THE LEGISLATED REVIEW OF COMMUNITY TREATMENT ORDERS

FINAL REPORT

Prepared for
Ministry of Health and Long-Term Care

Prepared by
R.A. Malatest & Associates Ltd.

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Contact Information:
Dr. Deborah McLeod
R.A. Malatest & Associates Ltd.
Phone: 1-888-689-1847
Fax: 1-866-288-1278
E-mail: d.mcleod@malatest.com
Web: www.malatest.com

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ABBREVIATIONS AND DEFINITIONS

ACT	Assertive Community Treatment
CCB	Consent and Capacity Board
CDS - MH	Common Data Set – Mental Health
CTO	Community Treatment Order
Forms	Form 1: Application by Physician for Psychiatric Assessment Form 45: Community Treatment Order Form 46: Notice to Person of Issuance or Renewal of Community Treatment Order Form 47: Order for Examination Form 48: Application to Board to Review Community Treatment Order and Notice to Board by Physician of Need to Schedule Mandatory Review of Community Treatment Order Form 49: Notice of Intention to Issue or Renew Community Treatment Order Form 50: Confirmation of Rights Advice
Levels of Care	Levels of care range from Level 1, where individuals capable of self-management may attend outpatient clinics or see physician once a month, to Level 5, where individuals with difficult to treat psychiatric conditions require high levels of care in a secure setting. Levels 4 and 5 provide residential treatment to mental health consumers who require high levels of support in a supervised setting.[1]
LHIN	Local Health Integration Network
MHA	Mental Health Act
MOHLTC	Ministry of Health and Long-Term Care
OCAN	Ontario Common Assessment of Need Tool
OHIP	Ontario Health Insurance Plan
PGT	Office of the Public Guardian and Trustee
PPAO	Psychiatric Patient Advocate Office
SDM	Substitute decision-maker

[1] http://www.ontla.on.ca/library/repository/mon/25001/306980.pdf

EXECUTIVE SUMMARY

Background

On December 1, 2000, the Ontario government introduced legislative changes to ensure that people with serious mental illness receive the care and treatment they need in a community-based system. *Bill 68 (Mental Health Legislative Reform), 2000* included the introduction of **Community Treatment Orders (CTOs)** for:

- Individuals with serious mental illness and who have a history of repeated hospitalizations and who meet the committal criteria for the completion of an application by a physician for a psychiatric assessment in the *Mental Health Act* (MHA); and
- Involuntary psychiatric patients who agree to a treatment/supervision plan as a condition of their release from a psychiatric facility to the community.

Explicit criteria which must be complied with before a CTO may be issued relate to hospitalization, existence of a community treatment plan; examination by a physician within the 72 hours before entering into the CTO; ability of the person subject to the CTO to comply with it; provision of rights advice and informed consent by the consumer or a substitute decision-maker (SDM).

In Canada, all jurisdictions with the exception of New Brunswick and the Territories use CTOs or comparable legislation (Rynor, 2010). CTOs fall into two main categories: preventative and least restrictive (Churchill, 2007). Preventative CTOs have the power to prevent the deterioration of mental health by mandating the treatment outlined in the community treatment plan. In Ontario, legislation falls into the preventative category and was also designed to provide a less restrictive alternative to institutionalization while preventing so-called 'revolving door' mental health consumers. Mandatory treatment also assists in protecting consumers against self-harm and, for a small minority, against harm to others.

When any form of mandatory treatment is considered, safeguards must be in place to ensure the rights of a person are respected. Ontario's safeguards for consumers subject to a CTO include that the CTO process is consent-based and all statutory protections governing informed consent apply. That is, with adequate rights advice and legal advice, the consent of a person subject to a CTO, or his or her substitute decision-maker (SDM), if he or she is incapable, must be voluntary and informed.

The Review

Section 33.9 of the *MHA* requires the Minister of Health and Long-Term Care to establish a process, every five years, to review:

- The reasons that CTOs were or were not used during the review period;
- The effectiveness of CTOs during the review period; and
- Methods used to evaluate the outcome of any treatment used under CTOs.

The first review was completed by Dreezer and Dreezer in 2005 and the reviewed draft was ratified in 2007. The Ministry of Health and Long-Term Care (MOHLTC) commissioned R.A. Malatest & Associates Ltd. to complete the second review, the findings of which are provided in this report.

Approach to the Review

Information for the review was collected from early April until early May, 2012 from the following sources:

- Literature - papers and reports identified from academic databases and provided by stakeholders;
- Administrative data – data provided by the MOHLTC and sourced from the Common Data Set-Mental Health (CDS-MH) and from the CTO-Ontario Health Insurance Plan (OHIP) billing database; provided by the Psychiatric Patient Advocate Office (PPAO); provided by the Consent and Capacity Board (CCB); and data provided by CTO coordinators and others for their areas;
- Consultation with stakeholders –focus groups and interviews were completed with 128 stakeholders including health professionals, service delivery agencies, consumers and their family, friends and SDMs, other agencies (the police, the PPAO, the CCB, the Ontario Review Board), and consumer groups; and
- An on-line survey completed by 411 people (including 47 consumers) with an interest in CTOs.

Although the time frame for the review prevented wider consultation, the MOHLTC may want to consider consulting with consumers and other stakeholder groups about the findings of the review and the implementation of the review's recommendations.

Evidence about CTOs

A CTO is not a treatment; it is a mechanism which mandates adherence to a community treatment plan and it is important to note that a CTO is only as effective as the community treatment plan that sits under it. Studies summarized in the literature review section of this report have found outcomes such as improved quality of life, fewer hospital admissions and readmissions, and reductions in episodes of homelessness for people on CTOs.

However, there is limited empirical data generated from randomised controlled trails (considered to be the gold standard of evidence) about the extent to which CTO are effective in improving outcomes rather than comparable care without a CTO. Methodological and ethical issues mean there is unlikely to be robust empirical evidence about the impact of CTOs.

Use of CTOs

While challenges with incomplete administrative data limited the accuracy of estimates of the number of people issued a CTO, it is clear that the number of CTOs issued, reissued and renewed has steadily increased since 2001. Most CTOs were issued by physicians at hospitals or by physicians working with Assertive Community Treatment (ACT) Teams. CTOs were most commonly issued to people with schizophrenia or schizoaffective disorder, or bipolar disorder.

The Reasons That CTOs Were or Were Not Used During the Review Period

Consumers' feelings about their CTOs ranged from very positive to resentful, and attitudes often related to whether or not consumers had provided their own consent. The incentive of getting out of hospital was a strong motivation for consumers or their SDM to consent to a CTO. Subsequently, many consumers recognized the benefits of their CTO and the community treatment plan delivered under the CTO.

CTOs provided relatives and friends with comfort and relief by ensuring preventive support for consumers, quick assistance upon relapse, and adherence to medication while reducing negative interactions with law enforcement and allowing those who are SDMs to be a part of the process.

The main reasons that consumers and SDMs resisted CTOs were the undesirable side effects from medication and the mandatory nature of a CTO. However, many consumers and SDMs felt that while the CTO process might not be perfect, it was still worthwhile. Others did not: some SDM refused to consent to a CTO and some consumers appealed to the CCB to have their CTO removed.

Most of the mental health professionals we talked to used CTOs to some extent; however, the characteristics of consumers for which they were used varied. One common factor was that almost every treatment plan included medication and CTOs were considered to be effective in improving adherence to medication. CTOs were also used because health professionals found them effective in linking consumers to services and in increasing communication and understanding among service providers. CTOs were also considered to have been effective in reducing the frequency of hospitalizations and improving safety in the community.

The main factor health professionals cited as limiting the use of CTOs by themselves and their colleagues was the time and effort required throughout the CTO process.

The Effectiveness of CTOs during the Review Period

In this review the effectiveness of CTOs has been assessed by considering the following within the context of the mental health services currently available:

- **Effects on Consumer Well-Being and Satisfaction**

Interviewed health professionals held the view that a consumer's well-being improved when they adhered to treatment plans, which almost always included medication. Some consumers were willing to adhere to their medication, others did not recognize that they needed medication or did not consider that the benefits of the medication outweighed the side-effects they were experiencing. Most who did continue with medication said they recognized an improvement in their lives.

Most consumers who responded to the survey agreed they felt better since being on a CTO. More than one-half reported an improved quality of life, were more satisfied with the treatment received under their CTO than with other treatment options, and felt CTOs were the best option for their situation.

The family, friends and SDMs we were able to engage with were almost uniformly positive about CTOs. They commented on the improvements they observed in their loved-one's quality of life and improvements to their own well-being as they worried less about them.

- **The Effectiveness of the Process**

CTO Administration

The implementation of CTOs varied across the province; in particular, the roles of CTO coordinators and case managers included different responsibilities and levels of interaction with consumers and community services. Feedback from review participants confirmed the importance of the CTO coordinator when considering the effectiveness of a CTO. Approaches and processes may be different, but the presence of a dedicated CTO coordinator affected how well those processes worked and helped ensure accountability for all parties involved in the CTO. Insufficient numbers of CTO coordinators were reported as limiting the number of CTOs that could be issued.

When CTOs Were Used

There seemed to be variation in the consumer groups to whom CTOs were issued. From some we heard that CTOs were increasingly being used as a preventive measure rather than as a last resort. In the survey, while approximately two-thirds of psychiatrists and CTO coordinators did not agree that CTOs should be a last resort, most other stakeholders felt that CTOs should be a last resort.

Consent and Coercion

An essential element of the CTO process is that consumers or their SDM provide informed consent. Since the first review, there appears to have been a movement away from consumer consent to being issued CTOs with SDM consent. While almost one-half of the consumers responding to the survey were not concerned about the amount of choice they had under a CTO or their rights under a CTO, a similar number were concerned.

Non-adherence to a CTO

As with other processes associated with CTOs, methods for addressing non-adherence to the CTO differed across regions and depended on the CTO team. Only slightly more than one-quarter of survey respondents considered that methods for dealing with non-adherence to a CTO were satisfactory.

- **Discharge from a CTO**

There was limited data available on the duration of CTOs; however, some CTOs were renewed multiple times over a period of years. In the survey, only one-quarter of respondents agreed that CTO consumers maintained their gains after the CTO expired. Some stakeholders suggested that CTOs should last for a longer period. There was considerable variation among health professionals on when to discharge an individual from their CTO and no standard processes were in place.

- **Factors Impacting on the Effectiveness of CTOs**

Community Treatment Plans

A CTO provides a mechanism by which a consumer is mandated to adhere to a community treatment plan. The most commonly used treatment plans for schizophrenia and bipolar disorders included medication, which is more effective when it is combined with other services. The quality of the community treatment plan being delivered as part of a CTO and of the services available for inclusion in a treatment plan, are therefore major factors impacting on the effectiveness of a CTO. There is

considerable variation in the content of community treatment plans, from medication alone to comprehensive plans including a range of different supports.

Access to Services

CTOs were reported as effective in increasing communication between health professionals and in linking consumers with services. However, access to services, including access to case management, was a key factor impacting on the effectiveness of CTOs. Access to services was identified as limiting the use of CTOs and many stakeholders felt that CTOs were not available to all who could benefit. While most consumers who took part in the survey were satisfied with the treatment plan delivered through their CTO, 40% were concerned, or very concerned about the availability of services in their community.

Across all groups in the survey, more than half agreed that the lack of income support and housing limited the effectiveness of CTOs. Interviewed consumer representatives emphasized the challenges of homelessness for people with mental health problems and noted that CTOs were ineffective when the consumer could not be located.

Participants in the review discussed the extent to which CTOs were used to gain access to services or whether as many CTOs would be required if there was more access to intensive case management. While some stakeholders felt that CTOs took resources away from non-CTO clients, this opinion seemed to be not as widely held as in the first review. CTO coordinators reported that CTO consumers were also being placed on waiting lists for case management support and other services. It seemed that a general lack of services was more the issue.

Variations in Practice

The effectiveness of CTOs was linked to the quality of the community treatment plan the CTO had been issued to deliver and to the access to the services required for an effective care. There was evidence of variation in practice with respect to community treatment plans, and the CTO processes between LHINs. The approach to CTOs and to community treatment plans differed depending on the preferences of the coordinators and psychiatrists, and the availability of services and supports. Some practitioners used CTOs extensively; others used them in a more limited way and only for patients who were capable of providing their own consent. Some community treatment plans were very detailed and included a range of social supports, others included only medication. Views on reissuing CTOs and on how and when to discharge consumers also differed.

While the legislated criteria for issuing a CTO were clear, the translation of those criteria into practice was not set out in program guidelines or in best practice standards and it seemed that there were different interpretations and standards in different LHINs. While we saw some excellent examples of effective practice and dedicated health care providers, we also heard of examples where the CTO process was not working as well. An effect of assigning CTO funding to Local Health Integration Networks (LHINs) to allocate to agencies has contributed to the lack of a central process for providing program standards or to allow information sharing between stakeholders. This lack of central coordination may underpin some of the variation in practice found during the review.

