Value of community treatment orders remains at issue

Published at www.cmaj.ca on Apr. 16

For the better part of a decade, doctors and psychiatrists in most provinces have been able to issue community treatment orders compelling mentally ill patients to accept treatment, medication and supervision as a condition of living in the community.

Yet, some experts say many doctors and psychiatrists are still reluctant to invoke the mandatory treatment for seriously ill psychiatric patients, while others contend more research is needed to determine whether patients would actually benefit.

All Canadian jurisdictions, with the exception of New Brunswick and the three Territories, authorize the use of community treatment orders or variations such as extended leave provisions.

"Most jurisdictions in Canada have adopted the legislation," says Dr. Richard O'Reilly, a professor of psychiatry at the University of Western Ontario in London, Ontario. "Now I think that doctors and particularly psychiatrists need to adopt the legislation. I think that pressure must come from the public and governments to ensure that happens."

The reluctance of some to use community treatment orders "is a disservice … in situations where they meet the criteria and would clearly benefit from it," O'Reilly argues. "To allow somebody to be discharged from a hospital where they've had five admissions under the Mental Health Act over a period of a year or two, who then ends up threatening relatives or acting in a dangerous way in the community, or deteriorating to the point where they are at risk of threatening their own lives, that's just not good enough."

O'Reilly cites the high-profile case of Jeffrey Arenburg, who murdered 55-year-old Ottawa, Ont., sportcaster Brian Smith in 1995, as an example of a patient who would have benefited from a community treatment order.

Tony Lyons

Community treatment orders are "not effective with everybody," says Ann-Marie O'Brien, a community treatment order coordinator for the Royal Ottawa Mental Health Centre in Ottawa, Ontario.

"Nobody sees that Arenburg was a victim of this as well," O'Reilly says. "He was allowed to be psychotic in the community and killed somebody for which he had to lose liberty for many years. Then, darn it, when he was eventually let go from that system, nobody thought to provide treatment and supervision so that he didn't do the same thing again. And he ended up assaulting someone."

Erick Fabris, however, urges caution. In 1993, then 24-year-old Fabris was institutionalized for a month and "given psychiatric diagnosis and treatment on a locked ward. This led to my questioning and researching psychiatric theory and interventions."

Fabris wrote in an email that he now considers himself a survivor of a prognosis that labeled him bipolar and subjected him to mandatory treatment that once convinced him "I was ill for life, would never work, and had no hope of carrying on adult relationships."

The doctoral candidate in sociology and equity studies at the Ontario Institute for Studies in Education in Toronto, Ont., said his research indicates there is "no compelling evidence to say people might clearly benefit from legally mandated psychiatric treatment."

"CTOs [community treatment orders] bring intrusive ward practices into the home and community, such as making family members oversee a treatment plan that enforces treatment compliance," he said. "While CTOs are sometimes used simply to obtain scarce services, or to ensure providers stick to a discharge plan, legal compulsion should not be necessary to achieve such goals."

Fabris said that while Ontario's legislation has been proclaimed a success by the only Canadian legislated review of community treatment disorders, "it documents several anecdotes of abuses and failures. The report admits there is a paucity of good research on legally mandatory treatment in the community, and the best studies say there is little difference between state-ordered and ordinary outpatient treatment programs. According to the report, many clinicians find CTOs cumbersome, confusing, poorly supported and ineffective. Many clients find CTOs oppressive and stigmatizing."

The *Report on the Legislated Review of Community Treatment Orders, Required Under Section 33.9 of the Mental Health Act* — which was conducted in 2005 for the Ontario Ministry of Health and Long-Term Care, five years after the province passed legislation allowing for community treatment orders — also noted that the inherent coerciveness involved in such orders often presents problems for those invoking them as the orders are seen by many as "violating an individual's rights" (www.health.gov.on.ca/english/public/pub/ministry_reports/dreezer/dreezer.pdf).

O'Reilly agrees that community treatment orders can be bureaucratic and complicated to implement but argues that the real problem is that

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community services have not kept pace with intentions.

"Deinstitutionalization is replete with examples of promises to put services in the community for the seriously mentally ill, but failure to do that. So we are continuing to downsize with limited services for people in the community."

Ann-Marie O'Brien, a community treatment order coordinator for the Royal Ottawa Mental Health Centre in Ottawa, Ont., says a better understanding of the appropriate use of community treatment orders is needed.

"We know they are effective, but we have to get better at understanding with whom. They're not effective with everybody. This is not a panacea, a one-size-fits-all. We have to be clearer in our understanding of who community treatment orders work for and who they don't work for," O'Brien says.

O'Reilly says mental health professionals are just now "starting to get beyond the stage of, do these things work, do the ethical issues that they raise outweigh the benefits. I think we're now at the stage where we see that we really have to have community treatment orders if we're going to try to manage these individuals in the community and we're just starting to look at what is the best way to do it." — Becky Rynor, Ottawa, Ont.

DOI:10.1503/cmaj.109-3237