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CANADIAN APPROACHES TO MANDATORY COMMUNITY TREATMENT: LEAST RESTRICTIVE ALTERNATIVES?

by

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KEY WORDS

Community treatment order, mental health legislation, conditional leave

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Abstract

Objective: *This article reviews the literature on Mandatory Community Treatment (MCT) and assesses whether Canadian MCT provisions are compatible with the principle of using the least restrictive alternative compared with involuntary inpatient detention.*

Method : *The 13 Mental Health Acts in Canada provide ample diversity to study MCT provisions. This article describes the differences among the Canadian jurisdictions, reports on the Canadian empirical studies, discusses the clinical and legal issues that provoke debate and places Canadian legislation in an international context*

Results: *Most Canadian jurisdictions have a form of conditional leave from hospital and three have community treatment orders. Some jurisdictions use a dangerousness criterion for both in and outpatients but others have introduced a deterioration criterion. In all jurisdictions, extensive prior hospitalization is a condition for community treatment orders, but only one jurisdiction requires previous inpatient detention for initiating conditional leave. Some jurisdictions require consent for the MCT. The two Canadian empirical studies using patients as their own controls reported reduced hospitalization Canadian laws are designed to reduce hospitalization for revolving door patients rather than being based on the principle of using the least restrictive alternative.*

Conclusion: *We conclude that legislation that minimizes the use of inpatient admission is more appropriate for contemporary Canadian circumstances.*

1. Introduction

Mandatory community treatment is said to be a least restrictive alternative compared with involuntary inpatient detention. This article examines mandatory community treatment laws in Canada and their compatibility with the principle of using the least restrictive alternative. Mental health legislation is a provincial responsibility in Canada. There are 10 different provincial Acts and three territorial Acts. The term mandatory community treatment (MCT), as used here, includes conditional leave from hospital and community treatment orders (CTOs). It does not include provisions of the Criminal Code like bail conditions or probation, nor does it include guardianship legislation, which may be used for similar purposes. MCT has been, or is, still controversial in parts of Canada as evidenced by the opposition to the Ontario provisions passed in 2000, by the Canadian Mental Health Association (CMHA) (CMHA, Ontario Division, 1998). Some acceptance appears to have been achieved as displayed by a quotation five years later "We were able to achieve dramatic reductions in hospitalizations and hospital stays. We were able to show, after one year, a 94 to 96% reduction in hospital days." (CMHA, 2006). However, in Nova Scotia in 2005 the CMHA opposed the introduction of CTOs. Groups that support CTOs include the Canadian Psychiatric Association (2003) and the Schizophrenia Society of Canada (2005).

This article will discuss the principles underlying MCT and contrast the different types of provisions and their development in Canadian jurisdictions, especially as they relate to the principle of using the least restrictive alternative. It also reviews Canadian evaluative research, and identifies various issues including consent and safeguards. It compares Canada's approach with that used in other countries and concludes with recommendations that would change Canadian approaches to encompass a truly least restrictive approach to mandatory treatment.

2. Purpose And Principles Underlying Mandatory Community Treatment

There appear to be two principles underpinning MCT laws: the reduction of rehospitalization and the use of the "least restrictive setting". The "least restrictive" principle is required of all laws that restrict freedom by the *Canadian Charter of Rights and Freedoms*[3]. The "purpose" section of the Ontario CTO provision embodies both principles:

> "The purpose of a community treatment order 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 is less restrictive than being detained in a psychiatric facility. Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who, as a result of his or her serious mental disorder, experiences this pattern: 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 changes and, as a result, the person must be readmitted to a psychiatric facility." [4]

[3] Canadian Charter of Rights and Freedoms. Part 1 of the Constitution Act, *1982*, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

3. Types Of Mandatory Community Treatment

Conditional leave from hospital and CTOs are the two types of MCT provisions in Canadian Mental Health Acts. There are also a number of mechanisms in guardianship, the Criminal Code and advance directive legislation that can be used to support compulsory treatment in the community. However, these will not be discussed in this article (see Gray et al., 2000).