We also found that all stakeholders (including consumers and their families) identified a need for more information about CTOs.

Methods Used to Evaluate the Outcome of any Treatment Used Under CTOs

Clinical judgement was the primary method used to evaluate the outcomes for CTO consumers. Administrative data provided some information about the outcomes of treatment used under CTOs. Improving the quality of administrative data would help in assessing the effectiveness of CTOs in Ontario. The introduction of the Ontario Common Assessment of Need Tool (OCAN) has the potential to provide a means for collecting information about outcomes for CTO consumers, allowing a more accurate assessment of the strengths and weaknesses of the process.

Recommendations:

The recommendations that arose from the review are summarized below and each is discussed in more detail in Section 8 of the report.

1. Mental health care providers and consumers should continue to have access to CTOs.
CTOs are an effective way to provide treatment and support in the community for some consumers.

2. The MOHLTC should support further research to understand what it is about CTOs that underpin their effectiveness.
There is insufficient information about what aspects of CTOs are effective, how to improve CTOs, and the duration of CTOs. Additional information is required and to inform further policy development and implementation of CTOs.

3. The MOHLTC should continue to work with service providers and the LHINs to ensure that robust data are available to track, at a minimum, the numbers of CTOs being issued, who they are issued by and the profile of consumers issued a CTO.
Good administrative data are an important source of information to assess the effectiveness of a program. There is currently no reliable province-wide information about CTOs.

4. The MOHLTC should lead the development of province-wide program standards.
There is considerable variation in many aspects of practice. There are no province-wide program standards defining 'best practice'. Program standards should include information about cultural competency.

5. Increased education about and awareness of CTOs is required and the MOHLTC should work with professional and other stakeholder groups to develop and disseminate information and educational material about CTOs.
Increased access to information is required by consumers, their family and friends as well as by health professionals.

6. The MOHLTC should consider whether a review of the safeguards in place for consumers is warranted.
Stakeholders were not satisfied with aspects of the safeguards currently in place. Increases in the number of CTO consented to by SDMs, consumer perceptions that the CCB process is not effective for them, and suggested changes to the duration of CTOs warrant a review of the current safeguards.

SECTION 1: BACKGROUND

1.1 Community Treatment Orders (CTOs)[2]

Mandatory or compulsory treatment in the community aims to prevent so-called 'revolving door' mental health consumers. People who are admitted to hospitals or psychiatric facilities as inpatients, receive treatment, and are released upon which time they do not continue further voluntary treatment, relapse, and are rehospitalized. Legislation for compulsory outpatient treatment was designed not only to provide a less restrictive alternative to involuntary hospitalization, which would reduce consumer time in hospital, but to also limit the risk of violent behaviour from the small group of mental health consumers who are at a high risk for victimization or perpetration of violent behavior.

Compulsory community treatment is currently used all over the world. The name given to this form of treatment may be different in other jurisdictions; however, for the purpose of this review all such treatment will be referred to as CTOs. The Dreezer and Dreezer report outlined key features of CTOs in New Zealand, Australia, Scotland, England and Wales, Israel and 41 states in the USA.

1.1.1 Preventative vs. Least Restrictive

CTOs fall into two main categories: preventative and least restrictive (Churchill, 2007). In Ontario, legislation falls into the preventative category. Preventative CTOs have the power to mandate treatment for consenting consumers to prevent the deterioration of mental health whereas least restrictive CTOs may mandate treatment only where the mental state of a person has deteriorated, as an alternative to hospital admission or continuing long-term psychiatric admission (Churchill, 2007). These two categories are not necessarily distinct as many jurisdictions, such as New Zealand and Australia, have CTOs which combine the two philosophies (Churchill, 2007).

1.2 Community Treatment Orders (CTOs)[3] in Ontario

On December 1, 2000, the government introduced legislative changes to ensure that people with serious mental illness receive the care and treatment they need in a community-based system. *Bill 68 (Mental Health Legislative Reform), 2000* which included the introduction of CTOs, passed Third Reading on June 21, 2000 with the support of 82 out of 103 members of the Ontario Legislature representing all three political parties. The legislation is detailed in Appendix A.

The legislative changes have helped facilitate care for clients by ensuring that people posing a risk to themselves or others get the care and treatment they need. The legislation allows for a CTO to be issued by a qualified physician to provide a person with community-based treatment or care and supervision that is less restrictive than hospitalization.

CTOs are for:

[2] http://www.health.gov.on.ca/english/public/pub/mental/treatment_order.html
[3] http://www.health.gov.on.ca/english/public/pub/mental/treatment_order.html

- Individuals with serious mental illness and who have a history of repeated hospitalizations and who meet the criteria in the MHA for the completion of an application by a physician for a psychiatric assessment, if they reside in the community; and
- In-patients in psychiatric facilities who are likely, because of mental disorder, to meet the committal criteria in the MHA if they do not receive continuing treatment or care and continuing supervision in the community after discharge.

The criteria for making an order include:

a. a history of hospitalization;
b. a community treatment plan for the person has been made;
c. examination by a physician within the previous 72 hours before entering into the CTO plan;
d. ability of the person subject to the CTO to comply with it;
e. consultation of the person and the person's SDM, if any, with a rights adviser; and
f. consent by the person or the person's SDM to the community treatment plan.

CTOs are valid for six months unless they are renewed or terminated at an earlier date.

A CTO may be terminated where the physician reviews the person's condition and determines that the person is able to live in the community without being subject to the CTO or when the person or his or her SDM withdraws consent from the CTO.

1.2.1 Safeguards for Persons Subject to a CTO

Safeguards have been put in place to ensure the rights of a person subject to the order are respected. The CTO process is consent-based and all statutory protections governing informed consent apply. The rights of a person subject to a CTO include:

a. a right of review by the CCB with appeal to the courts, each time a CTO is issued or renewed;
b. a mandatory review by the CCB every second time a CTO is renewed;
c. a right to request a re-examination by the issuing physician to determine if the CTO is still necessary for the person to live in the community;
d. a right of review of findings of incapacity to consent to treatment;
e. if the person is an involuntary patient, a right of review to determine whether the prerequisites for involuntary admission are met at the time of the review; and
f. provisions for rights advice.

With adequate rights advice and legal advice, the consent of a person subject to a CTO, (or his or her SDM, if he or she is incapable), must be voluntary and informed.

Under the *Health Care Consent Act*, physicians and other health practitioners may not administer a treatment unless the person or his/her SDM has given informed, voluntary consent to the treatment and this consent is not obtained through misrepresentation or fraud. Under this *Act* a person has the right to consent or to refuse a particular treatment if he or she is mentally capable. A person is capable with respect to proposed treatment if he or she is able to understand the information that is relevant to

making a decision about the treatment and able to appreciate the reasonable foreseeable consequences of a decision or lack of decision.[4]

1.3 The Process for Issuing a CTO

A CTO may be issued only by a psychiatrist, a physician practicing in the area of mental health or a physician working in a mental health facility. To qualify for a CTO, during the last three years, the consumer must have been admitted as an inpatient to a psychiatric facility at least twice or for a total duration of 30 days, or have previously been subject to a CTO.

Before a CTO may be issued, the physician must develop a community treatment plan that includes all services and the terms of the CTO. This treatment plan must name all participant's treatment partners and be consented to by the consumer, or if incapable, by their SDM. If the consumer is unable to consent to the community treatment plan, the plan will be provided to both the consumer and their SDM.

Within 72 hours prior to the treatment plan being entered into, the physician must examine the individual to establish the need for care and the likelihood of adherence; that the services prescribed are available; that the person meets the criteria for a Form 1 (application for a psychiatric assessment) if not currently a patient in a psychiatric facility; and that the person is likely to seriously harm themselves or others, or suffer substantial mental or physical deterioration or serious physical impairment, if they remain in the community.

Before a CTO may be issued, the physician must complete Form 49 (Notice of Intention to Issue or Renew Community Treatment Order) and provide a copy, including the community treatment plan, to the consumer and his or her SDM, if any. The physician must also notify the rights adviser, of his or her intention to issue a CTO. Rights advice is provided to the consumer and the SDM and Form 50 (Confirmation of Rights Advice) is completed. The consumer may refuse rights advice but the SDM cannot. Since legislative changes to the *MHA* in May 2010, SDMs from the Office of the Public Guardian and Trustee (PGT) only need to be provided rights advice for first issuances of CTOs, and not for renewals.

The physician subsequently issues Form 45 (Community Treatment Order) with the community treatment plan. These are provided to the consumer and SDM as well as to all other persons named in the community treatment plan. A Form 46 (Notice to Person of Issuance or Renewal of Community Treatment Order) must also be provided to advise the consumer of his or her right to a hearing before the CCB. The Board may confirm a CTO if it determines that the statutory criteria for issuing or renewing the CTO are met at the time of the Board's hearing. The Board must revoke the CTO if it determines that the criteria are not met at the time of the hearing.

A consumer may apply to the CCB, by completing Part 1 of Form 48 (Application to Board to Review Community Treatment Order and Notice to Board by Physician of Need to Schedule Mandatory Review of Community Treatment Order), and may be assisted by a rights adviser to do so. The hearing determines whether the legal criteria for the CTO have been met but does not consider the provisions of

[4] See section 4 of the HCCA. http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

the treatment plan. CTOs being renewed for a second time, and every second time thereafter, are automatically heard at the CCB. The issuing physician must complete Part 2 of Form 48.

A CTO expires six months after it is made, unless it is renewed or terminated in accordance with the MHA. A CTO may be renewed up to one month after expiration.

While the CTO is in force, the person who is subject to the CTO or his or her SDM may ask the issuing physician to review the person's condition and determine whether the CTO continues to be necessary. If it is not necessary, the physician must terminate the CTO and notify the person and anyone who is providing services under the community treatment plan, that the CTO has been terminated.

If a consumer fails to comply with his or her community treatment plan, or refuses to be examined within 72 hours of their withdrawal of consent (or the SDMs withdrawal of consent) and the physician still believes that the conditions for issuing a CTO and Form 1 (Application by Physician for Psychiatric Assessment) apply the physician, after attempting to contact and assist the person to comply with the Plan, may issue Form 47 (Order for Examination) which may be enforced for 30 days after being issued. Form 47 gives police the authority to take the individual into custody and then to the physician who issued the form. Upon examination of the individual the physician may apply to have a psychiatric assessment of the individual, issue another CTO or release the individual without a CTO.

1.4 Similarities and Differences between CTOs in Ontario and Other Jurisdictions

In Canada, all jurisdictions with the exception of New Brunswick and the Territories use CTOs or comparable legislation such as provisions for extended leave (Rynor, 2010). Mental health consumer eligibility for CTOs is narrower in Ontario than in some other parts of the country. For example, in Ontario, CTOs may only be issued to mental health consumers with a prior history of hospitalization, whereas in Alberta, CTOs may be issued to those with a history of hospitalization, those lawfully detained in a custodial institution but who would have met the criteria to be hospitalized at that time or those who have no history of hospitalization or incarceration, but whose recurrent behavior puts themselves or others at risk or who are at risk of mental health deterioration.[5] Further, in Alberta CTOs are issued by a physician (psychiatrist to general practitioner). In Quebec a psychiatrist must petition a judge in the Superior court (Frank, 2005). These examples illustrate some of the differences between mental health legislation under the umbrella of CTOs.

The major difference between CTOs issued in Ontario and most jurisdictions outside of Canada is that CTO consumers in Ontario, or their SDM, must consent to the CTO. Further, CTOs in Ontario are issued by physicians, whereas CTOs in some other jurisdictions are issued by the court system.

1.5 The Scope of the Community Treatment Order Review

As outlined in ss. 33.9 of the *MHA*, a review of CTOs is required every five years subsequent to the first review. The report of the first review was completed and released to the public in May 2007.

1.5.1 The First Review

A brief summary of key findings from Dreezer and Dreezer is appended (Appendix B).

[5] http://www.albertahealthservices.ca/hp/if-hp-mha-summary-changes.pdf

1.6 Scope of the 2012 Review

The MOHLTC requested that the second review address the following questions:

- The reasons that CTOs were or were not used during the review period;
  - What factors impact consumers', physicians' and substitute decision-makers' decisions to use/accept a CTO?
  - What alternatives to CTOs are being used to manage consumers in the community?
  - What are the characteristics of consumers using CTOs?
  - Where are CTOs originating?
- The effectiveness of CTOs during the review period;
  - What effects do CTOs have on consumer well-being and satisfaction?
  - What services and supports are CTO consumers receiving?
  - What are the factors impacting on the effectiveness of CTOs?
  - Are CTOs completed for consumers when they are discharged from hospitals?
  - Is there a standard discharge planning process for a CTO consumer?
  - How many times, on average, are CTOs renewed for the same consumer?
- Methods used to evaluate the outcome of any treatment used under CTOs.
  - What consumer outcomes are being measured?
  - How are consumer outcomes being measured?

