

Research Insights of Regional Mental Health Care London and St. Thomas is a peer-reviewed journal designed to publish reviews, case studies and articles as they pique the interests of our clinicians and emerge from reflections on daily clinical work. The purpose is to encourage local scholarly endeavours and provide an initial forum of presentation. The papers may later be submitted to other journals for publication.

Research conducted at Regional Mental Health Care London and St. Thomas, St. Joseph's Health Care, London is part of Lawson Health Research Institute.

Research INSIGHTS

REGIONAL MENTAL HEALTH CARE LONDON AND ST. THOMAS



Managing Editor:
J.D. Mendonca PhD, CPsych

MARCH 2013 | VOL. 10 NO. 1

OUTCOMES, INHERENT CONTRADICTIONS AND PUZZLING ISSUES:

Consent and Capacity Board (CCB) members' experiences with Community Treatment Orders (CTOs)

Deborah Corring, Cathy Plyley, Joe Skufca

Research Insights of the Regional Mental Health Care London and St. Thomas is a peer-reviewed journal designed to publish reviews, case studies and articles as they pique the interests of our clinicians and emerge from reflections on daily clinical work. The purpose is to encourage local scholarly endeavours and provide an initial forum of presentation. The papers may also be later submitted to other journals for publication.

Research conducted at Regional Mental Health Care London and St. Thomas,
St. Joseph's Health Care, London
is part of Lawson Health Research Institute.

Managing Editor
J.D. Mendonca PhD, CPsych

Instructions for Authors:

Manuscripts submitted for publication should not exceed 4000 words and follow the style of the Canadian Journal of Psychiatry. The manuscript should be arranged in the following order: 1) Title page 2) Structured Abstract, Clinical Implications and Limitations, and Key Words 3) Body Text 4) Funding Support and Acknowledgements 5) References 6) Tables and Figures. The Managing Editor may be approached for any unique stylistic variations required by the subject matter.

Research and Education Unit,
Regional Mental Health Care London,
850 Highbury Avenue,
LONDON, ON N6A 4H1
Telephone: 519/455-5110 ext. 47240
Facsimile: 519/455-5090

www.lhrionhealth.ca/research/hohsr/

ISSN 1496-9971

Outcomes, Inherent Contradictions and Puzzling Issues: Consent and Capacity Board (CCB) members' experiences with Community Treatment Orders (CTOs)



Deborah J. Corring, PhD

Mental Health Transformation Project Lead,
Regional Mental Health Care London and St. Thomas



Cathy Plyley, RSSW

Community Treatment Order Consultant
Regional Mental Health Care London and St. Thomas



Joe Skufca, BA RSSW

Community Treatment Order Consultant
Regional Mental Health Care London and St. Thomas

KEY WORDS

Community treatment order, involuntary treatment, review boards, outcomes

Address correspondence to:

Dr. Deborah J. Corring
Regional Mental Health Care London,
St. Joseph's Health Care London,
850 Highbury Avenue, PO Box 5532, Stn B,
London, ON, Canada N6A 4H1.
E-mail: Deb.Corring@sjhc.london.on.ca

ABSTRACT

Objective: Passage of community treatment order (CTO) legislation occurred in Ontario, Canada in June 2000. The literature has documented perspectives of several stakeholders. One stakeholder perspective we have not found in the literature as yet, is that of the individuals who serve on Consent and Capacity Boards (CCB) which independently reviews CTOs. This study explores this perspective.

Methods: A qualitative design was used consisting of semi-structured interviews with 10 CCB members. Interviews were audiotaped and transcribed and analyzed using constant comparative method.

Results: There was unanimous agreement from all of the participants in this study that CTOs were beneficial to the persons who were subject to them. Participants also noted dilemmas that arose when patients were doing well; namely, the need for mandated frequency of reviews and the quandary concerning discontinuing the CTO.

Conclusions: The debate between those advocating the use of CTOs and those against their use continues with polarizing views at either end of the continuum. The one extreme emphasizing the violation of a person's rights and the other extolling the many benefits. This study reports the many benefits as seen by the members of the CCB, as well as inherent contradictions, puzzling issues in current CTO review process and ways in which the process could become more effective and efficient.

