studies.htm>> (last modified 3 July 2001) (date ac-

Nevertheless, IOC research is complex and results difficult to interpret. Gerbasi et. al. point out that “[r]esearch in this field faces daunting methodological problems. It is particularly difficult to identify and isolate the components of coercive care that may contribute to improved outcomes.”¹⁴⁴

The second generation of studies are now just emerging and are more methodologically sound. There have been two major randomized clinical trial studies in the last five years: one study in New York City conducted at Bellevue Hospital¹⁴⁵ and another in North Carolina led by Duke University researchers.¹⁴⁶ The New York study was based on two groups randomly selected (court-ordered and regular outpatients) that both received the same intensive community services as the other. The end result showed no differences between the two groups in terms of patient compliance with treatment, rates of hospital recidivism, lengths of stays when re-hospitalized, quality of life, incidents of homelessness, and no differences in arrests or violent acts.¹⁴⁷ The North Carolina study measured IOC in terms of length of period committed. In general, there were no significant differences in hospital recidivism between the outpatient commitment group and the control comparison group. However, there were differences noted between short and long term outpatient commitment in that the longer term (more than 180 days) outpatients were less likely to be readmitted to hospital.¹⁴⁸

In 2001 the RAND Institute for Civil Justice conducted a study on the effectiveness of involuntary outpatient treatment for the California Senate who were considering an IOC legislative proposal.¹⁴⁹ This study included an evidence-based review of the empirical literature, statutory and case law of eight states with outpatient treatment systems similar to California’s community treatment system but who had IOC legislation as part of the system. One of the three basic questions asked was “does involuntary outpatient treatment work?.” They investigated both the New York and the North Carolina studies noted above. The New York study was found to be sound but that some factors of the study (e.g. small sample group

cessed: 28 September 2003) [Bazelon Center *Studies of Outpatient Commitment*] notes that “most of the studies that [proponents] rely on are seriously flawed, and some are presented in misleading ways.” See also M. Susan Ridgely, Randy Borum & John Petrila, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States* (Santa Monica, Ca.: RAND Law & Health, The RAND Institute for Civil Justice, 2001 <<http://www.rand.org/publications/MR/MR1340/>> (date accessed: 28 September 2003) [Ridgely et. al., *RAND Study*] at xvi where the authors note that “[t]he first generation of studies mostly found limited positive results from involuntary outpatient treatment; however, these studies were plagued by significant methodological limitations...In addition, this body of research did not specify for whom, how, or under what circumstances court-ordered outpatient treatment may work.”

¹⁴⁴ Joan B. Gebasi, Richard J. Bonnie & Renee L. Binder, “Resource Document on Mandatory Outpatient Treatment” (2000) 28 J. Am. Acad. Psych. L. 127 at 128.

¹⁴⁵ Policy Research Associates, *New York Study*, *supra* note 43.

¹⁴⁶ Swartz et al., *Randomized Trial*, *supra* note 43.

¹⁴⁷ See Bazelon Center, *Studies of Outpatient Commitment*, *supra* note 143.

¹⁴⁸ *Ibid.*

¹⁴⁹ See Ridgely et. al., *RAND Study*, *supra* note 143.

sizes, non-equivalent comparison groups, and inconsistent enforcement of orders) prevented its conclusions from being definitive. The RAND Institute found that the North Carolina study generally supported the New York study in terms of hospital recidivism findings when compared to non-IOC patients. The RAND Institute also noted that in the North Carolina study, the reason that long term IOC patients fared much better than short term IOC patients in terms of hospital recidivism was that they tended to receive more intensive mental health services as part of their outpatient treatment order.¹⁵⁰ The RAND Institute concluded that the North Carolina study did not determine whether court orders without intensive services had any effect or not. The final outcome of the RAND study was that

the RAND team's research could not provide an answer to the question of whether an involuntary outpatient treatment system in California is worth the additional costs to mental health treatment systems, the courts, and law enforcement. Nor are there cost effectiveness studies that compare the relative return on investment of developing an involuntary outpatient treatment system or focusing all available resources on developing state-of-the-art community-based mental health treatment systems... The lack of empirical evidence about the comparative effectiveness of involuntary versus voluntary treatment is troubling — decisions may be influenced more by advocacy than by fact.¹⁵¹