SECTION 2: APPROACH TO THE REVIEW

This section outlines the approach to the review, stakeholders to the review and the evidence that was used to inform the review.

2.1 Governance of the review

Governance of the review was provided by a CTO Review Reference Committee selected by the MOHLTC. The mandate of the CTO Review Reference Committee was to provide advice on the CTO review process. As such, committee members were asked to provide feedback to the consultants, recommend literature sources and discuss report recommendations. Members with CTO experience were selected for the Reference Committee to ensure that there were consumer voices at the table. In forming the Reference Committee, the Ministry aimed to ensure representation from the key provincial health care provider associations, consumer stakeholder groups and those in a position to support the CTO Review process (internal stakeholders). While ideally the panel would reflect broad geographic representation, unfortunately this was not possible for the 2012 review. The 2012 review also did not include a Francophone member, although members of the public were welcome to complete the survey in French and the final report will be translated for posting on the Ministry website.

Members with a clear conflict of interest were not invited to be part of the committee. For the purposes of this committee, a conflict of interest existed if the person had issued a CTO or coordinated services for clients on a CTO. Therefore, psychiatrists and CTO co-ordinators were not invited to be members of the committee, although they were welcome to participate in the process by completing the survey or participating in interviews.

Committee members had to have the ability to attend meetings (in person or by phone) and review written materials, often with a quick turnaround. All of the members of the Reference Committee were required to sign a confidentiality agreement and declare any conflicts of interest. The Reference Committee was chaired by the MOHLTC.

2.2 Sources of Evidence

Information for the review was collected from early April until early May, 2012. The following sources of information were used to inform the review:

- Literature - peer reviewed papers, reports and gray literature;
- Administrative data;
- Consultation with stakeholders – health professionals, service delivery agencies, consumers, family, friends and SDMs, agencies and advocacy groups; and
- On-line survey of people with an interest in CTOs.

2.3 Literature Review

The review included evidence-based scientific and gray literature, as well as accounts related to evaluations of CTOs in Ontario, other Canadian provinces and international jurisdictions, and reports provided by stakeholders to the review. The focus was on updating the literature since 2005 as

literature prior to that date were included in the Dreezer and Dreezer report.[6] The following key words were used to access literature for the review:

- Community treatment order;
- CTO;
- Involuntary outpatient commitment;
- Compulsory treatment; and
- Brian's law.

2.4 Administrative Data

An analysis of quantitative data was a key line of evidence to answer the evaluation questions. However, analyzing the data provided was a challenge to the current review as it had been to the previous review. The Dreezer and Dreezer review noted that the data on CTO consumers and their care was "dispersed, fragmented and incomplete". The current review found that this approach to CTO data had not largely changed. There continues to be confusion among stakeholders about the data being collected. Some stakeholders who were asked by the Ministry to record data reported that they did not do so. Others recorded the information requested, but did not provide it to the central database. Other stakeholders however, had very complete data, but they were limited in their scope to a given element of CTOs (such as advice services) or to a given sub-region of Ontario.

Quantitative data collected through MOHLTC (i.e. OHIP CTO billing codes,[7] CTO reporting to CDS-MH and the Psychiatric Patient Advocate Office rights advice database), among other sources, were a key line of evidence for the review. Data were also provided to us by CTO coordinators in the regions (sources are described in Appendix C).

The analysis of data then is based on incomplete and hard-to-reconcile sources. Even with these limitations in mind, the administrative data provides valuable insights to the realities and trends of CTOs in Ontario. These data shed light on:

- The characteristics of CTO consumers;
- The geographic use of CTOs;
- The use of CTOs by functional centre; and
- The referral source of CTOs.

2.5 Individual and Group Interviews

Individual and group interviews were one mechanism used to gather input from stakeholders to the review. Group interviews are ideal for respondents to share their opinions in a moderated discussion format and to gain information that is more 'synergistic' than may be collected from individual interviews. Some key stakeholders were identified by MOHLTC for inclusion in the interviews. Others

[6] Dreezer and Dreezer Inc. Report on the legislated review of community treatment orders, required under Section 33.9 of the Mental Health Act, December, 2005.

[7] Not all physicians that issue a CTO necessarily bill using the OHIP codes, some psychiatrists are paid through sessional fees and some are on salary.

were recruited by the evaluation team. Email invitations were sent to all CTO coordinators, case managers and ACT Team leaders in Ontario, inviting them to take part in an interview, to distribute the link to the on-line survey and to disseminate information about focus groups, interviews and the surveys to others in their networks (including health professional colleagues, clients and their family and friends). Table 2-1 below summarizes the interviews completed. Details of stakeholder groups are provided in Appendix D.

Table 2-1: Interviews with Stakeholders

Participant Type	Type of Meeting	Number of Groups	Total Number of Participants
Group Interviews			
Consumers	In person	3	13
Friends and Family	In person	1	11
CTO Coordinators / Case Managers	Telephone	4	49
Psychiatrists	Telephone	3	10
Psychiatrists	In person	1	2
Service providers	In person	1	6
PPAO	Telephone	1	4
ACT Teams	Telephone	1	11
MOHLTC	Telephone	1	4
Other stakeholders	In person	1	3
	Sub-Total	**17**	**113**
Individuals or small group interviews			
Stakeholder Groups	Telephone	8	10
Consumer groups and advocacy	Telephone	5	5
	Sub-Total	**13**	**15**
	Total	**30**	**128**

Individual and group interviews were facilitated using semi-structured interview guides. The guides set out the specific topic or topics to be covered in an interview, but allowed the interviewer flexibility to include new questions as a result of what the interviewee says. The main areas explored included:

- For consumers, family and friends: Experiences of CTOs; how CTOs worked or did not work for individuals and their families, friends and SDMs; perceptions of CTOs; and potential improvements to CTOs.
- For CTO coordinators/ case managers/ psychiatrists and other health professionals: the coordinator/ case managers' role; processes related to CTOs and availability of services; and effectiveness of CTOs.
- For other stakeholders: their role in the CTO process, their perceptions of how CTOs were used and of the effectiveness of CTOs.

Interviews were conducted in the official language of the key informant's choice.

2.6 On-line Survey

The timeline for the project limited opportunities to conduct a large number of face-to-face key informant interviews or focus groups. An on-line survey, accessible through any internet browser,

provided the opportunity for as many people as possible to provide feedback. As well as being completed on-line the survey could also be completed over the telephone using a toll-free number, or as a hard copy.

The survey was based on the rating scales used by Dreezer and Dreezer, as well as newly developed scales and provided space for respondents to make comments. A copy of the survey is appended (Appendix E).The survey requested information about:

- What factors impact consumers', physicians' and SDMs' decisions to use/accept a CTO; and
- What effects CTOs have on consumer well-being and satisfaction.

The link to the on-line form was advertised through flyers provided in hard copy and electronic form to CTO coordinators, case managers and consumer groups. The MOHLTC and members of the CTO Review Reference Committee were also asked to disseminate information about the link through their networks. The link was also added to newsletters produced by consumer organizations.

The survey was open from April 16 to May 7. The survey was completed by a total of 411 individuals representing a range of different stakeholders (Table 2-2).

Table 2-2: Survey Completions by Type of Respondent

Type of Respondent	Total Completions	LHINs Represented by Respondents*
Consumer	47	9
Family/Friend (including family, friend SDMs)	20	9
SDM	14	7
Psychiatrist	40	10
CTO Coordinator	23	10
CTO Case Manager	28	11
Community Mental Health Worker	133	13
Inpatient Mental Health Worker	40	10
ACT Team	11	7
Legal system	3	
Consumer Advocate/ Peer support worker	27	11
Mental Health Researcher	3	
Government	4	
Rights Adviser	12	6
Other	6	
Total	**411**	**14**

*Not provided where the number of people in a category was small.

2.7 Analysis

Data from all lines of evidence were summarized and linked with the relevant review questions.

Qualitative data were analyzed thematically. Recordings from interviews and focus groups were transcribed and the qualitative analysis software package NVIVO was used to code the data into key themes. Key themes were derived from the review questions. Open-ended comments in response to the on-line survey were also coded using NVIVO.

The analysis of administrative data concentrated on two requirements. The first was to find data to answer the questions posed about CTOs for this review. The second was to update the data presented in the earlier Dreezer and Dreezer report. In some cases not enough administrative data were available to answer an evaluation question with administrative data or to update the earlier report, but in most cases the data were able to at least shed some light on the current status of CTOs.

Data from on-line submissions were analyzed descriptively by producing frequency tables for each question. Data were cross-tabulated against respondent category (e.g. professional grouping, whether the respondent was a consumer) and by LHIN.

2.8 Strengths and Limitations of the Review

Limited time frame: Information for the review was collected from early April until early May, 2012. While the time frame was limited, the evaluation team used a number of approaches, including an on-line survey, to solicit the views and opinions from as wide a range of stakeholders as possible.
The evaluation team was successful in capturing the views of 539 stakeholders (although there may have been some duplication between focus group participants and survey respondents). While we are confident the review includes the breadth of stakeholder views, there may be health professionals who do not use CTOs that we failed to reach. The MOHLTC, stakeholders may want to consider consulting with consumers and other stakeholder groups about the findings of the review and the implementation of the review's recommendations.

Data captures breadth of views but not the prevalence: As most data included in the review were qualitative, and as the survey was not based on a random sample, the prevalence of reported views is indicative only.

Questionnaire development: The time frame did not allow the questionnaire used in the on-line survey to be tested and pre-tested as rigorously as the evaluation team would have liked. We drew on the questions and statements used in the first review both to provide continuity and because of the limited time frame. We did receive feedback from some survey participants that the wording used in some questions was not appropriate for consumers.

Not all information shared with us has been reported: Although a considerable amount of information was collected this report limits its scope to the three review questions specified by MOHLTC.

Administrative data:

- *Comparisons with the Dreezer and Dreezer Review* – This review compares data with that provided in the first review. However, it is important to note that the first review included data to 2003 and that these data related to the time when the program was newly implemented and inclusion of CTO data in the CDS was not mandated until 2005. Therefore increases such as in the number of CTOs issued may not be as large as they appear.
- *Generalizability of regional data* – A number of databases provided for the review were specific to a given LHIN or other sub-region of Ontario. In some cases, several of these sub-region databases have been included in the report, at least allowing for analysis from multiple sub-

regions. However, some data were only provided by a single sub-region. The degree to which the data found in a sub-region holds for the population of CTO consumers across Ontario is not known.

- *Conflicting findings* –Different databases revealed different findings. In cases where data sources differed, conflicts have been noted and reasons for differences have been presented, where possible. Data are presented in a way that identifies their source.
- *Comparability of data over time or between regions* – Where possible, the data presented in the earlier review (Dreezer and Dreezer) have been updated in this review. However, in some instances the comparability of the current administrative data to previous data is not perfect. Often data were not collected in the same manner. Also, previous data were broken into seven MOHLTC regions of Ontario. The current data is broken into 14 LHINs. All reasonable efforts have been made to reconcile data. For a description of how the seven regions were mapped onto the 14 LHINs, see Appendix C.

SECTION 3: LITERATURE REVIEW

This section of the report provides an update on the literature that has been published since the first legislated review of CTOs. A bibliography is provided in Appendix F.

3.1 Demographics of Consumers

There have been a handful of studies on CTOs in the Ontario context (O'Brien, 2005; 2009, Hunt, 2007). Each of these studies contained some demographic information, which has been compiled. In these studies, 50% of CTO consumers were female and the most common diagnosis for consumers on a CTO was schizophrenia at 73% (n=333), a condition which reportedly affects one percent of Ontarians.[8] Many (29% to 50%) of the consumers had co-morbidity with some form of substance abuse and most were never married, or were divorced (O'Brien, 2005; 2009). Ontario demographic figures mirror those from other international jurisdictions (Gibbs, 2005, Segal, 2006a; b). One Ontario study (O'Brien, 2005) indicated that 56% of CTO consumers lacked the capacity to consent to their CTO. Of the consumers requiring a SDM, 85% had a family member provide consent and the remaining 15% used the PGT. Studies examining the demographics of mental health consumers issued a CTO also identified histories of contact with law enforcement, perpetrating violence, substance abuse, and a high rate of hospitalization as significant factors in the use of CTOs (Swartz, 2006).