3.1 Conditional Leave From Hospital

If a patient continues to meet the criteria for involuntary hospitalization, conditional leave from hospital is a mechanism whereby the patient may live in the community, providing the patient adheres to the specified conditions of the leave. Of the 13 Canadian *Mental Health Acts,* nine have explicit conditional leave provisions. Jurisdictions differ on preconditions, committal criteria, renewals, consent and service requirements for putting a person on conditional leave.

The least restrictive approach to conditional leave would mean that a person who continued to meet the inpatient criterion could be put on leave from a first admission. All Canadian jurisdictions can do this except Manitoba, which restricts a person from going on leave, thus confining them to the hospital, unless they meet preconditions of prior hospitalization. These preconditions include a total of 60 inpatient days as an involuntary patient or three involuntary admissions, during the previous two years. [5]

Another means of restricting the number of people who may be eligible for conditional leave is to have a narrow involuntary inpatient criterion based on dangerousness. As a result, psychiatrists may be reluctant to release potentially dangerous people into the community. While some jurisdictions have retained a physical dangerousness inpatient criterion (e.g. Quebec[6], Alberta[7], North West Territories[8]) a number have supplemented it with a "likely to suffer substantial mental or physical deterioration" alternative (e.g. British Columbia[9], Saskatchewan,[10] Manitoba,[11] Ontario[12], Nova Scotia[13]). Thus, a person who was likely to stop treatment and deteriorate significantly, without some compulsion to stay on medication, would still meet the inpatient criterion in the community even though their continuing adherence to the medication was preventing deterioration.

Another way of limiting conditional leave is to put a time limit on it, even though the person continues to meet the criterion. In Ontario, leave is limited to three months[14], in

[4] Mental Health Act, R.S.O., c. M.7 as am. (s. 33.1(3)).
[5] Mental Health Act, C.C.S.M. c. M110, s. 46.
[6] An Act Respecting the Protection of Persons Whose Mental State Presents a Danger to Themselves or to Others, R.S.Q. c. P-38.001, s.7.
[7] Mental Health Act, R.S.A. 2000, c. M-13, s. 6.
[8] Mental Health Act, R.S.N.W.T. 1988, c. M-10, s.13.
[9] Mental Health Act, R.S.B.C. 1996, c. 288, s. 22(3)(c).
[10] Mental Health Services Act, S.S. 1984-85-86, c. M-13.1, s. 24(2)(a)(iii)
[11] Mental Health Act, C.C.S.M. c. M110, s. 17(1)(b).
[12] Mental Health Act, R.S.O. 1990, c. M.7, s. 20(1/1)(a).
[13] Involuntary Psychiatric Treatment Act, S.N.S. 2005, c. 42, s.17(c)(ii). (Not yet proclaimed).
[14] Mental Health Act, R.S.O., c. M.7 as am. s.27(1).

Nova Scotia to six months[15] and in New Brunswick to ten days.[16] All other jurisdictions that use conditional leave allow it to continue indefinitely providing the regularly scheduled renewal examinations show the person meets the committal criteria.

If the person or the substitute decision maker must consent to the person going on conditional leave, but refuses, that may have the effect of keeping the person detained in a more restrictive environment than is clinically necessary. Although Ontario requires consent for CTOs (see below), it does not require consent for conditional leave. Manitoba,[17] Prince Edward Island,[18] the Yukon[19] and Nova Scotia[20] require consent. In other jurisdictions with conditional leave provisions, it is sufficient if the hospital authorizes the leave.