What is interesting in the RAND study is that they report on a clear evidence-based review of alternative community-based health treatment programs that have had good outcomes, particularly assertive community treatment (ACT).¹⁵² In the end, the authors could not give a recommendation to implement involuntary outpatient commitment legislation in California, noting the inherent difficulties of implementation.¹⁵³ In any event, whether IOC is implemented or not, it is clear that what is required for successful treatment of persons with severe mental illness is a well-coordinated and dedicated community health services system. The RAND authors note that their study “suggests that a...commitment order...[only] *when combined with intensive mental health services*, may increase treatment adherence and reduce the risk of negative outcomes such as relapse, violent behaviour, victimization, and arrest.”¹⁵⁴ Moreover, the authors underline the response they received from study participants that “*emphasized that outpatient commitment is*

¹⁵⁰There is a common thread running through a number of studies finding positive results of IOC. Almost any IOC program that is “successful” is accompanied by a high degree of dedicated, flexible staff and highly developed resources and services made available to IOC patients. See *e.g.* Hiday & Scheid-Cook, *supra* note 140 at 230.

¹⁵¹RAND Law & Health, *Does Involuntary Outpatient Treatment Work?* (Research Brief) (Santa Monica, Ca: RAND Law & Health, The RAND Institute for Civil Justice, 2000) at 5, online: RAND Law & Health Research Brief<<http://www.rand.org/publications/RB/RB4537/>>(date accessed: 28 September 2003).

¹⁵²*RAND study*, *supra* note 143 at 28-32 under section heading: “What Does the Empirical Literature Tell Us About the Effectiveness of Alternatives?”

¹⁵³*Ibid.* at xxii under section heading “Summary.”

¹⁵⁴*Ibid.* at xvii.

not a 'silver bullet' and that it simply cannot work in the absence of intensive clinical services."¹⁵⁵

The conclusion of the RAND study is not dissimilar to the conclusion that the National Organization of the Canadian Mental Health Association (CMHA) makes in its policy paper *Community Committal*.¹⁵⁶ The Association notes both the case for and against community committal but then summarizes that

CMHA tries to represent the interests of consumers, family members, service providers, and community groups. Where is the common ground? It lies in the acknowledgment that current mental health services of all kinds are less than adequate in terms of accessibility. Given the strong feelings about compulsory community treatment and its limited use in practice, at this point it will be more productive to focus on ways to improve supports and services rather than getting caught up in the community committal debate.¹⁵⁷

The policy paper then notes the need to identify systems and models that have shown some success and to build on them. CMHA advocates the policy of *A New Framework For Support*¹⁵⁸ based on a voluntary model to support people living in the community with mental illness. This model is based on two fundamental assumptions: "[1] the way in which Canadian communities provide services and supports to people with mental illness needs to be reformed and restructured [and] [2] [t]he most basic ways in which we think about and understand mental illness

¹⁵⁵ *Ibid.* at xx. Despite the conclusion of the RAND study, the California Senate went ahead with its proposal and has legislated for IOC in the form of Assembly Bill No. 1421, effective January 1, 2003. AB 1421 amended the Lanterman-Petris-Short Act (the existing mental health law in California) and enacted the Assisted Outpatient Treatment Demonstration Project Act, which would run until January 1, 2008, when it would be reviewed. This legislation permits county mental health departments to order outpatient treatment for people with serious mental illness who cannot take care of themselves or are likely to harm themselves or others. The criteria for placing a person on an order for assisted outpatient treatment includes a requirement for "at least twice within the last 36 months, [a person's mental illness having] been a substantial factor in necessitating hospitalization", or where there has been "one or more acts of serious and violent behaviour toward himself or herself [the patient] or another, or attempts to cause serious harm within the last 48 hours." The rationale is to prevent a relapse or deterioration resulting in harm and is presented as a "least restrictive placement". What is interesting about this legislation is that, after incorporating some of RAND's statements and data within the bill, the legislation then allows for assisted outpatient treatment to be optional on a county-by-county basis. A county cannot order such treatment unless it complies with the extensive requirements to provide a certain level and quality of treatment, supervision, and community and health services as outlined clearly in the legislation. This legislation is now known as "Laura's Law" and was developed in response to the death of a mental health worker by a person with mental illness who refused treatment.