3.2 CTOs and Schizophrenia

The majority of CTOs issued in Ontario (Hunt, 2007; O'Brien, 2005; 2009) and other jurisdictions (Gibbs, 2005; Segal, 2006a) have been for people with schizophrenia. People with schizophrenia can have difficulty thinking logically, telling the difference between real and unreal experiences, and can behave inappropriately in social situations. Symptoms of schizophrenia can include hallucinations, delusions, loose associations, social isolation and bizarre behavior (DSM-IV-TR, 2000). Schizophrenia has an identified genetic component but manifestation is also linked to environmental variables.

Accepted medical treatment for schizophrenia revolves around taking antipsychotic medication (Allen, 1996), either orally or provided in long acting injections, in conjunction with other services such as cognitive behavioural therapy and social support. Side effects of these medications may include: sedation, dizziness, weight gain, restlessness, slow movements, tremors (Dolder, 2008), and sexual dysfunction (Smith, 2002). Medications may also lead to the serious movement disorder tardive diskinesia, although the risk of this side effect is greater with first generation antipsychotics (Miyamoto, 2012).

One of the most difficult aspects of schizophrenia is that up to one-half of individuals diagnosed do not believe that they are ill or need treatment, and more than one-half of people given antipsychotic drugs do not adhere to the treatment prescribed (McEvoy, 2004; McIntosh, 2006). Lack of adherence to medication increases the risk of suicide three-fold (Hawton, 2005). Long acting injections of antipsychotic medication, administered every two to four weeks (depending on the drug) (Aldrige, 2011), may help improve adherence to medication regime (McEvoy, 2004). However, relapses may still occur when a consumer does adhere with their medication regime (Link, 2008). Studies showed that

[8] http://www.schizophrenia.on.ca/about-schizophrenia/3-about-schizophrenia/3-who-gets-schizophrenia.html?active=1

symptoms at the time of admission (Haas, 1998) and long-term outcome (Harrigan, 2003) were better for people after shorter durations of untreated psychosis than for those where treatment was delayed.

3.2.1 Effects of Non-Adherence

Failure to adhere (comply) to medication by people diagnosed with schizophrenia may have serious consequences. Non-adherence to medication increases the risk of deterioration of mental health function and may increase the risk of victimization, substance abuse, reduced life satisfaction, and violence (Ascher-Svanum, 2006). It is also associated with relapse, psychotic symptoms, hospital admissions (Morken, 2008), and increased risk of suicide (Novick, 2010).

Not only is adherence to medication important to help prevent relapse, but psychosis may be a feature resulting from withdrawal of the anti-psychotic medication Clozapine and not a re-emergence of the underlying illness (Moncrieff, 2006).

3.2.2 Alternative Treatment

While psychotic symptom management through medical intervention is the treatment traditionally recommended by physicians, some view refusal of treatment as a valid option and a constitutional right (Buchwald, 1986). Studies on the psychosocial treatment of schizophrenia showed that family therapy may help decrease the risk of relapse, while cognitive behavior therapy may reduce hallucinations and delusions (Bustilo, 2001; Lewis, 2005). The addition of a physical component to therapy, such as yoga, may also help improve symptoms (Duraiswamy, 2007).

3.3 Effectiveness of CTOs

When evaluating the effectiveness of a health care service intervention, clinical experiments using randomized controlled trials (RCT) provide the highest standard of evidence. However, RCTs are not always possible due to the ethical and moral implications of withholding possibly important treatment options from study subjects. For this reason there have only been two RCTs of CTOs (Steadman, 2001; Swartz, 1999), both of which were analyzed in the review papers by RAND Corporation and the Cochrane Collaboration and subsequently described in the Dreezer and Dreezer report. The Cochrane Collaboration review was updated in 2011; however, no further RCTs were available to be added to the review (Kisely, 2011).

The Cochrane Collaboration review concluded that there was no evidence that CTOs were effective as CTO consumers did not experience any significant differences in service use, social functioning, or quality of life compared to control groups. The number of patients “needed to treat” to prevent one hospital admission was eighty-five, and two hundred and thirty-eight to prevent one arrest. The review did find that CTO consumers were less likely to be victims of crime, both violent and non-violent (Kisely, 2011).

Since the previous legislated review of CTOs no new RCTs have been conducted; however, there have been a small number of quasi-experimental studies that have looked at the effectiveness of CTOs in Ontario, as well as similar legislation in other jurisdictions. These studies have typically used administrative data to perform mirror image tests where individuals act as their own control, or have been case controlled studies where the control group is individuals not on CTOs, but with similar

demographic profiles and clinical diagnoses as the consumers receiving mandated treatment. Studies have used several different outcome measures to assess the effectiveness of CTOs and at times results have been contradictory. The outcome measures used are outlined below and summarized by study in evidence tables provided in Appendix G. Some pitfalls of this type of experimental design as well as caution in the interpretations of results obtained will be provided later (Section 3.4).

3.3.1 Quality of Life

Although there is little empirical evidence regarding improved quality of life in mental health consumers issued a CTO there have been several qualitative studies that outline consumer perspectives of CTOs. These studies have outlined both positive and negative perceptions of consumers regarding their CTOs.

Positive Consumer Perspectives
Qualitative studies have shown that many positive consumer perceptions of CTO are associated with positive outcomes such as increased supports and access to services (Gibbs, 2005), employment, self-perception of improved mental health and positive social interactions with friends and family (Schwartz, 2010). Consumers also viewed the CTO as positive when it came as an alternative to inpatient treatment (Gibbs, 2005; O'Reilly, 2006). Often, consumers who had been on CTOs for longer periods of time gained insight into the benefits of mandated treatment (Gibbs, 2005).

Negative Consumer Perspectives
The most common negative perception of being on a CTO was the aversion to feeling controlled. Specifically, many CTO consumers did not like being mandated to adhere to their medication regime (Schwartz, 2010) or having reduced input into their medication (Gibbs, 2005). In addition, some CTO consumers had negative feelings about the restrictions placed on their travel and choice of living accommodations (Gibbs, 2005).

Many consumers also had negative perceptions of being defined as mentally ill and identified both professional and community based stigma (Schwartz, 2010). Sources of professional stigma included depersonalization through diagnostic language and paternalistic ideology from service providers. In the community, CTO consumers felt stigma from the label of mental illness, the perception of increased scrutiny, and isolation (Schwartz, 2010). Many consumers also identified some form of coercion while on a CTO (O'Reilly, 2006).

Despite these negative perceptions, only a minority of CTO consumers in the studies were strongly opposed to their treatment order, and most saw it as a helpful step towards stability and independence (Gibbs, 2005; O'Reilly, 2006).

Homelessness
Another problem for individuals with severe mental illness is homelessness (Folsom, 2005). Individuals with severe mental illness are more likely to experience periods of sustained homelessness than the rest of the population (Folsom, 2005).

A study of CTO case notes in Australia showed a reduction in the number of episodes of homelessness experienced during the CTO period compared to the period prior to being issued a CTO (Ingram, 2009). Similar results were described by a study of CTO consumers in Ottawa, Ontario that showed CTOs increased the use of supportive housing in consumers (O'Brien, 2005).

3.3.2 Hospital Utilization Rates

One of the aims of CTO legislation was to improve outcomes and reduce the dependence on hospitals by mental health consumers who have showed a history of non-compliance with voluntary treatment options. By mandating treatment in the community, CTOs aim to reduce the number of admissions to hospital and reduce the length of hospital stay when they are necessary.

Hospital re-admission rates
Several quasi-experimental studies have compared the number of hospital admissions before and after a CTO was issued, or between CTO users and similar individuals not issued a CTO. Many of these studies showed that consumers who received a CTO had a reduction in the number of hospital admissions (Segal, 2006b, Hunt, 2007, Kallapiran, 2010).

In a study of Ontario health care consumers, the frequency of admission to the hospital was significantly lower in the CTO group than the comparison group (Hunt, 2007). However, this study only evaluated the effectiveness of the order while it was in place and did not examine whether this pattern was sustained once the order was lifted.

In a study of the Victorian (Australia) Psychiatric Case Registry, the number of hospital admissions for CTO consumers was significantly lower during a CTO in a case controlled study; however there was also a similar reduction in the number of hospital admissions in the comparison group (Segal, 2006b). Another study in Victoria showed that consumers on their first CTO were more likely to be readmitted to a hospital than a similar consumer without a CTO; however, consumers who had been issued more than one CTO were less likely to be readmitted (Burgess, 2006). The researchers suggested the difference could be attributed to increased insight, and improved cognitive reasoning, by consumers who have greater experience with CTOs or by increased monitoring of first time CTO recipients resulting in quicker identification of relapse.

Length of Hospital Stay
Another variable that may be considered when evaluating hospital utilization rates is the length of hospital stay for each admission. Studies of the Victorian Psychiatric Case Registry showed a reduction in the duration of hospital stays for consumers who have received a CTO (Segal, 2006a; b; 2009; Hunt, 2007, Kallapiran, 2010). However, further analysis of the Victorian Psychiatric Case Registry showed no significant difference in the reduction of inpatient days between the CTO and comparison group (Segal, 2006b). Possible confounders in comparing this trial to others of CTOs are that it used a sub-sample of CTO consumers (who had been receiving outpatient treatment for more than 180 days).

Time to Readmission
The time between the issue of a CTO and readmission to hospital may also help inform the effectiveness of the program. A study in Montreal, Canada using administrative data for mental health consumers on a CTO, showed the longest period of time between admissions came directly after a CTO was issued (Frank, 2005).

3.3.3 Participation in Community Services

One of the benefits of a CTO is that it provides consumers with the opportunity to access services in the community where they can form connections that may help to prevent, or quickly identify, a relapse.

A study of CTOs issued in Ottawa, Ontario from the Royal Ottawa Mental Health Centre and the Montfort Hospital showed an increase in the mean number of services consumers with CTOs accessed after consenting to a CTO and 80% of CTO consumers sampled (n=84) showed an increase in the number of community based services accessed (O'Brien, 2009). Another Ontario study conducted in Toronto, found consumers on a CTO were less likely to continue to participate in services a year after discharge than those in the comparison group; however, approximately three-quarters of consumers exiting a CTO remained engaged with community services (Hunt, 2007).

Researchers believe that the trend away from the use of voluntary services by consumers with expired CTOs may be driven by '…a subgroup of individuals on CTOs who are more likely to disengage from treatment when they are given the chance to do so. Conversely, there is also evidence for another group of CTO clients who do continue to engage in formal community support of their own choice.' In this study, 64% of consumers voluntarily remained with case management after the expiration of their CTO (Hunt, 2007). What researchers identified as unclear in this study was whether the CTO helped people with schizophrenia learn to manage their medication and improve their own insight or if it helped to build a support system within their community (Hunt, 2007).

A study of the Victorian Psychiatric Case Registry in Australia showed that consumers on a CTO were more likely to access services while on a CTO. However, the services accessed were involuntary, and there was no difference in services accessed post-CTO between CTO and non-CTO groups (Segal, 2006b).

3.3.4 Risk to Self and Others

When left untreated, serious mental illness can diminish insight as well as cognitive functioning (Geller, 2000). The great majority of consumers of mental health services are not violent or more dangerous than other individuals (Torrey, 1994). There are, however, small subgroups (especially those with positive psychotic symptoms such as hallucinations or delusions) that are more likely to be dangerous (Swanson, 2008). Factors such as a history of violence, drug/alcohol abuse, and non-adherence to medication and the absence of contact with a mental health professional bring with them an increased risk of future violence (Torrey, 1994; Swanson, 1997). A Danish longitudinal birth cohort study which followed all individuals born between 1944 and 1947 until age 44 showed that 2.2% of men in the cohort had been hospitalized at sometime for severe mental illness (Brennan, 2000). These individuals were responsible for 10% of violent crime committed during the study period (Brennan, 2000).

A mirror image study of CTOs in South Australia showed a significantly reduced rate of offending per person (50% reduction) and of violent offending per person while on a CTO as well as in the year following discharge compared with the year before being issued a CTO (Hough, 2005). The same study showed that 69% of people on a CTO did not commit an offence during any of the study period (before, during and after CTO) and 88% did not commit a violent offence (Hough, 2005). A study of assisted outpatient treatment in New York State showed that the odds of perpetrating a violent crime were four times higher in the comparison group and that those on a CTO had a reduced number of episodes of

aggression while on the order (Phelan, 2010). These results are further supported by a qualitative study from London, Ontario that showed a reduction in police contact time, during a CTO (Corring, 2010).

Persons with serious mental illness also have higher mortality rates than the general population (Felker et al, 1996). Increased mortality may be due to lack of connection with primary care, or side-effects of medication. Through more frequent contact with mental health service providers a CTO may provide protective oversight that will help to identify a relapse or other problem more quickly.