Clinical Implications and Limitations: CCB members come from three potentially very different perspectives – those of physicians, lawyers and members of the public. They arguably bring a more “objective” perspective regarding CTOs than other stakeholder groups, so it would seem particularly significant that without exception they have found CTOs to be of benefit to the people who are subject to them. Many were also puzzled that CTOs are not used more often by physicians given the considerable benefits to the patients. Further research is needed to understand what the barriers are for clinicians who do not use CTOs in their practice on a regular basis.

INTRODUCTION

Innovations in treatment have resulted in a consistent trend towards deinstitutionalization and community rehabilitation of persons with severe and persistent mental illness (Mitelman & Buschbaum, 2007). Increasingly they are guided and encouraged to adapt to community living, some under the auspices of CTOs (Gray & O'Reilly, 2005). CTOs are “*legal interventions intended to improve treatment adherence among persons with serious mental illness*” (Swartz & Swanson, 2004, p.585). Thus, CTOs assist in the implementation of a supervised plan of care, the intent being to halt the spiral of homelessness, incarceration, relapse and re-admission to hospital (Swartz & Swanson, 2004). Passage of community treatment order legislation occurred in Ontario, Canada in June 2000 under Bill 68 (Ontario Ministry of Health and Long-Term Care, 2009).

Consent and Capacity Board (CCB)

The CCB is a tribunal established by the Province of Ontario that is designed to review, among other things, whether a person should be continued on a CTO. The CCB members are lawyers, physicians and lay members of the public appointed by the Lieutenant Governor of Ontario and provide oversight to issues related to a patient's right under the Ontario Mental Health Act. The Consent and Capacity Board of Ontario is an independent body with the task of ensuring that the rights of vulnerable persons are balanced with public safety.

The Board is responsible to hold hearings in relationship to a number of provincial acts:

- i) the Health Care Consent Act which, is concerned with issues related to a person's capacity to consent to treatment and those decisions made on behalf of incapable individuals,
- ii) the Mental Health Act, which covers civil commitment which includes involuntary status, capacity as it applies to finances and CTOs,
- iii) the Substitute Decisions Act, which governs, among other things – guardianship of property,
- iv) the Personal Health Information Act, which safeguards the rights of those unable to provide appropriate consent for the sharing of information, and
- v) the Mandatory Blood Testing Act, which contains provisions for the testing of blood for analysis.

The majority of hearings (80%) held by the Consent and Capacity Board are to review a person's involuntary status in a psychiatric hospital as described in the Mental Health Act and reviews under the Health Care Consent Act regarding a person's capacity to consent to treatment.

The Board that was involved in this study is an experienced one, having held 169 hearings in 2011 and 74 in the first six months of 2012. It is an individual's choice (and right) to be represented by legal counsel at CCB hearings. Each hearing involving legal counsel can vary in time from a few hours to a few days depending upon what aspect of the CTO is being challenged. The board reviews of involuntary status are often combined

with a challenge to the status of incapacity to consent to treatment (as a finding of capacity would nullify the CTO).

CTO Review Process

The CTO process is supported by CTO coordinators. In a recent evaluative report (Dreezer & Dreezer, 2005), one of the primary consultants noted, *“The CTO coordinators across the province have proven themselves to be an indispensable resource at all stages of the CTO process. They educate, coordinate, and facilitate the process. They provide essential assistance to physicians and are a key link between clients, families, hospitals and community agencies”* (p.18). The role of the CTO coordinator extends from start to finish in the CTO process. Although the overall responsibility for a CTO is with the physician the functional and practical aspects fall to the CTO coordinators. These aspects include ensuring that the paperwork is prepared and distributed properly, that the legal timeframes have been adhered to, that the parties and service providers named in the plan are engaged, that the appropriate consents have been obtained, that the issuing of CTOs is monitored and that the request for a review by the CCB is directed through the appropriate channels. In addition, liaison with the Psychiatric Patient Advocate Office ensures that appropriate rights advice has been given. CTO coordinators also work with the physicians to develop the CCB Summary for the boards, make themselves available to attend seated boards, participate in

teleconference boards as appropriate, and assist with legal questions that arise by consulting counsel and preparing the physicians for any issues that may be raised in the review board hearings.

The review board process contains an emphasis on compliance with the specific requirements of the legislation. The following steps typically unfold.