¹⁵⁶ *Supra* note 136.

¹⁵⁷ *Ibid.* at 9.

¹⁵⁸ John Trainor, Ed Pomeroy & Bonnie Pape, *A New Framework for Support* (Policy Paper — edited and abridged) (Canadian Mental Health Association, 1993), online: Canadian Mental Health Association <http://www.cmha.ca/english/research/framework/framework_full.htm> (date accessed: 28 September 2003).

need to be re-examined and changed.”¹⁵⁹ The model has two components, the Community Resource Base and the Knowledge Resource Base, which shifts the focus from a service paradigm (thus reflecting a medical practitioner-provider viewpoint) to a community services paradigm (which puts the viewpoint of the mental health consumer in the centre). This model not only includes traditional mental health services but also generic services and supports (such as housing, income, and employment training and opportunities), the role of family and friends, and the peer support and self-help of consumers themselves.

In terms of mental health services themselves, there a number of different alternatives to coercive community treatment that CMHA advocates. Among these is the PACT (Program for Assertive Community Treatment) that is one of the featured models in Health Canada’s Best Practices report¹⁶⁰ (as well as a model that received favourable review in the RAND study). PACT is based on voluntary treatment and system responsiveness built on consumer-provider trust and rapport. Other alternatives include mobile crisis intervention teams that bring treatment on demand to persons experiencing a mental illness crisis, early intervention that encourages treatment when it is initially sought by many health consumers before severe psychosis or suicidal tendencies develop, advance psychiatric care directives allowing for different treatment directions in the event that a person with mental illness is deemed non-competent and the availability of emergency services (e.g. enough facility beds to accommodate 72-hour short-term hospital stays) when a consumer so requests.

Another key element to an effective community system is the forming of partnerships that tap into community resources which provide non-medical supports and services such as social assistance, public housing and family services as well as other community resources that provide the core of all Canadians community life — religious organizations, interest-based and social groups, and service clubs (such as Kiwanis and Big Brothers and Sisters).¹⁶¹ Family and friends that assist and support persons with mental illness should also have available support.

Perhaps the most important element to an effective system is changing the attitudes of professionals within the system, the larger community outside the system and even of mental health consumers themselves through education and awareness initiatives to eliminate the myths, misconceptions and contradictions that currently plague the mental health system. Decision-making and strategy planning should involve not only mental health professionals but the consumers themselves, who know the process of recovery better than anyone.

¹⁵⁹ *Ibid* at 4.

¹⁶⁰ Health Canada, *Review of Best Practices in Mental Health Reform* (Review Report — updated 15 January 2003) (Ottawa: Supply and Services Canada, 1994) at 3-6, online: Health Canada <http://www.hc-sc.gc.ca/hppb/mentalhealth/pubs/bp_review/e_sec1rev.html> (date accessed: 28 September 2003).

¹⁶¹ *Supra* note 158 at 5.

Finally, in order to make a community mental health system function as it should, the reinvestment of funds into the community is essential. Just as treatment must be conceptualized in new and different terms outside the institution, funding must also be re-conceptualized in terms of community reinvestment. Mental health services have always suffered from lack of contribution from government, but the mental health system will never come together until government reallocates funding to all sectors that play a part in the mental health community support system.¹⁶² Considering that CTOs, in order to become effective, are dependent on an enhanced community support and service system, and that CTO implementation itself is only going to add costs to the system overall, funding should already be on the top of the list in developing the least restrictive alternative to treating those with severe mental illness.