A study from Australia compared Victorian Psychiatric Case Registry records for individuals released from hospital on a CTO with individuals released unconditionally. Individuals on a CTO had a 14% decrease in their risk of non-injury related mortality (Segal, 2006c). A New York State study also showed a lower risk of suicide in the mandated outpatient treatment group (Phelan, 2010).

The reduced mortality rate for those on a CTO may be interpreted as a justification to the loss of autonomy experienced by consumers. '…civil libertarians see outpatient commitment as an invasion of privacy that should be allowed only for the most extreme cases. These results, however, may suggest that failure to use conditional release in less severe cases may be viewed as withholding an intervention that could save lives' (Segal, 2006c).

A gender difference in mortality rates has been shown. The Victorian Psychiatric Case Registry study showed an overall decrease in mortality for those on CTOs, however, men on CTOs were more likely to die than men not on a CTO. Women, on the other hand, had a lower risk of death when on a CTO (Segal, 2006c). Authors of the study speculated that '…women may adapt better to the dependent situation of conditional release and thus benefit most from its oversight.'

3.4 Assessing Effectiveness of CTOs

Despite a large number of studies conducted over the past few decades, the evidence for the effectiveness of CTOs remains weak. The two RCTs conducted and subsequently reviewed by RAND and the Cochrane Review group showed little to no evidence for the effectiveness of this type of legislation. The problems with these studies were well identified by Dreezer and Dreezer.

More recent literature published on the subject has consisted of studies with less rigorous experimental design. The problems with studies investigating the effectiveness of CTOs have been well documented in Dr. O'Reilly's recent book chapter, Research on Community Treatment Orders, in Applied Research and Evaluation in Community Mental Health Services (Vingilis, 2011). A summary of the limitations of recent studies, taken from this chapter, is outlined below.

3.4.1 Mirror Image Design

In a mirror image experimental design those receiving an intervention serve as their own control. This design may also be referred to as a before-and-after study. One benefit of this type of study is that since each individual serves as their own control, the subject match is perfect. However, these types of studies can be confounded by temporal effects. Another possible pitfall of a study using a mirror image design is that results may be misleading due to a phenomenon known as regression to the mean. Those being issued CTOs are likely at a low point in their mental wellness as CTOs are typically a last resort for those who have a history of non-adherence to treatment. This raises the possibility that, just by chance

alone, their mental health will improve during the period that they are on the CTO. The fact that mirror image design uses each individual as their own control makes this impossible to identify.

3.4.2 Case Controlled Studies

In a case controlled experimental design, individuals who have received an intervention are matched based on demographic variables to a control group that is not receiving the intervention. For some variables, such as gender, or age, matching is simple. Other demographic variables, such as clinical diagnosis are more difficult to match. In evaluating CTOs it has been argued that consumers on CTOs form a group for which a naturalistic control group may not be possible to identify (Kallapiran, 2010; Kisely, 2006). This may be because consumers of CTOs are compelled to treatment due to repeated lack of adherence to treatment in the past. It may be the underlying causes of non-adherence to treatment that defines this group and makes it impossible to replicate with non-CTO consumers for whom the legislation is not necessary.

3.4.3 Jurisdictional Differences

No two jurisdictions with CTOs are completely alike. Each jurisdiction has differences in legislation. CTOs may be issued by psychiatrists or court-mandated. They may be least restrictive or preventative or a combination of the two. CTOs may be solely for inpatients who meet the criteria for involuntary committal. They may apply to any consumer of mental health services. They may require consumer consent or they may be mandated. Further, the community treatment options available may be different from one region to the next. These differences make comparisons of studies from one jurisdiction to another difficult, or even impossible.

3.4.4 Type of Data Needed to Validate CTOs

RCTs for this type of intervention may not be possible in the future. Ethical and moral implications to providing different mental health treatment to different study groups are both illegal and abhorrent to most researchers. Further, it is potentially unsafe to release untreated mental health consumers who are known to be a risk to themselves or others back into their communities when it is known they will not receive treatment voluntarily. For these and other reasons, it is unlikely that there will be any RCTs conducted in the near future (O'Reilly, 2006).

Another pitfall of research on CTOs is the lack of a standard by which success is measured. For example, a reduction in hospital admissions is an objective of CTOs. However, an admission could be a benefit if it means that mental health care service providers quickly identify a relapse as delays in treatment may result in worse symptoms and require more intensive intervention.

There should also be a distinction made between efficacy (does a CTO work under ideal settings) and effectiveness (do CTOs work in practice). Most studies use administrative data, which tests the latter (Frank, 2005). However, administrative data is collected for administrative purposes and may not be appropriate for research. Administrative data can also contain incomplete or duplicate records which could alter the results. Caution should therefore be used when interpreting studies that have used administrative data.

Finally, studies on long-term post-CTO outcomes have not been performed. Most published studies only deal with the time before, during and, at times, a year after the CTO. As CTO legislation has been in

place in Ontario for almost twelve years it is advisable to pursue follow-up research of consumers when possible. It is important to know how many people need a CTO for a short period of time, until they gain insight, and the number of consumers who will stop treatment as soon as the order is lifted.

3.5 Coercion

Coercion is considered by some to exist in mental health care services forming a hierarchy of treatment pressures that increases from persuasion, leverage, inducement, threat to compulsion (Molodynski, 2010). Typically coercion, in the form of threats and compulsion, is used as a last resort (Molodynski, 2010). The judicious use of coercion is viewed by proponents as a means to facilitate treatment engagement (Torrey, 2001). Coercion in the form of compulsory treatment can lead to (and may be a requirement to achieve) clinical improvements (Link, 2008). However, consumer perceptions of coercion may have detrimental effects on treatment. Coercion may lead to increased feelings of devaluation and discrimination, which leads to lower self-esteem (Link, 2008). It may also have treatment effects, such as delaying, or preventing, mental health consumers who are suffering a relapse from seeking help (Swartz, 2003).

The sense of control by others and the loss of freedom and coerced adherence to medication and unpleasant side effects were disadvantages noted by CTO consumers in a New Zealand study (Gibbs, 2005). While there is less coercion in the Ontario context, due to the requirement that consumers or their substitute decision-maker consent to treatment, it does exist (Dreezer, 2005). By leveraging involuntary admission to the hospital against consent to a CTO, psychiatrists are mandating treatment but allowing consumers to determine the location at which treatment occurs.

3.6 Stigmatization

In a recent review (2001), Link and Phelan identify stigma as being present '…when elements of labeling, stereotyping, separation, status loss and discrimination occur together in a power situation that allows them.' Consumers of mental health services will often feel stigma from being identified as mentally ill. Being issued a CTO may increase feelings of stigmatization by legally defining an individual as mentally ill. Feelings of stigma may reduce the effectiveness of treatment or cause a consumer to discontinue treatment.

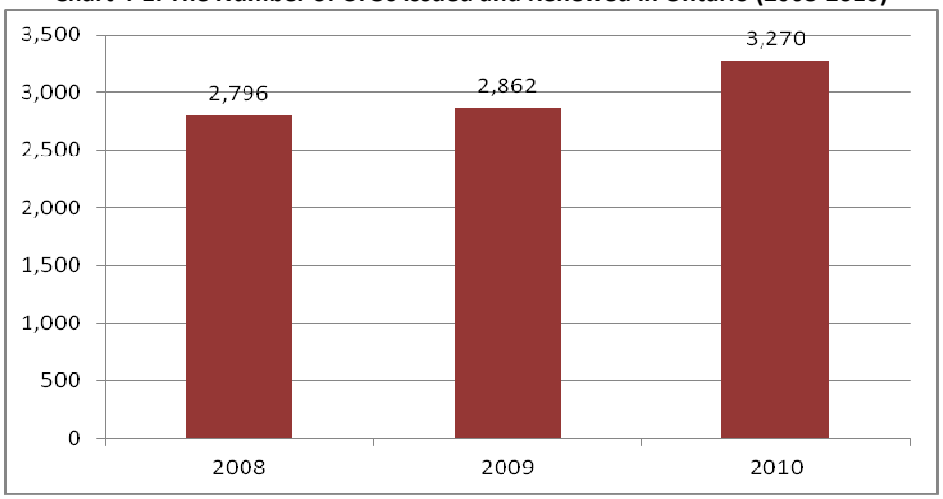
SECTION 4: USE OF CTOs DURING THE REVIEW PERIOD

The number of CTOs issued, reissued and renewed has steadily increased since 2001. Most CTOs were issued by physicians at hospitals or in ACT Teams. CTOs were most commonly issued to people with schizophrenia or schizoaffective disorder, or bipolar disorder.

4.1 Numbers of CTO Issued

In the first review, Dreezer and Dreezer reported that the number of CTOs issued had grown substantially over the first few years of implementation. In 2001, only 109 CTOs were issued or renewed. By 2003, that number had risen to 459. However, the data in the first review were likely to not reflect the total numbers of CTOs issued as submitting data to the CDS was not mandated until 2005. The CDS suggests that growth has continued since that time.[9] As of 2010, over 3,200 CTOs were issued or renewed in Ontario (Chart 4-1).[10] This equates to approximately one in 76 Ontarians who access provincial mental health services being issued a CTO (1.3%).[11] When considering Ontario's population as a whole, the prevalence of CTOs (issues or renewals) has risen from an estimate of less than five per 100,000 in 2003 to 36 per 100,000 in 2010/11.

Chart 4-1: The Number of CTOs Issued and Renewed in Ontario (2008-2010)



Source: Common Data Set Mental Health (CDS-MH)

[9] Another data source, the CTO Information Record database, suggests that the number of CTOs peaked in 2008 at 2014 CTOs and has slid substantially in the succeeding years (to 1214 in 2010). The researchers have heard from various stakeholders that this database suffers from a lack of reporting and the observed downturn is more likely the result of information not being entered, as opposed to a reduction in the number of CTOs being issued. The researchers have thus opted to report the data from the common database. The finding that CTO usage has continued to grow is supported by other databases, such as the PPAO data reported in section 6.4.1.

[10] Other data sources again contradict the number of CTOs being issued. The OHIP billing code data, though used in this report to understand CTOs in terms of regional and gender breakdowns, estimates a much lower number of CTOs. Researchers have also heard that this database suffers from inconsistent reporting and thus the central database is preferred.

[11] The 1.3% rate is calculated from 8,928 CTOs among 681,801 mental health service recipients between 2008/09 and 2010/11.

Estimating the actual number of CTO consumers at one time is difficult. For example, one consumer may be issued a CTO in 2001, then renewed every six months thereafter, while another consumer may be issued multiple CTOs per year due to CTOs lapsing (missing their renewal deadline of one month after the end of a CTO). Regional data provided that estimates the number of unique CTO consumers within a jurisdiction suggest that CTO usage has grown steadily since 2005 (Table 4-1).

Table 4-1: Number of Unique CTO Consumers during Review Period at Select LHINs

	Number of Unique CTO Consumers						
LHIN/Region	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Brant and Haldimand/Norfolk					7	14	22
Champlain	100	100	120	139	173	160	
Hamilton		66	93	123	143	180	207
Toronto	129	147	160	193	211		

Source: Brant Source, Champlain Source, Hamilton Source, and Toronto Source.

4.1.1 Regional Variation in Implementing CTOs

When regional data were examined, variation in the proportion of people seeking mental health services was seen along with variation in the number of CTOs issued, reissued or renewed each year. Doubts around the quality and quantity of administrative data from all LHINs in all years prevented accurate assessment of regional differences in CTOs implementation. For example, one LHIN reported the unlikely case of 328 CTOs in 2008/9, then down to 49 in 2009/10, and then back up to 428 in 2010/11. A detailed table of reported CTOs by LHIN is appended (Appendix H).

Table 4-2 shows the reported use of CTOs per 100,000 population for each LHIN (and earlier region). South East reported the most CTOs relative to its population. In 2010/11, 119 CTOs were reported issued or renewed per 100,000 adult citizens. Again, it is important to note that observed differences may reflect differences in documenting CTOs (providing data to the MOHLTC) rather than actual differences in usage.

Despite the uncertainty over data quality and quantity, there is a definite long term trend towards increased use of CTOs that is true of all LHINs. The ratio of CTOs as a proportion of citizens has increased significantly.