To help ensure that the person on leave has the supports needed to continue in the community, a number of Acts make explicit reference to providing the services necessary to meet the conditions of the leave. For example, in British Columbia the legislation reads: "… the director may release the patient on leave from the designated facility providing appropriate support exists in the community to meet the conditions of the leave."[21]

3.2 Community Treatment Orders

Unlike conditional leave, the person does not have to be in hospital when placed on a CTO. Saskatchewan was the first jurisdiction to introduce CTOs in 1994[22] followed by Ontario in 2000[23] and Nova Scotia in 2005[24] (not yet proclaimed). Quebec has a form of MCT, which is more like outpatient committal available in the US, whereby a judge can authorize treatment for an involuntary inpatient and that compulsory treatment can continue in the community.[25]

In theory, CTOs can be less restrictive than conditional leave because conditional leave requires at least one hospitalization for the person to be on leave from the hospital; whereas for all Canadian CTOs the person does not, by law, have to be in hospital to be put on the CTO. In practice, however, it is highly unusual for a person to be put on a CTO while in the community (O'Brien and Farrell, 2004). This is also true in New Zealand (Dawson, 2005 p. 26.). Thus, CTOs appear to be less restrictive than leave, which requires a prior involuntary admission, but in practice there is little difference between the two.

[15] Involuntary Psychiatric Treatment Act, S.N.S. 2005, c. 42, s.43.
[16] Mental Health Act, R.S.N.B. 1997, c. M-10.2, as am., (s. 20).
[17] Mental Health Act, C.C.S.M. c. M110, s. 46(10).,
[18] Mental Health Act, S.P.E.I. 1994, c.39, as am. (s. 25).
[19] Mental Health Act, S.Y.T. 1989-90, c.28, (s. 26).
[20] Involuntary Psychiatric Treatment Act, S.N.S. 2005, c. 42, s.43(2).
[21] Mental Health Act, R.S.B.C. 1996, c. 288, as am. (s. 37).
[22] Mental Health Services Act, S.S. 1984-85-86, c. M-13.1, s. 24.1
[23] Mental Health Act, R.S.O. 1990, c. M.7, s.33.1.
[24] Involuntary Psychiatric Treatment Act, S.N.S. 2005, c. 42, s. 47. (Not yet proclaimed).
[25] Civil Code of Quebec, R.S.Q. 1991, c. 64. Art. 16.

There are significant differences in least restrictive options between Canadian CTOs and conditional leave when it comes to the requirement for prior hospitalization. Conditional leave requires only the current hospitalization; although in practice, it is often used for people with multiple hospitalizations. The exception is Manitoba[26] where conditional leave has similar restrictive preconditions to Saskatchewan.

Under a CTO, a person may meet all the criteria for a CTO (essentially the involuntary inpatient criteria), but unless they have had a significant history of past hospitalization they do not qualify for the CTO. For example, the Ontario precondition (s. 33.1(4)(a)), requires at least one of the following in the previous three years: (a) cumulative inpatient hospitalization of 30 days, (b) two or more admissions, unless the person has been on a prior CTO. The Saskatchewan[27] requirement is for a total of 60 days as an involuntary inpatient or three involuntary admissions, during the previous two years. The Nova Scotia requirement is that the person must have, within the previous two years, a total of 60 days as an inpatient or two previous admissions.[28] It is clear that CTOs in Canada are restricted to "revolving door" patients and cannot be used to prevent people from becoming revolving door patients. In contrast, conditional leave could be used for both groups.

In sum, all CTOs are renewable, whereas the many of the provincial conditional leave provisions are not. All CTOs use a deterioration criterion as do a number of conditional leave provisions. CTOs are therefore equivalent to ‘leave’ except where the ‘ leave’ uses a dangerousness criterion, as discussed above.

4. Other Mandatory Community Treatment Mechanisms

The province of Quebec has a unique MCT mechanism that has elements of conditional leave and CTOs. Unlike other provinces, in Quebec a judge authorizes both involuntary admission and treatment. Frank et al. (2005, p. 867) report that:

The authorization of the court is necessary where the person who may give consent to care… is incapable of giving his consent … or, without justification, refuses to do so

And that the court orders:

…generally state that the patient must attend outpatient facilities for a two-year period and comply with the medications and treatment plan of the treating physician. If the patient does not comply with the order, the police are required by the order to bring the patient to the hospital for readmission.