The Nova Scotia government has already embarked on the least restrictive alternative when it initiated its mental health review. *Mental Health: A Time for Action*¹⁶³ outlined the process necessary in order to update the mental health care system by identifying key issues through meetings with various stakeholders (over 300 people and 71 organizations), reviewing 125 written submission and 36 previous reports on mental health services, and visits in various parts of the province and then making 70 major recommendations to overhaul the mental health system in Nova Scotia. Four of the five issues identified include:

- the need for increased consumer participation in the decision making process, planning, evaluation and delivery of mental health care;
- the provision of a full range of mental health services and supports in the community, especially the provision of appropriate housing;
- better communication and co-ordination of services amongst government departments, mental health providers, community agencies, and consumers; [and]
- the need for additional funding to provide the necessary community resources to allow mental health consumers to be fully integrated into the community and provide continuity of care.¹⁶⁴

In addition, the Department of Community Services that works with the Department of Health in the provision of services had its community residential service system of community based options evaluated by Dr. M.J. Kendrick who made thirty-four recommendations to improve and update the system.¹⁶⁵ This report

¹⁶² *Ibid.* at 5. “[I]n order for all sectors to play their parts effectively, however, resources must be more equitably balanced among all the sectors”

¹⁶³ Bland & Dufton, *supra* note 8.

¹⁶⁴ *Ibid.* at 1 under section heading “Executive Summary”.

¹⁶⁵ Michael J. Kendrick, *An Independent Evaluation of the Nova Scotia Community Based Options*

dovetails in with the recommendations of the Department of Health review report. These are the reports that the government should be considering when deliberating on the most effective and least restrictive alternative for treatment of persons with mentally ill persons. Although the Law Reform Commission did consult with numerous individuals and groups in both professional and layperson capacities, there is no indication in its report introduction that, beyond meetings and consultations with the Mental Health Services Division of the Department of Health, there was any consideration (much less synchronization) of the Department of Health and Department of Community Services reports and initiatives.¹⁶⁶ If this is so, the Commission missed out on an opportunity to make a legal contribution to a broad-based, well-coordinated and forward-looking mental health system and network for Nova Scotia.¹⁶⁷

Summary

CTO/IOC legislation is a bewildering array of presumptions and inconsistencies. It is a reaction to the inherent difficulties of de-institutionalizing treatment into the community and has been based on heated arguments of misconceptions and misunderstandings of various proponents and opponents of CTOs/IOC. Legislators in the United States have implemented widely varying legislation over the past twenty-five years yet there is little common basis for states to proceed on or even to analyse when conceptualizing IOC legislation. It isn't surprising that Canada, after looking towards the United States as a leader in mental health legislation, is also encountering inconsistent and illogical legislation from province to province. To compound Canada's own inconsistencies, Canadian courts have not generally followed the lead of the United States of protecting fundamental rights within Canadian mental health legislation. As a result, Canadian provinces still rely on a broad *parens patriae* justification when infringing the rights of mental health patients and have not truly effected the narrower danger standard that is stated within its legislation.¹⁶⁸ Provincial legislators should be very careful when proposing CTO legislation that will further erode patients' rights.

Many provinces and states use the least restrictive alternative to justify the use of CTOs/IOC, either as a catch phrase or as a legitimate factor in considering options. Generally, though, the principle is used in terms of coerced treatment rather than a person's fundamental right to liberty or not to be arbitrarily detained. Legislators have translated the institutional model of medical treatment to the community by intrinsically linking treatment to committal. The most obvious

Community Residential Service (Nova Scotia Department of Community Services, February, 2000) <http://www.gov.ns.ca/coms/files/files_pdf/kendrick.pdf> (date accessed: 12 October 2003).

¹⁶⁶ See Frankel, *supra* note 16 for a critical review of how the government of Nova Scotia has approached and failed in the reform of community-based services, particularly in the lack of coordination between the Department of Community Services and Department of Health.

¹⁶⁷ Law Reform Commission of Nova Scotia, *supra* note 9 at 1-3.

¹⁶⁸ But see *infra* note 169.

contradictions of community treatment is the backwards slide of preventive commitment based on deterioration rather than purely danger. This includes the arbitrariness of releasing hospitalized patients on a continuing deterioration or even danger basis rather than fully discharging them. Another major problem is taking away a patient's inherent right, either by denying the patient's own decision-making if competent, or by ignoring prior wishes or substitute decision-making, to accept or refuse treatment. Legislators have succumbed to an artificial concept that mentally ill persons are dangerous or incompetent and do not have the ability to choose treatment when they are decompensating. Thus they have provided for patients' treatment in a confusing array of CTOs/IOC, all dependent on interference or restriction of a person's basic right to decide for himself.