Table 4-2: CTOs (Issues and Renewals) by LHIN and Region per 100,000 Population (2003 and 2010/11)

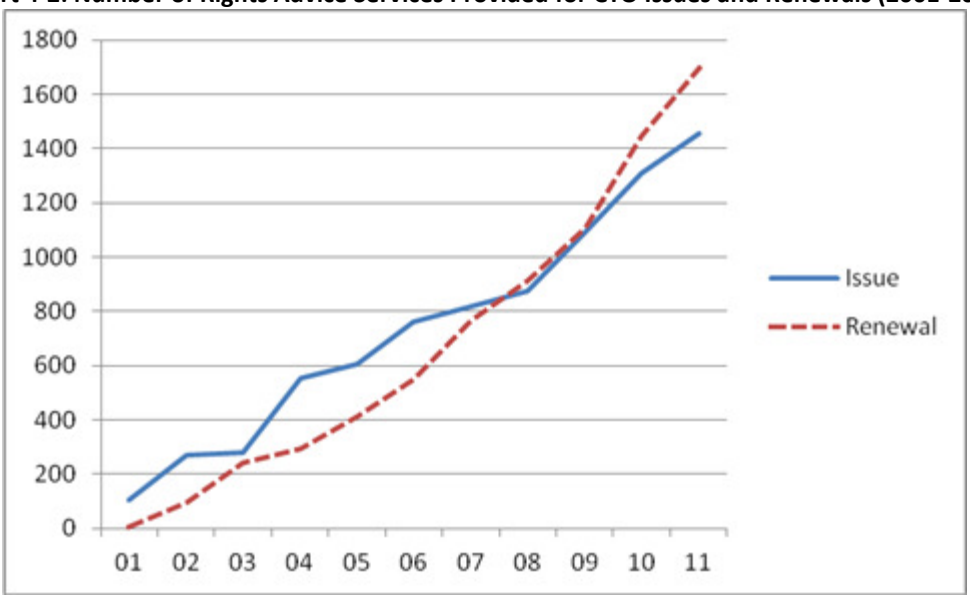
First Legislated Review		Second Legislated Review	
Region	CTOs/100,000 (Pop +15)	LHIN	CTOs/100,000 (Pop +20)
Central East	1.83	Central	19.5
		Central East	29.8
Central South	1.53	Hamilton Niagara Halidimand Brant	13.9
Central West	2.91	Central West	19.9
		Mississauga Halton	7.6
		Waterloo Wellington	57.0
East	5.16	Champlain	26.9
		South East	119.3
North	10.35	North East	66.4
		North Simcoe Muskoka	80.9
		North West	65.1
Southwest	4.77	Erie St. Clair	34.3
		South West	29.0
Toronto	7.07	Toronto Central	55.1
2003 Total	**4.54**	**2010/11 Total**	**35.9**

Sources: CDS-MH (CTO data) and Ministry of Health and Long-Term Care (Population data extrapolated from 2006 Census) for Second Legislated Review; Dreezer and Dreezer Report for First Legislated Review (CTO data from CTO Information Record; population data from Ministry of Finance, 2004).
Note: The Dreezer and Dreezer Report mistakenly reported 4.54 per 10,000 Ontarians in 2003. The correct figure was 4.54 per 100,000 Ontarians.

4.1.2 Type of CTO

CTOs may be first issues or renewals and no robust province-wide data were available to differentiate accurately between first issues, reissues and renewals. The PPAO data were able to provide a sense as to the ratio of issues versus renewals. In Chart 4-2 the number of rights advice services provided for CTOs issues and renewals over time is illustrated. It is not surprising that there were few renewals at the outset of CTOs in Ontario. However, over the past decade the number of advice services provided for renewals has surpassed the number provided for issues.

Chart 4-2: Number of Rights Advice Services Provided for CTO Issues and Renewals (2001-2011)



Source: PPAO.

4.1.3 Where CTOs are Originating

For the most part CTOs originate from their respective mental health case management services, followed by ACT Teams, and counseling and treatment (together accounting for 80% of CTOs). However, these proportions differ by year and at the LHIN level (Appendix H). These data on CTOs are perhaps more linked to who provides the data to the CDS and the preferences of physicians in a region than the services available in a region.

The ability to understand the referral source of CTOs was limited by the data available. Data about referral source were provided for two sub-regions, both of which recorded the information differently. For instance, the database from Champlain records referrals based on active CTOs, while the database from Toronto records referrals based on unique consumers. Not surprisingly, both datasets highlight the importance that hospitals directly play in referring mental health consumers for CTOs. The Champlain dataset suggests an interesting trend towards an increasing proportion of CTOs originating from outpatient services (Table 4-3). Perhaps this trend reflects the growing proportion of renewals relative to issues. Due to the differences in recording referral source, the data from Toronto cannot confirm this finding.

Table 4-3: Referral Source for All Active CTOs (Issued and Renewed), Champlain (2005/06-2009/10)

Referral Source	2005/06 (n=83)	2006/07 (n=94)	2007/08 (n=120)	2008/09 (n=134)	2009/10 (n=150)
Hospital - Inpatient	80%	71%	72%	50%	50%
Hospital - Outpatient	18%	22%	16%	39%	44%
Community	2%	6%	12%	11%	6%
Missing	*0%*	*0%*	*1%*	*0%*	*0%*

Source: Data provided by Champlain source.

4.2 The Characteristics of Consumers using CTOs

According to review participants, the typical CTO consumer tends to have a history of hospitalization and is unwilling to adhere to medication.

> *That is the profile of someone who is on a CTO, someone who has great difficulty tolerating the anti-psychotic medication which generally causes them to be non-compliant. It's not the people or their illness, it's the drugs, and how well they're tolerated by a particular person in this position. - Stakeholder*

4.2.1 Age and Gender

Based on administrative data, the majority of CTOs were issued to males under 45 years of age (Table 4-4). This finding is consistent with the literature. Consumers older than 45 years were more likely to be female. This relationship between age and gender may be weakening over time as the proportion of men in the upper age brackets has increased during the timeframe of the second review.[12]

Table 4-4: Consumer Gender and Age for All CTO Forms Submitted to OHIP (2002-2009)

	2002-2005			2006-2009		
Age Group	**% Female**	**%Male**	**Total**	**% Female**	**% Male**	**Total**
15-19	37%	63%	83	45%	55%	40
20-44	30%	70%	1439	26%	74%	1594
45-64	66%	34%	936	57%	43%	947
65-74	72%	28%	134	60%	40%	168
75+	65%	35%	143	58%	42%	136
Grand Total	**47%**	**53%**	**2735**	**40%**	**60%**	**2885**

Source: OHIP.

There also appears to be a relationship between gender and the type of CTO. When looking at OHIP the majority of CTO issues (OHIP code K887, CTO initiation) were for male consumers (Table 4-5). However, females were more prevalent among renewals (OHIP code K889).

[12] This finding is based on OHIP data, which is known to be incomplete. Support for this finding can be found by looking at the regional data provided by Toronto. These data show that 47% of CTO consumers aged 15 to 40 were female; while for CTO consumers over 40, 63% were female.

Table 4-5: CTO Forms Submitted by Gender of Consumer (2002-2009)

CTO Fee Schedule Code	Consumer Gender	2002-2009
Initiation (K887)	Female	41%
	Male	59%
	Total Initiations	1,920
Supervision (K888)	Female	42%
	Male	58%
	Total Supervisions	2,902
Renewal (K889)	Female	53%
	Male	47%
	Total Renewals	798
All CTO OHIP Codes	**Female**	**43%**
	Male	**57%**
	Total Forms	**5,602**

Source: OHIP.

The OHIP data also shows differences between LHINs and the gender of CTO consumers (though the results should be viewed with caution because as stated previously the OHIP data is considered incomplete and numbers are small for some LHINs (Table 4-6).

Table 4-6: Consumer Gender by Region for All CTO Forms Submitted to OHIP, 2002-2009

LHIN	% Female	% Male	Total
Central	57%	43%	961
Central East	41%	59%	431
Central West	14%	86%	122
Champlain	48%	53%	1,360
Erie St. Clair	51%	49%	67
Hamilton Niagara Haldimand Brant	23%	77%	405
Mississauga Halton	53%	47%	192
North Simcoe Muskoka	38%	62%	149
North East	86%	14%	28
North West	94%	6%	33
South East	15%	85%	13
South West	50%	50%	155
Toronto Central	36%	64%	1,658
Waterloo Wellington	37%	63%	38
Unknown	88%	13%	8
Ontario	**43%**	**57%**	**5,620**

Source: OHIP.
Note: Totals are number of K887 (CTO Initiation), K888 (CTO Supervision), and K889 (CTO Renewal) forms submitted by physicians. The figures are consistently lower than the total number of CTOs initiated and renewed reported in the CDS-MH and PPAO reports.

4.2.2 Diagnosis

According to data from Toronto, one-third of CTO clients had been hospitalized three or more times in the two years prior to being issued a CTO. The majority of CTO consumers were diagnosed with schizophrenia or another psychotic disorder. From the data available there appeared to be variation between regions about other illness information/issues recorded (Table 4-7).

Table 4-7: Diagnoses, Illness Information and Other Issues for CTO Consumers

Hamilton (Consumers active 2010/11, n=180)	**Illness Information / Issues**	**% of CTO consumers**
	Referred from area serving individuals with schizophrenia and other psychotic disorders	89%
	Threat to others/attempted suicide	77%
	Substance Abuse / Addiction Issues	59%
London (Consumers active 2000-2012, n=657)	**Primary Diagnosis**	**% of CTO consumers**
	Schizophrenia	63%
	Schizoaffective disorder	17%
	Bipolar disorder	13%
	Other Psychotic disorder	5%
	Other	1%
Toronto (Consumers active 2005/06-2010/11, n=378)	**Primary Diagnosis**	**% of CTO consumers**
	Schizophrenia or Other Psychotic Disorder	65%
	Mood Disorder	26%
	Unknown or Service Recipient Declined	8%
	Anxiety Disorder	0%
	Personality Disorder	0%
	Other Illness Information / Issues	**% of CTO consumers**
	Threat to others/attempted suicide	13%
	Substance Abuse / Addiction Issues	11%
	Dual Diagnosis (Development Disorder)	3%
Ontario (All CTOs 2000-2003, n=937)	**Psychiatric Diagnoses (more than one may apply)**	**% of CTOs**
	Schizophrenia	67%
	Schizoaffective Disorder	15%
	Bipolar Disorder	13%
	Substance /Alcohol Abuse Disorder	5%
	Other Disorders	4%
	Other Psychotic Disorder	3%
	Personality Disorder	3%
	Depression	2%
	Development Disorder	1%

Source: Hamilton, London and Toronto data provided by Hamilton Source, London Source and Toronto Source respectively; Ontario data from Dreezer and Dreezer Report.

4.2.3 Socio-Demographic Profile

The ethnicity, education, primary income and language of CTO consumers could be examined through the Toronto dataset but these data were not available province-wide. Thus the findings here, although informative, may not be true of CTOs in Ontario, in general.

CTO consumers in Toronto were generally representative of their city's diversity (Table 4-8). The notable exception would be the above average number of consumers described as 'Black'. There may also appear to be a modest below-expected number of South Asian CTO consumers. Not included in this table is that less than 1% of consumers were Aboriginal. However this should not be surprising as despite having the largest number of Aboriginals in any Ontario city, only 0.5% of Toronto's population identifies as Aboriginal.[13]

Table 4-8: Ethnicity of Active CTO Consumers in Toronto (2005/06 to 2010/11)

Ethnicity	% of CTO consumers (n=378)	Ethnicity	% of Toronto CMA
Caucasian	55%	Non-Visible Minority	57%
East Asian	13%	Chinese + Japanese + Korean	11%
Black	13%	Black	7%
South Asian	10%	South Asian	14%
Other Visible Minority	5%	Other Visible Minority	10%
Latin/Hispanic	2%	Latin American	2%
Unknown	2%	Unknown	<1%

Source: CTO data provided by Toronto Source; demographic data from Ontario Ministry of Finance (based on 2006 Census).[14]
CMA stands for Census Metropolitan Area.

In terms of linguistic profile, English was the primary language of 73% of Toronto CTO consumers (2005/06-2010/11). Moreover, it was the preferred language for service of 90%. Although English was the dominant language, this finding means that 27% of CTO consumers' ability to communicate in English may be limited as it is their second language, and 10% may require services in another language.

Toronto CTO consumers generally had lower levels of educational achievement than the Toronto workforce. Two-thirds of Toronto's labour force had post-secondary education, compared to 37% of CTO consumers (Table 4-9). This low rate of post-secondary attainment is likely in part due to the age of onset of schizophrenia often impacting on successful participation in the education system.

[13] 2006 Census. http://www.statcan.gc.ca/pub/89-638-x/2009001/article/10825-eng.htm
[14] http://www.fin.gov.on.ca/en/economy/demographics/census/images/cenhi06-11-5.gif

Table 4-9: Highest Education Level of Toronto CTO Consumers (2005/06-2010/11, n=378)

Level of Education	% of CTO Consumers	% of Toronto CMA
Post-Secondary	37%	64%
Secondary	44%	27%
Primary	15%	7%
Less than Primary	1%	2%
Unknown or Service Recipient Declined	3%	<1%

Source: CTO data provided by Toronto Source, demographic data from Statistics Canada – Labour Force Survey.[15]

CTO consumers can be considered to be a financially at risk group. Three-quarters of consumers in Toronto required some form of social assistance, while only 8% had an independent source of income.