Thus, a patient could be in hospital for a short period and then placed, for up to two years, on an order very similar to a CTO or conditional leave. This appears to be a least restrictive scheme compared with other Canadian CTOs because, patients do not have to meet a precondition of prior hospitalization as with a CTO, and are not subject to the possibility of the substitute decision maker withdrawing consent. However, it is potentially more restrictive, in that at least in theory, a person who does not meet

[26] Mental Health Act, C.C.S.M. c. M110,; (s. 46).
[27] Mental Health Services Act, S.S. 1984-85-86 c M-13.1 (s. 24.3(a)(ii)).
[28] Involuntary Psychiatric Treatment Act, S.N.S. 2005, c. 42, s. 47. (Not yet proclaimed).

inpatient committal criteria may be required to comply with a plan of treatment in the community.

5. Studies Of Mandatory Community Treatment In Canada

Does the evidence from studies in Canada suggest that MCT measures reduce hospitalization? The two studies completed to date suggest that it does.

In Quebec, Frank et al. (2005), studied 42 patients who served as their own controls. The mean age was 48.4 years. Fifty-five percent had a diagnosis of schizophrenia, 21% bipolar disorder and 19% schizoaffective disorder. There was an average of 5.7 admissions per person prior to the treatment order. Before the order, the median duration of community tenure was 128 days, but increased to 662 days with the treatment order: 5.17 times longer. The authors concluded:
"…we found that compulsory outpatient treatment was associated with significant lengthening of the time until readmission compared with the previous five-year period" (p. 869).

Countering the argument that only intensive as opposed to compulsory community treatment is needed, the authors concluded that "… all patients in Quebec have equal, free, and ready access to the same spectrum and intensity of services that are offered. To our understanding, the main barrier to services for the patients we report on here was their own poor compliance or unwillingness to receive services" (p. 869). On the criticism that system changes could have occurred to explain the marked increase in time in the community they state, "Finally, no identifiable changes in access to or the nature of the psychiatric care delivery system such as the institution of assertive community treatment teams occurred during the duration of the study" (p. 869).

In an Ontario study, O'Brien and Farrell (2005) analyzed results from 25 people, during a one-year period before and after being placed on a CTO. The mean age of the patients was 45 years and patients were diagnosed with schizophrenia in 64% of cases and 44% had a concurrent substance abuse disorder. A significant decrease in hospital admissions occurred from an average of 1.9 admissions in the year prior to the use of a CTO to 0.6 in the year following the initiation of the CTO. Notably, 56% of the people had no admissions after being placed on a CTO. Similarly, hospitalization days dropped from an average of 133 prior to the CTO to 22 following the CTO. The improved community tenure was accompanied by an increase in the use of support services and supportive housing.

Seventy-two percent of the psychiatrists in the province of Saskatchewan answered a questionnaire concerning their use of and opinions about CTOs (O'Reilly, Keegan and Elias, 2000). Approximately half of the 69 psychiatrists who returned questionnaires had used CTOs. Sixty-two percent of the psychiatrists who responded indicated they were either satisfied or extremely satisfied with the effect of CTOs on patient care, while 10% were either dissatisfied or extremely dissatisfied. The authors concluded, "While CTOs are used for only a small number of patients in Saskatchewan, they are a clinically useful tool for dealing with a group of otherwise difficult-to-treat patients" (p. 79).