- i) To start the mandatory review of a CTO, a Form 48 is delivered to the CCB by Health Records or a responsible person of the health facility.
- ii) If the client wishes to challenge the CTO, the Form 48 is sent to the CCB by a ‘rights advisor’ from the Patient Psychiatric Advocates office, and a full board hearing is scheduled within seven days of issuing a CTO.
- iii) If the client is not challenging the CTO, the client is asked to sign a waiver stating they do not wish to attend or have legal counsel. The CCB still needs to meet, but it does allow for the Board to convene by telephone conference. Should the client change their mind, they may do so and a Board will convene in person.
- iv) The members of the Board then review all of the data related to the case and ensure that the requirements of the legislation are being followed.

Consent and Capacity Board members are provided with a historical summary at each review board for a CTO. Information such as

hospitalization history, symptom management and significant lifestyle measures such as social and vocational progress are reviewed at these hearings. For clients with a significant number of CTOs the longitudinal progress can be noted.

Search for Balance

Persons under CTOs are very likely to be middle-aged (range 20-55 years) with a diagnosis of either schizophrenia or schizoaffective disorder (Dreezer & Dreezer, 2005). People placed on CTOs have very significant needs. In addition to a diagnosis of severe and persistent mental illness, each person must meet the criteria for a CTO. This includes considerable previous hospitalization and meeting the same ‘harm’ criteria as an involuntary patient. The legislated purpose for a CTO is *“to provide a person who suffers from a serious mental disorder with a comprehensive plan of community based treatment or care and supervision that are less restrictive than being detained in a psychiatric facility”* (emphasis added) [Ontario Ministry of Health, Mental Health Act, 2010 amendment, 33.1 (3) Purposes]. Such a plan is judged to be needed because the person has evidenced the following pattern as a result of serious mental disorder: the person is admitted to a psychiatric facility where his or her condition is usually stabilized; after being released from the facility, the person often stops the treatment or care and supervision; the person’s condition deteriorates and, as a result, the person must be re-admitted to a psychiatric facility.

Those in favour of CTOs argue that they provide a source of support for deinstitutionalized individuals who lack insight into their own illness and who may, consequently, pose a risk to their own safety and/or the safety of others or likely to suffer significant mental or physical deterioration (O’Reilly, 2004). Evaluative studies have found that CTOs can result in a decrease in violent behaviours, a reduction in hospital admissions and an increase in the use of community-based support programs and housing (O’Brien and Farrell, 2005; Swartz and Swanson, 2004). Individuals often experience mental health crises that result in contact with the police. Corring et al (2010) in a study exploring quality of life issues with individuals on CTOs reported a reduction in post-CTO police contact time (p.6).

Those opposed to CTOs argue that they involve coercion of patients, and that this coercion may ultimately transcend to other forms of psychiatric or physical treatment (O’Reilly, 2004). Interestingly, in the Dreezer report (2005), the issue of why clients across the province decide to accept or not accept a CTO was noted. Reasons for ‘accepting’ included: support to get over the rough spots, access to services, pressure from health providers, incapable acquiescence, a desire to avoid future hospitalizations and satisfaction with a previous CTO. Reasons for ‘not accepting’ were noted as: lack of insight, concerns regarding autonomy and dignity, dissatisfaction with a substitute decision maker and graduation (a belief that they have already derived maximum benefit).

In a more recent review of the use of community treatment orders in Ontario (Malatest, May 2012), individuals interviewed reported having a positive experience with a CTO. They talked about an improved quality of life and more effective linkages with community services – an observation reported largely by those who had consented to their own CTO, but also echoed by families and service providers.

The literature has documented the perspectives on these issues from the viewpoint of the subjects of this legislation and their families and the perspectives of several stakeholders, including physicians, families, and service providers, which have generally found CTOs to be viewed positively (Corring et al, 2010; O’Reilly et al, 2006). One stakeholder perspective we have not found in the literature as yet, is that of the individuals who serve on mental health tribunals.

We believe that the appraisals of these custodians of the legal process surrounding the legislation will provide a unique aspect of the debate. As previously noted, the review board members have a more “objective” perspective in that they are not personally invested in the outcome as patients’ families and treating physicians could be, given the nature of their relationships. Board members have also seen multiple cases including both inpatients and outpatients to judge the success of CTOs compared with families or patients whose experience is usually confined to one case.