Table 4-10: Primary Income Source for CTO Consumers as of Admission Date (2005/06-2010/11, n=378)

Baseline Primary Income Source	Total
Disability support (e.g. Ontario Disability Support Program, CPP Disability Benefits)	65%
Employment insurance (e.g. EI, Private Insurance, Ontario Works)	10%
Family	8%
Independent source (e.g. Employment, Pension)	8%
No source of income	2%
Other	6%
Unknown/Declined	*2%*

Source: CTO data provided by Toronto Source

Many CTO consumers lived on their own (Table 4-11). While only data for Toronto was available for this metric, the proportion of consumers' living arrangements appears to have remained generally static over the past decade.

Table 4-11: CTO Consumer Living Arrangement prior to Program Admission

Living arrangement	2000-2003 All CTOs		2005/06-2010/11 Toronto Consumers	
	Count	%	Count	%
Self	427	44%	164	43%
Parents	203	21%	77	20%
Non-relatives	151	16%	46	12%
Spouse/partner	85	9%	26	7%
Relatives	45	5%	22	6%
Children	32	3%	16	4%
Don't Know/Missing	*25*	*3%*	*27*	*7%*
Total	968	100%	378	100%

Source: Toronto data provided by Toronto Source. Ontario data from Dreezer and Dreezer Report.

[15] http://www.toronto.ca/invest-in-toronto/labour_force_education.htm

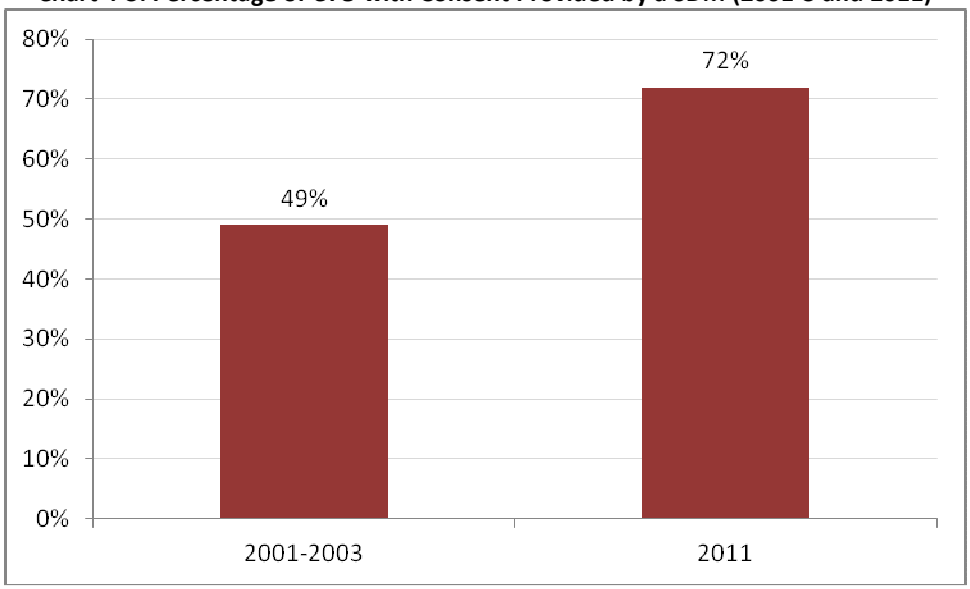
4.3 Substitute Decision-Makers (SDM)

In instances where a person is not able to understand health information about a proposed treatment and appreciate the results of treatment, and treatment options, including refusing treatment, a SDM may be appointed. Capacity is determined based on an assessment by a mental health practitioner and the criteria are set by the *Health Care Consent Act*. If a person is found to be incapable to consent to such treatment, a SDM is appointed. The SDM may be a guardian appointed by the court, a person with a "power of attorney for personal care" authorizing him or her to make health care decisions, a representative appointed by the CCB (any person may apply to the Board to be appointed as the SDM), spouse or partner, a child or parent (custodial parent if the patient is a minor), a parent who has access rights (if the patient is a minor), a brother or sister, any other relative, or the PGT (in that order).

The SDM is expected to make decisions that reflect the principles of the legislation and also to make decisions based on prior capable wishes. When these are not known, the SDM can act in best interest.

The first CTO review found that the consent for CTOs was divided fairly evenly between clients and SDMs. This appears to be no longer the case. The current data suggest that the majority of CTOs are consented to by a SDM, at 72% of all CTOs (issues and renewals) in 2011 (Chart 4-3) and this proportion may be more consistent with the original intention of the legislation. Some physicians we spoke to were of the opinion that if a consumer was able to consent to treatment, they did not need a CTO. This philosophy may explain why increasing proportions of CTO consumers have an SDM.

Chart 4-3: Percentage of CTO with Consent Provided by a SDM (2001-3 and 2011)



Source: PPAO.

The ratio between consumer consent and SDM consent varied by LHIN. For instance, Central East LHIN issued more CTOs through client consent than SDM consent. In contrast, Mississauga Halton and Waterloo Wellington issued almost all CTOs through an SDM. When changes were compared over time, all regions of Ontario have moved towards greater use of SDMs in their CTO issues and renewals (Table 4-12).

Table 4-12: CTO Consent (Issues and Renewals), by LHIN and Region, 2001-03 and 2011.

Region	2001-2003		LHIN	2011	
	Client	SDM		Client	SDM
Central East	76%	24%	Central	46%	54%
			Central East	67%	33%
Central South	55%	45%	Hamilton Niagara Haldimand Brant	24%	76%
Central West	76%	24%	Central West	16%	84%
			Mississauga Halton	6%	94%
			Waterloo Wellington	6%	94%
East	42%	58%	Champlain	21%	79%
			South East	43%	57%
North	62%	38%	North East	45%	55%
			North Simcoe Muskoka	35%	65%
			North West	17%	83%
Southwest	43%	57%	Erie St.Clair	36%	64%
			South West	8%	92%
Toronto	40%	60%	Toronto Central	22%	78%
Total	**51%**	**49%**	**Total**	**28%**	**72%**

Source: 2011 data from PPAO; 2001-2003 data from Dreezer and Dreezer Report

SECTION 5: THE REASONS THAT CTOs WERE OR WERE NOT USED DURING THE REVIEW PERIOD

Consumers' feelings about their CTOs ranged from very positive to resentful, and attitudes often related to whether or not consumers provided their own consent. The incentive of getting out of hospital was a strong motivation for consumers or their SDM to consent to a CTO. Subsequently, many consumers recognized the benefits of a CTO and the community treatment plan delivered under the CTO.

CTOs provided relatives and friends with comfort and relief by ensuring preventive support for consumers, quick assistance upon relapse, adherence to medication while reducing negative interactions with law enforcement and allowing those who are SDMs to be a part of the process.

The main reasons that consumers and SDMs resisted CTOs were the undesirable side effects from medication and the mandatory nature of a CTO. However, many consumers and SDMs felt that while the CTO process might not be perfect, it was still worthwhile. Others did not: some SDM refused to consent to a CTO and some consumers appealed to the CCB to have their CTO revoked.

Most of the mental health professionals we talked to used CTOs to some extent; however, the characteristics of consumers for which they were used varied. One common factor was that almost every treatment plan included medication. Most psychiatrists also agreed that CTOs were effective in increasing communication and understanding among service providers.

Many factors were considered to be very important in supporting or encouraging the use of CTOs in Ontario. These included: reducing the frequency of hospitalizations, safety in the community, adherence to medication, and access to services. The main factor health professionals cited as limiting the use of CTOs by themselves and their colleagues was the time and effort required throughout the CTO process.

5.1 Factors Impacting Decisions to Use/ Accept a CTO

5.1.1 Perspectives of Consumers

Although the time period for the review was limited we were able to hear from 60 consumers, either through the survey or in person. We also heard from consumer groups and peer supporters. Through these contacts we heard a range of views that were consistent with views reported in the literature and in the Dreezer and Dreezer review where the longer timeline permitted more extensive discussions with consumers.

My CTO is a good thing. I'm getting out more. Doing more. I feel better. – Consumer

Many consumers initially resisted their CTO but eventually accepted the CTO due to the benefits they experienced such as feeling better and the various supports and services with which they were linked. While some consumers who participated in the review thought the CTO was coercive, they also reported improvements in their quality of life as a result of the CTO and accompanying supports they received. Some mentioned now being able to pursue studies and other goals. Another common theme from discussion with consumers was the social aspect. For consumers

with few family members or friends, appointments associated with the CTO were an opportunity for social interaction that was previously lacking. One consumer reported now *"feeling like part of a team".*

Consumers also mentioned the importance of the services accompanying the CTO. Some said they did not have positive relationships with their physicians, therefore the support of the CTO coordinators, case managers and other service providers was crucial to their adherence to their treatment plan and the CTO.

It has allowed me access to the community when I thought I was stuck in a hospital. I don't like psychiatrists and medication. - Consumer

Other consumers were less positive about the CTO but recognized the advantage of being able to return to the community as opposed to remaining in hospital. Reasons for not using CTOs often related to not wanting to take medication. Consumers' reasons for not taking medication varied, but the main complaint was about the undesirable side-effects of some medication (Table 5-1).

Table 5-1: The Voices of Consumers

Reasons for Use of CTO	Reasons why CTOs are Not Used
Consumers	
• Support 'It helps to have someone guide you and be your backup. I like being on a team' – Consumer • Access to services 'I get everything I need. Everything is there for me.' - Consumer • Improved quality of life 'I was paranoid for four years. It's an awful feeling. My meds changed all that.' - Consumer • Opportunity for social interaction 'I don't always agree with them all the time, but I welcome them in. It's nice to have visitors.' - Consumer • Alternative to hospitalization 'If I didn't have it, I wouldn't be where I am today. I'd still be in the hospital.' – Consumer 'They sign the CTO so they can get out of the hospital.' – Rights Adviser • Family pressure to continue with treatment 'I've already recovered. I feel great most of the time. My husband and son want me to stay on the meds.' - Consumer	• Lack of autonomy/coercive 'They lie to you to get you to sign it. They put me on a trustee without my free will. …I did things better on my own.' - consumer 'I can't get support without signing the papers. They wouldn't come.' - Consumer • Prefer not to take medication 'The medication has awful side effects. ' - Consumer • Lack of insight 'The doctors hated me. I don't know why they were torturing me with pills.' - Consumer • Stigma 'Some of the people that I work with feel really stigmatized of being on an order and can't wait to get over it.' – Case Manager

5.1.2 Perspectives of Family, Friends and Substitute Decision-Makers

The family members we were able to talk with were very caring and had their loved-one's best interest at heart. They perceived CTOs as a means to ensure safety for their loved-one and to help be a part of their treatment. They found value and comfort in being able to be part of the discussions. Being "on the same page" and being informed was important for relatives who were SDMs.

CTOs also helped provide relatives and friends with a way to obtain preventive support for their loved-one. Relatives and friends said they may be the first to notice that a mental health consumer was struggling. In the absence of a CTO, relatives and friends said they did not have any means to obtain support until the situation reached a critical point. The CTO also provided relatives and friends with a way to obtain support without judicial consequences as with a CTO, family members and friends felt they could call the police without having to worry about charges being laid as police had another option. Finally, relatives felt that the CTO helped reduce the 'revolving door' and that there were benefits for all in providing mental health services to consumers in the community instead of the hospital. For the relatives who were SDMs that we spoke to, their greatest fear was that the CTO would be taken away; their greatest hope that their loved-one would sign them voluntarily.

Table 5-2: The Voices of Family and Friends

Reasons for Use of CTO	Reasons why CTOs are Not Used
Family and Friends	
• Preventative support • Rapid assistance in times of relapse • See improvement in quality of life 'I see CTOs as working to maintain compliance with treatment in the community, reduced hospitalizations, fewer episodes of deterioration, facilitating engagement with community resources, improved quality of life.' - SDM • Positive perception of previous CTO • Access to services 'I think they [CTOs] are wonderful because it has given our son a secure and safe place of residence.' – Family member • Ability to be involved in care of loved-one 'Families have been in the wake of severe mental illness and also asked to support the treatment of this illness. However, they have often been unable to have a reciprocal working relationship with service providers. With the introduction of CTOs, this changed.' – CTO coordinator • Relief and comfort of not being the only one responsible for care 'All these things [supports of CTO] are wonderful to a family who has a sick family member.' – Family member • Keeps loved-ones in the community 'Having RNs provide injections in a welcoming environment (as opposed to psychiatrists in a hospital setting), has greatly improved my family member's compliance with the CTO.' - SDM • Ensures adherence to medication 'we've been told through the years that the longer you go through that non-treatment type of seesaw, the more difficult or the longer it takes for the treatment to be effective the next go 'round.' – Family member	• Negative perception of previous CTO • Dissatisfaction with medication prescribed I've also seen now, this is rare, when we have families that are becoming more unwilling to go along with the CTO. I've seen recently where there is talk about a CTO and the family declines as substitute decision-maker. I think they are being more nervous about the medication they are using on the young people now. On the other side, the family hasn't seen any real benefit in the past on medication.' - Physician • Mandatory nature of treatment

5.1.3 Perspectives of Health and Service Providers

Respondents to the on-line survey were asked about how important a range of factors were in supporting or limiting the use of CTOs in Ontario. In interviews, stakeholders were also asked about the reasons why CTO were used or not used during the review period.