Very few studies have been able to isolate the key factors of what makes CTO/IOC work, although recent studies seem to suggest that CTOs/IOC won't work if there isn't the corresponding support/service system. At the same time, there have been studies of voluntary treatment plans that are succeeding, such as assertive community treatment, that do not rely on coerced treatment. Among these are PACT, case management, mobile crisis units and early intervention methods such as the delivery of emergency services (at a facility) when so requested.

When considering CTOs as part of recommended amendments to the *Hospitals Act*, the Law Reform Commission certainly started on the right track by consulting a broad range of stakeholders and advisory groups within the Nova Scotia's mental health system. Unfortunately, the Commission derailed and did not fully develop its inquiry. Ideally, the Departments of Justice (or the Law Reform Commission), Community Services, and Health should have modelled a full-scale investigation after the RAND study developed for the California Senate. Consultation is definitely necessary, but it needs to be followed up with empirical evidence or at the very least other studies. Realistically, this may be beyond the financial means and resources of the Nova Scotia government. However, it is not beyond the reach of the Commission to explore such controversial issues further to see why certain legislation has been implemented in different provinces and whether it has proved effective or not. As New Brunswick is currently the only province that has considered and rejected CTOs, concentrating instead on community services and supports development, they deserve more than a cursory glance by the Commission and any inquiry performed by New Brunswick may contribute valuable insight as to why *not* legislate CTOs. This would be a more practical approach for the Commission to take rather than doing a survey of what other provinces are legislating and then accepting it blindly with or without the support of their stakeholders and advisory groups.

The focus of the de-institutionalization movement was to revolutionize how persons with mental illness are treated. A return to an institution mentality is not needed. Patience and the support of a new and better system that puts voluntariness and the mental health consumer in the centre of decision-making is the most promising way to effective mental health care.

Epilogue

Two very recent decisions suggest there may be change in the air and that courts may be turning away from the *parens patriae* justification.¹⁶⁹ In a June 6, 2003 decision, *Starson v. Swayze*¹⁷⁰, the Supreme Court of Canada overturned the Ontario Consent and Capacity Board finding that an inpatient was incapable consenting to or refusing treatment. The Court ruled that the Board used insufficient evidence in the statutory test for capacity to find that Mr. Starson lacked the requisite understanding of his illness¹⁷¹ and appreciation of the consequences to refuse treatment.¹⁷² As well, the Court noted that the Board improperly allowed its own conception of the inpatient's best interest to influence its finding of incapacity.¹⁷³

In *Haugan v. Whelan*, released May 7, 2003, the Ontario Superior Court of Justice overturned the Consent and Capacity Board's decision to confirm a Community Treatment Order made under Ontario's new legislation.¹⁷⁴ The Court found that the Board erred in holding that it was not necessary to consider all of the criteria as set out by s. 33.1(4) of the *Mental Health Services Act* and that it was sufficient that "the patient was on the slippery slope towards meeting the criteria."¹⁷⁵

To date, *Haugan v. Whelan* has been the only court interpretation of Ontario's (or any other province's) CTO legislation. A *Charter* challenge has yet to be made. It is much too soon to see what kind of impact these decisions make in the landscape of CTO legislation in Canada. Much will depend on the actual implementation of Community Treatment Orders which may or may not be challenged and reviewed within the court system.

¹⁶⁹ This paper was originally conceived and written in April, 2002 and then updated in October, 2003 for publication.

¹⁷⁰ [2003] 1 S.C.R. 722, (2003) 225 D.L.R. (4th) 385, 2003 S.C.C. 32.

¹⁷¹ *Ibid.* at paras. 93-95.

¹⁷² *Ibid.* at paras. 96-108.

¹⁷³ *Ibid.* at paras. 111-112.

¹⁷⁴ (2003) 64 O.R. (3d) 713.

¹⁷⁵ *Ibid.* at paras. 3-16.