The purpose of this study was to explore the experiences of Consent and Capacity Board (CCB) members with community treatment order reviews: first, with respect to their *opinions on the effectiveness* of CTOs, and secondly, with respect to issues related to the *process* of reviewing CTOs, given the intended impact of the legislation enabling CTOs on rehabilitation in the community.

METHOD

This study employed qualitative methodology in order to explore the perspectives of members of a CCB in southwestern Ontario, Canada. Ten (10) in-depth semi-structured interviews were completed. The interviews were 60 to 90 minutes in length. A semi-structured interview guide was used (see Appendix A). The CCB members interviewed were psychiatrists, lawyers, and community members, with a minimum of three persons from each category. Participants were recruited using the snowball convenience approach (Atkinson & Flint, 1961). This is a non-random method of data collection suited to naturally occurring small samples of persons who are connected to each other, such as CCB members. The likelihood of bias is recognized and offset by strict adherence to protocols of data collection. The validity of the data arises from members' wide experience with the CTO legislation and with weighing the progress of mentally ill persons (Faugier & Sargeant, 1997).

Participants were informed of the study by the Chair of the Board and then contacted by one of the authors to ascertain their agreement for participation. Signed consents were obtained. Several of the participants had served on review boards in other jurisdictions and most have had several years of experience on boards reviewing CTOs involving inpatients and outpatients.

All interviews were audiotaped and transcribed verbatim. Qualitative data was coded and thematic analysis was conducted using the constant comparative method (Lincoln & Guba, 1985). Trustworthiness strategies included saturation, triangulation and peer debriefing. Experts in the field recommend the use of a trustworthiness strategy called “saturation” to estimate the number of participants. Saturation is defined as reaching the point at which the investigator has obtained sufficient information to gain an understanding of the phenomenon and when further information gathered does not provide any new insights (DePoy & Gitlin, 1994). Six to eight in-depth interviews are considered sufficient to explore a phenomenon in-depth and reach saturation (McCracken, 1988). Triangulation is achieved when the researchers employ multiple data sources, multiple methods or multiple researchers (Denzin, 2006). Triangulation for this study was used by sampling multiple types of review board members’ perspectives and multiple researchers (three). Peer debriefing is a technique that ensures data analysis is representative of the phenomenon under investigation and requires the use of more than one

researcher in the analytic process (Lincoln & Guba, 1985). All of the researchers in this study were involved in the analysis of transcripts and were in agreement with the stated themes. Results will be illustrated with verbatim quotes from the transcripts.

RESULTS

There was unanimous agreement from all of the participants in this study that CTOs were beneficial to the persons placed on the procedure. All participants made positive comments about the effectiveness of CTOs and on one indicated that CTOs harmed patients or impeded their recovery. They were also able to identify the positive aspects of the current process and ways in which the process could become more effective and efficient. The results have been organized around these two themes.

Positive Results for the Individual on the CTO

There were numerous quotes citing the benefits of the CTO for the individual as noted below.

P2 - The CTO almost always is a very positive experience for the board members because we see, almost always see a positive outcome; we see what a CTO has done. So we feel that while we uphold the legislation and restrict the person’s rights it allows us to see the best interest of the person is being served as well. I think it is not just legislative coercive structure. It is a more structured

approach to care, but there is a therapeutic component. Why do people stay on it when they actually have a history of not staying on anything else would be an interesting research question?

P3 - I think they are the best thing since sliced bread. I think for the most part, they are a godsend for patients. They have kept them out of hospital, they have kept them somewhat independent and sometimes very independent, and often more productive. What more can you ask for than that?I think they have been a big boon...

P5 – They (CTOs) seem like they are doing a really wonderful job. I know in the orders that I have been reviewing, I have been really impressed that some very ill people are being maintained in the community. They are doing what they are supposed to be doing and the ACT teams are doing a good job.

P6 - My experiences for the most part have resulted in me being very impressed with the whole concept of the CTO. I see it as a very important function to enable people to receive the kind of support they need within the community and stay out of hospital as much as possible. When the whole issue of getting people out of hospitals surfaced, a number of years ago, the goal was to, as I understood it, was to allow people to be in the community and have a support system there that works for them. Of course, we all know that a lot of that did not happen and hasn't happened to date. I am not suggesting that nothing has

happened, but we know that there are huge gaps in that particular plan. And in my view, the CTO has been one very major positive step in addressing that intention.