These Canadian studies showing a decrease in the use of hospitalization following the introduction of MCT are consistent with findings from international jurisdictions. For example, a large recent evaluation of New York State's MCT (Kendra's) law of nearly 4000 people had these results (New York,2005):

a. *Reduction of severest consequences of lack of treatment.*
   In the three years before compared to the three years after being placed on MCT rates dropped by: 77% for hospitalization, 83% for arrests, 74% for homelessness and 87% for incarceration.
b. *Reduction in harmful behaviour.*
   In the six months prior to being placed on MCT compared with the six months after being placed on MCT there were: 55% fewer individuals with suicide attempts or who engaged in physical self-harm, 49% fewer who abused alcohol, 48% fewer who abused drugs, 47% fewer who physically harmed others, 46% fewer who damaged property, and 43% fewer who threatened physical harm to others.
c. *Improved treatment adherence.*
   Adherence to medication increased significantly
d. *Patient approval of the MCT program.*
   Half said they did not like going on the order, but later 75% said the MCT had helped them gain control, 81% that it helped them stay well, and 88% said the MCT had a positive effect on the therapeutic alliance.
e. *System improvement*
   The New York State Office of Mental Health reported: " …implementation of processes to provide AOT [MCT] under court orders has resulted in beneficial structural changes to local mental health service delivery systems".

It should be noted that this New York State study, like the Canadian studies, is an "own control" design and is subject to the possibility that the results are attributable to factors other than the MCT. The positive results contrast with an earlier randomized controlled study of a pilot MCT system in New York City (Steadman et al. 2001). Although this study found the MCT group had an average of 43 days in hospital; whereas those not on a MCT spent 101 days. This was not statistically significant. Nor were arrests or homelessness different. However, there were major problems with the study including the police refusing to carry out pick-up orders for breach of conditions. As well, by chance, there were more subjects with substance abuse in the MCT group and substance abuse was correlated with more hospitalization.

6. Other Issues

In addition to the criteria and preconditions for MCT, the use of MCT to facilitate early intervention, treatment planning, service provision, consent and rights protection are important issues.

6.1 Early Intervention In Psychosis

Early treatment of psychosis is now considered a best standard of practice in psychiatric care. Facilitating early intervention appears to reduce the likelihood of relapses and by

limiting subsequent hospitalization supports the least restrictive principle. Where voluntary hospitalization is not possible, requiring multiple or lengthy hospitalization preconditions for MCT is counter-productive to facilitating early treatment. The Canadian CTOs contrast with the New Zealand model where compulsory treatment must be provided in the community if it is appropriate as the first option.[29] Thus, in New Zealand a young person undergoing a first episode of illness may be required to take treatment in the community rather than being involuntarily committed to hospital. Moreover, in New Zealand patients who require a period of hospitalization can be moved to the community as soon as it is appropriate while staying on involuntary status. Although this is not possible under Canadian CTO provisions it is theoretically possible under all Canadian leave provisions (except for Manitoba as explained above). However, the Canadian focus is primarily on using MCT for people who are already in the "revolving door" and it is not used to prevent people from reaching that stage.

6.2 Treatment Planning

In some Canadian jurisdictions (e.g. Ontario, Manitoba, Saskatchewan) the law requires the involvement of the patient as much as possible in the formulation of the community treatment plan. This is in spite of the fact that, by definition, most people are incapable of understanding and appreciating their need for the plan. For example, the Manitoba provision reads:

"the patient, the patient's representative, if any, the patient's attending psychiatrist and other health professionals and persons involved in the patient's care or treatment, develop a treatment plan for the patient that will form the basis of the leave certificate" (s.33.1(4)*(b)*).

6.3 Consent

Some MCT schemes in Canada require the patient or the substitute decision maker's consent. However, the true "voluntary" nature of the consent in a CTO applies to the relatively few people who are capable of entering into a "compulsory" agreement. Indeed, why they would do that is an interesting question. Community treatment orders for people who are incapable require a substitute decision maker's consent and this makes the order "compulsory" from the patient's perspective. Winick, (1999), has argued that patient involvement in the formulation and approval of a treatment plan improves adherence to that plan. Thus, the requirement for consent from the patient or the substitute decision maker may lead to better adherence to the plan. However, all Saskatchewan and some Ontario CTO patients are incapable and, by definition, are not able to understand or appreciate the plan. A problem with the consent model is that if the capable patient or the substitute decision maker withdraws consent for whatever reason the patient may suffer adverse consequences including the provision of treatment in a more restrictive setting.