P8 - As an outsider looking in, I am a fan of the CTO. I think they are very productive. I think they do a good job in keeping people out of hospital and giving people some sort of a normal life. For me, they are a success story, so I like CTOs. I sit often at hearings that are not CTO related where I am thinking, wow all that had to happen with this patient from the last release from hospital was for there to be a CTO, for there to be an ACT team, for there to be some outside intervention, minimal intervention and this person would not be back in hospital. I see that over and over, less in the [name of city] region and more outside. I am not sure why ..., but some regions seem very reluctant to follow through with a CTO.

It should also be noted that a number of quotes below which address the process issues also, include positive comments about the effectiveness of CTOs.

The Current Process: Positives and Grey Areas

- ***Positives***

There was across the board praise for the work that CTO coordinators do, the template developed by the coordinators for use by physicians, and the overall efficiency of the hearings.

P2 – *What I think is the biggest difference between the rest of the CCB hearings and CTO hearings is the CTO coordinator... This makes a huge difference. We almost always have a good summary. We almost always have the documents provided to us ahead of time, and the doctors are well prepared with the help of the CTO coordinator...*

P7 - *My experience to date certainly in the [name of city] area because they have had so much experience with CTOs is that they have developed a scheme, a plan that gives us a clinical summary setting out the criteria that are required under the Mental Health Act that is for CTOs. Once they have given that clinical summary at a hearing, it's marked as an exhibit, it becomes evidence and they only have to add to that clinical summary if there is any need to add to it. Just think that [name of city] is the bench mark for CTOs and clinical summaries, particularly the clinical summaries because they have been used ever since I have been on the Board.*

- **Grey Areas**
 - Inherent Contradictions

Several participants talked about whether there was a need for the mandated frequency of reviews when the patients were doing well (given the potential for harm in reviewing reasons for the CTO, the dilemma of when a CTO should be discontinued) and the necessity for reviews when patients are voluntarily agreeing to the CTO.

P8 - *If a person is doing well, it seems that the legislation wants us to get out of their lives. Yet that's the best thing happening to them, from a best interest standpoint – the CTO is providing them with the quality of life that they won't attain if it isn't there. So, I think that is a major challenge regarding the view of CTOs. If a report comes in and the information is that everything is going well, and they are even making their own treatment decisions, the question then comes, why do we need to have them on a CTO? The legislation doesn't really provide a framework to allow us to have the CTO stay in place unless the criteria is met; so for me that becomes a huge hurdle for the psychiatrist to try and say "yeah, we know it's the tenth renewal, we know that everything is working well and the patient is doing exceptionally well, but we are still fearful". It becomes quite a hurdle to climb.*

P4 - *... in terms of patients that are capable to consent to treatment the legislation requires that the review still take place ...if it is a capable treatment decision, then I don't know why the Board is required to review a patient's capable treatment wish when we don't review any other capable treatment wish. If a patient consents to taking medication that's much more intrusive than consenting to a CTO and no one reviews that capable wish. This one person will make dozens of other capable treatment decisions regarding their physical health that no one will review ... why are we reviewing this one? The problem is that with CTOs, they are generally doing well, and so when*

the person is doing well, we are having a hearing every six months to review the grounds for upholding the CTO, and they're reminded constantly of how they are when they're not well. So, if you're on a CTO for a number of years, and you've done well for years, to have to come to a hearing and hear the doctor say, but for the CTO, they'd be a danger to others, is really not a good thing to hear. It's not good to be reminded you've got this past, and you'll never really live it down. I think that it undermines their self-esteem.

○ Contested Versus Uncontested CTOs

This study involved a number of CCB members with considerable experience with its review process. Many of them observed that the majority of CTO mandatory review hearings they attended, were uncontested by the patient in question. One participant speculated that approximately 10% of the hearings he had been a part of, were contested. Several potential explanations are offered below.