6.4 Availability of Community Services

Most jurisdictions have a specific requirement that the resources necessary for the patient to meet the conditions of the order are available. This requirement may be implied even

[29] Mental Health (Compulsory Assessment and Treatment) Act, 1992, [AQ] s. 28(2).

when it is not specified. This provision is an essential protection for the patient and for the provider and should be made explicit in the Act or regulations. It is important to understand for many individuals with severe mental illness the presence of service does not mean that people will use them. Some researchers have concluded that even when services were readily available and patients were vigorously encouraged by case managers to avail themselves of the services, many did not until compulsion was introduced (Munetz, Grande, Kleist et al., 1996; Frank et al. 2005). Given that about half the people with schizophrenia do not believe they have a treatable illness (Amador and Johansen, 2000) it is understandable that some do not use available services.

6.5 Consequences Of Noncompliance

Why would a person comply with the conditions of an order if there were no consequences? Torrey and Kaplan (1995) have reported that in some of the 46 US states that have MCT there are no consequences for noncompliance. The consequences of noncompliance in Canada are either that the person can be apprehended and examined to determine if involuntary admission is warranted (e.g. Ontario (s. 33.3)), or they can be returned directly to hospital without a reexamination of their admissibility (e.g. British Columbia (s. 39)).

6.6 Protection Of Rights

Canadian jurisdictions have rights protections for patients on MCT that are very similar to those for involuntary inpatients. Rights protection for persons on MCT include substantive items such as specific criteria for involuntary services and procedural protections such as the use of qualified professionals to provide assessments, periodic reviews of the continuing need for involuntary services, access to a review tribunal or the courts, and mandatory provision of information to patients and next of kin about these rights. Some jurisdictions actually have more protections for an outpatient than an inpatient. For example, in British Columbia there is a mandatory review of the file by the tribunal after 12 months if the person is an outpatient, but not if they are an inpatient (s. 25(1.1)).

How the decision is made to put a person on MCT can be an important rights protection issue. In British Columbia it is the head of the psychiatric unit, but renewals are often delegated in rural areas to a nonpsychiatrist physician. In Saskatchewan, the procedure is that one psychiatrist must conduct an examination and, if the person objects, another psychiatrist must conduct an examination and both conclude that that the criteria have been met (s. 24.3(4)). One physician (with mental health experience) is sufficient in Ontario (s.33.1(4)). In Nova Scotia, one psychiatrist is required (s. 47).

7. Discussion

The MCT mechanisms of conditional leave and, CTOs have become more widespread in Canadian mental health legislation in the past decade and this trend may continue (Gray and O'Reilly, 2005).

Generally, Canadian CTO measures are considerably more restrictive than conditional leave because they require significant hospitalization preconditions; whereas leave (with

the exception of Manitoba) can be applied on the first admission. It is true that CTOs can be applied when the person is in the community. In practice, this rarely happens. Canadian jurisdictions' MCT laws are clearly aimed at people in the so-called "revolving door". This contrasts with some other international jurisdictions that take a "least restrictive setting" approach where a person who needs involuntary services can be treated in the community if that is appropriate and does not have to be deprived of their liberty by committal to a hospital, (e.g. New Zealand[30], Scotland[31]).

Given research findings and the experience of clinicians in Canada and other jurisdictions it is our opinion that the adherence to the least restrictive principle is greatest when MCT can be used for a patient who meets the criteria for involuntary admission without the requirement of previous hospitalization. MCT would then allow the person to be in the community or in hospital as the clinical need changed. Unfortunately there is no indication that Canada will follow its British Commonwealth cousins on this "least restrictive" path.

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[30] *Supra* Note 9. s. 28(2).
[31] Mental Health (Care and Treatment) (Scotland) Act 2003, s. 57.

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