P8 - I don't know if clients are given enough information about CTOs and about Board processes. Perhaps, explaining the information in plain, simple, clear language might be something that would be very helpful to them. Even if the terms and conditions of the community treatment plan were reviewed with them, it could be helpful. I am not sure that they have always fully understood. You might argue that the SDM needs to fully understand it, but I think it's also important to the patient because it is their life and it is what they have got to abide by in terms and conditions

P2 - ...the fact that most of the time the patients don't turn up, tells us that there is a good therapeutic alliance and the CTO has been the catalyst to build the relationship. I see it more as a catalyst than a coercive thing. It would be interesting to look at the patients – the ones who go for voluntary CTOs and those who are on involuntary incapable CTOs and see whether there is a difference between diagnoses. These are some interesting thoughts for research.

P9 - I don't know sometimes what to interpret into a client's non-attendance at a Board hearing. What's the reason for that? Could it be that they have been there before and they think the Boards is always going to decide in favour of the doctor, and so they don't want any part of the process? Do they think their non-attendance makes a statement? Is it because they are not organized enough to be able to appear and present? Is it that they don't want a lawyer because they have assets and might have to pay? There is any number of reasons why that might occur, and I don't really have a good sense of that...

○ Why Are CTOs Not Used More?

All participants emphasized the need for education regarding the appropriate use of CTO legislation for all stakeholders, most notably physicians. This might promote the use of CTOs by some physicians who seem reluctant to use them.

P5 - *They seem like they are doing a really wonderful job. I know in the orders that I have been reviewing, I have been really impressed that some very ill people that are being able to be maintained in the community; they are doing what they are supposed to be doing and ACT teams are doing a good job.*

P1 – *I think they are excellent. You know I still hear from time to time, psychiatrists saying I don't do CTOs because CTOs don't work. I was at a hearing last week where a psychiatrist, probably in his early to mid-seventies, who when a question was asked by a member of the Board if there was plans for a CTO for a patient who had been hospitalized like four times and is non-compliant to treatment, answer was 'oh they don't work'... and the second excuse often is that I don't do CTOs, because I don't follow patients and somebody else in the community follows the patients..., but I don't see why the person at the hospital cannot initiate the CTO and then let the other person in the community be the other signatory to the CTO.*

P6 - *The CTO is such a wonderful mechanism providing the kind of assistance and help that wasn't always there until very recent years. They suffered terribly, I think, and so stigmatized and hospitalized and yet don't get me wrong, I think there is a place for hospital. I think that in some cases, the patients might think it highlights stigma, but generally I think it minimizes stigma because again, it enables people.*

DISCUSSION

As noted in the Introduction, the debate between those advocating the use of CTOs and those against their use continues with polarizing views at either end of the continuum. The one extreme extols the many benefits to the individual, their family and the mental health service system, and the other emphasizes the violation of a person's rights. Previous studies by the principal investigator and others (Corring et al, 2010; O'Reilly et al, 2006) included perspectives of ongoing subjects of CTOs, their families, police and service providers have all identified benefits and negatives, but the majority report more positive than negative views. These findings are also consistent with findings from the mandated reviews of CTO legislation in Ontario (Dreezer 2005; Malatest, 2012). By interviewing review board members, this study has brought a unique perspective to the question of the effectiveness of CTOs. Review board members are independent from the CTO process and are appointed by the government to make objective reviews. While at "arm's length" from the participants in the CTO process, Board members are in a position to examine files concerning the people on CTOs in detail and draw objective conclusions. This study also shows that review board members view CTOs as effective while preserving rights.

Participants raised questions as to how CTOs facilitated improved outcomes for individuals. They wondered if the key factor was the clinical resources that supported a treatment plan or the

legal obligation of following the plan (and resultant stability in mental health) or a combination of both factors. They also identified ongoing dilemmas and potential solutions that need to be explored in future studies. For example, the dilemma of how to continue to justify a CTO for a person who is doing well and still considered ‘incapable’, might be resolved if the key phrase “likely to substantially deteriorate” is given a broader interpretation and consideration by the review board. Also the current procedure does not adequately respect people who have “done well for years” and yet have to “come to a CCB hearing and hear the physician recount, but for the CTO that they’d be a danger to others”. In these cases, Ontario might consider an alternative approach. In the British Columbia model there is a mandatory file review process and only if there is justification in the file, is a board hearing scheduled. Patients of course continue to be able to request a review. In addition, the patient could still choose not to participate even if a review was called. Another approach would be to only have CTOs for incapable persons. If a person is capable and agrees to the conditions of a CTO, perhaps that should be no different than agreeing to any treatment plan.

CONCLUSION

This study explores the experiences of CCB members, which come from three potentially very different perspectives – those of physicians, lawyers and members of the public. These individuals are appointed by the Lieutenant

Governor and are tasked with the very important duty of ensuring that the legislation governing the use of CTOs is used correctly. As noted previously, they arguably bring a more “objective” perspective regarding CTOs than other stakeholder groups, so it would seem particularly significant that without exception, they have found CTOs to be of benefit to the people who are subject to them. The inherent contradictions and puzzling issues that they reported reflect the extensive experience the members bring to the discussion, and the thoughtful consideration they have given to their deliberations over the years.

It would be the hope of the authors that the suggestions for change to the CCB review process of CTOs would be further investigated. In addition, we believe that the results of this study raise additional research questions that deserve further study and look forward to exploring those questions ourselves and invite others to do so as well.

REFERENCES

- Atkinson, R. & Flint, J. (2004). Snowball sampling. *The Annals of Mathematical Statistics* Volume 32, (1), 148-170.
- Corring, D., Anderson, K., Bateman, L., Harshaw, S., Shlomovitz, E., Diaz, K. & Peer, I. (November 2010). Perspectives on their quality of life provided by persons with serious mental illness who are on a community

- treatment order: A naturalistic enquiry involving 'critical case sampling. *Research Insights of the Regional Mental Health Care London/St. Thomas*, 7, (2), 1-16.
- Denzin, N. (2006). *Sociological Methods: A Sourcebook. Aldine Transaction. (5th edition)*.
- Dreezer & Dreezer. (2005). Report on the legislative review of community treatment orders, required under section 33.9 of the mental health act. *Queens Printer for Ontario*.
- Faugier, J., & Sargeant, M. (1997). Sampling hard to reach populations. *Journal of Advanced Nursing*, (26), 790-797.
- Gray, J.E., & O'Reilly, R.L. (2005). Canadian compulsory community treatment laws: Recent reforms. *International Journal of Law and Psychiatry*, 28, 13-22.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.
- Malatest, R.S. & Associates Ltd. Legislated Review of Community Treatment Orders (May 2012). *Ministry of Health and Long-Term Care, Toronto, ON*.
- Mitelman, S.A., & Buschbaum, M.S. (2007). Very poor outcome schizophrenia: Clinical and neuroimaging aspects. *International Review of Psychiatry*, 19(4), 347-359.
- O'Brien, A. A., & Farrell, S. J. (2005). Community treatment orders: Profile of a Canadian experience. *Canadian Journal of Psychiatry* 50(1), 27-30.
- Ontario Ministry of Health and Long-Term Care. (2009). Mental Health Reform. Retrieved May 11, 2009, http://www.health.gov.on.ca/english/public/program/mentalhealth/mental_reform/bill_68.html.
- Ontario Ministry of Health (2010). *Mental Health Act*. Retrieved November 28, 2012, http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm
- O'Reilly, R. (2004). Why are community treatment orders controversial? *Canadian Journal of Psychiatry* 49(9), 579-584.
- O'Reilly, R.L., Keegan, D.L., Corring, D., Shrikhande, S., Natarajan, D. (2006) A qualitative analysis of the use of community treatment orders in Saskatchewan. *International Journal of Law & Psychiatry*, 29, 516-524.
- Swartz, M. S., & Swanson, J. W. (2004). Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: What's in the data? *Canadian Journal of Psychiatry*, 49(9), 585-591.

APPENDIX A: Exploring Consent and Capacity Board (CCB) members experiences with Community Treatment Orders

Interview Guide Questions:

1. In your own words please describe your experience to date as a CCB member as it relates to hearings re CTOs.
2. What has been your experience with mandatory uncontested CTO reviews (vis-à-vis contested CTO reviews)?
3. What do you see as the major challenges of hearings regarding reviews of CTOs?
4. In your opinion are there changes to the CTO hearing process that could be made to make it more effective?
5. Is there anything else you want to note regarding CCB reviews of CTOs that we haven't asked about?