Factors Supporting the use of CTOs

Most of the health professionals we talked to used CTOs to some extent. Some used them infrequently and only with consenting consumers, and described their use of a CTO as a mutual contract where they undertook to provide services and support if the consumer undertook to adhere to their recommendations. Other health professionals used CTOs more frequently and some advocated for the use of CTOs for all discharges of patients with severe mental illness.

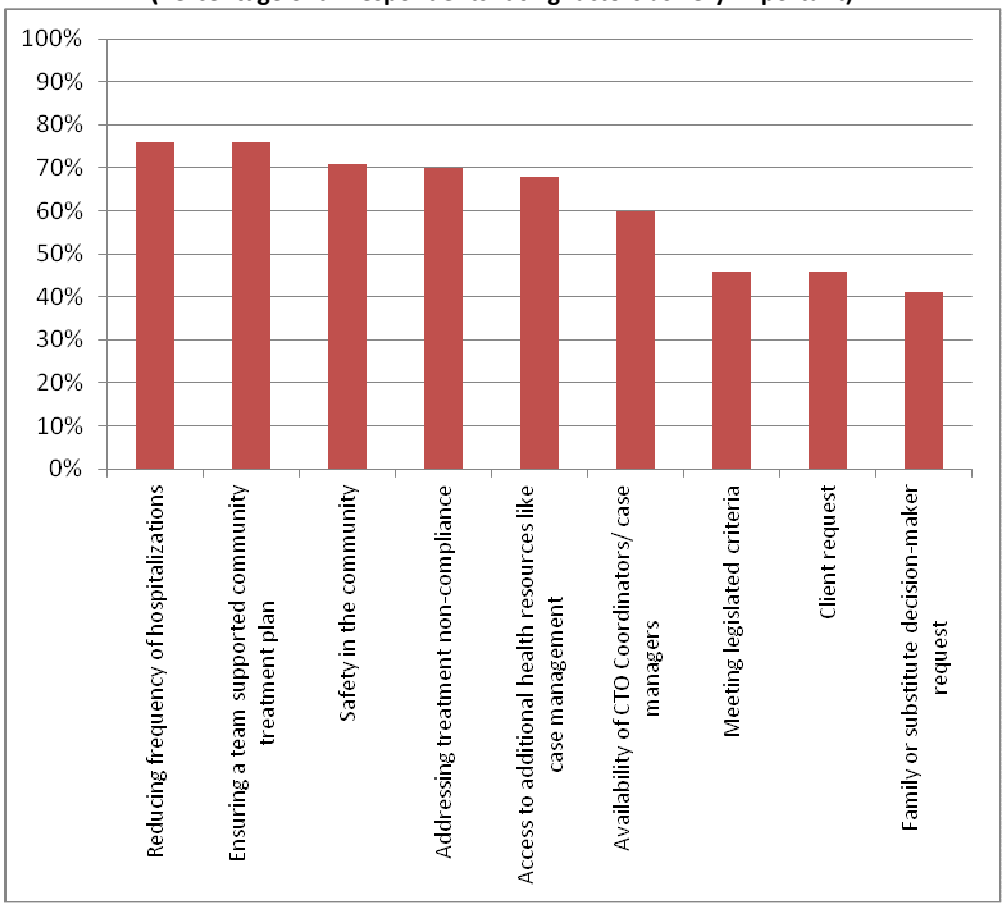
In the survey, across all groups, the factors most often considered to be very important in supporting or encouraging the use of CTOs in Ontario were: reducing the frequency of hospitalizations (76%); ensuring a team supported community treatment plan (76%); safety in the community (71%); addressing treatment non-compliance (70%); access to additional resources such as case management (68%) and the availability of CTO coordinators and case managers (60%) (Chart 5-1).

There were some differences between provider groups: psychiatrists were more likely to rate the capacity to address non-compliance as important; CTO coordinators were the group most likely to consider the availability of case managers; and consumer groups most often rated consumer consent as very important.

From our discussions with health professionals, it was also clear that for health and service providers CTOs provided consumers with a link to community services that may not be otherwise known (either due to lack of knowledge of the services or other systemic issues related to access). Other stakeholders also appreciated that CTOs provided clear instruction about processes for non-adherence to treatment and prevented consumers from falling through the cracks. The ability to locate and regain contact quickly after a consumer failed to adhere to their treatment plan was perceived as a major benefit of the CTO.

Some physicians want CTOs because in some way they feel there are less community resources that they are dwindling. So they need the extra arm of a CTO because the patient doesn't have a lot of support – CTO coordinator/case manager

Chart 5-1: Factors Supporting or Encouraging the Use of CTOs in Ontario
(Percentage of all respondents rating factors as very important)



A detailed table is provided in Appendix H

For some providers, the CTO was also used to bridge a gap in services. In particular, some physicians indicated using a CTO while the consumer was on the waiting list for ACT Team support. Interestingly, while many CTOs were used to facilitate a link to community services, some were also issued due to the lack of services available. CTOs provided physicians with the ability to remain in contact with the consumer and monitor their progress in the community, as opposed to simply discharging them from hospital.

Families have also requested CTOs for their loved-ones, and some physicians were issuing CTOs to comply with these requests. CTOs were also used for practical reasons. There was some mention that the demand for hospital beds has put some pressure on physicians to issue a CTO. It should be noted that CTOs were not issued to consumers who were not good candidates for the CTO, but rather that these pressures encouraged physicians to expand their comfort in using a CTO.

From discussions with review participants, it seemed that the CTO coordinators were often advocates for a CTOs and educated other health professionals about CTOs and encouraged their use among the local physicians. Further, service providers, such as ACT Team members often referred their clients for CTOs.

Factors limiting the use of CTOs in Ontario

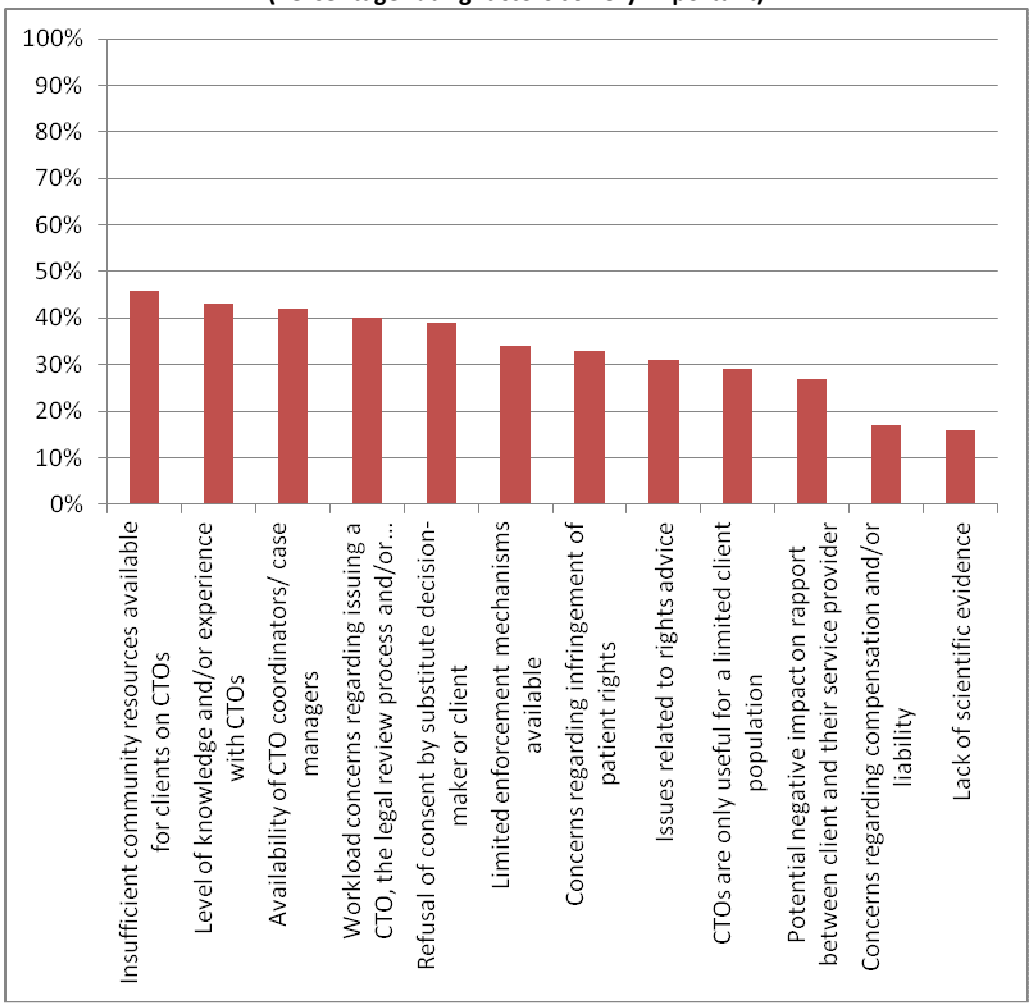
> *I think we as physicians, psychiatrists in particular, fail to use the mental health act for the benefit of the patient…. `well the CTO is a lot of work`…- Psychiatrist*

For the health professionals we talked to, the primary reasons for not using CTOs were the time and efforts required to issue and manage the CTO. Particularly for psychiatrists, the processes for issuing, renewing and the other requirements associated with CTO administration were described as cumbersome and time consuming. The CTO coordinators made a real difference to the time and effort required by psychiatrists and we heard that CTO coordinators could make things very easy by *"putting everything in front of the psychiatrists to sign".* While issues with CTO processes are discussed in a following section, it should be noted here that many physicians said they or their colleagues were reluctant to issue CTOs because of the work required to prepare for appeals and the mandatory review of every second CTO renewal. One perception expressed was that if a consumer did not have an SDM, they were more likely to appeal the CTO. Therefore these psychiatrists did not issue the CTO to avoid the appeal process. The time and effort required throughout the CTO process was frequently noted in the survey by all mental health professional groups as very important in limiting the use of CTOs (Chart 5-2).

Other limiting factors frequently noted in the survey were insufficient community resources available for CTO clients (46%); level of knowledge and/or experience with CTOs (43%); the availability of CTO coordinators/case managers (42%), workload concerns regarding issuing a CTO, the legal review process and/or supervising a client (40% of all respondents and 45% of psychiatrists); and refusal of consent by a SDM (39%). These factors were explained further in interviews. Lack of appropriate services available in the community was another common reason for not issuing CTOs. Whether it was availability of basic services like case management or other resources that the physician felt was necessary for an effective CTO, these influenced their decision to issue the CTO. When the availability of services changed, the possibility of a CTO was reconsidered.

Reluctance of the family was also mentioned as influencing the decision to issue a CTO. If families had not seen any improvement during previous CTOs and no benefit from medication, some were increasingly unwilling to accept the CTO. Some provided examples of family members who were the SDM declining or appealing the CTO.

Chart 5-2: Factors Limiting the Use of CTOs in Ontario
(Percentage rating factors as very important)



A detailed table is provided in Appendix H

Table 5-3 below provides an overview of the perspectives of health professionals.

Table 5-3: The Voices of Health Professionals

Reasons for Use of CTO	Reasons why CTOs are Not Used
Health Care Professionals	
• Ability to enforce adherence to medication '…it gives us the opportunity to not wait until they go and hurt themselves or possibly harm someone else before we get them into the hospital.' – ACT Team • Links clients to services • Provides additional support to clients • Championing of CTOs by other physicians or their CTO coordinator 'A good CTO coordinator makes a big difference on the usage of CTOs. A good CTO coordinator is involved in all aspects of the CTO including initiating and maintaining as well as a liaison with the service providers.' – Psychiatrist • Have seen positive outcomes for previous CTOs • See CTO as a two way contract 'I think another benefit would be that it has accountability for everybody, case managers, but also doctors' - Physician • Prevents consumers from slipping through the cracks '[The CTO] promotes vigilance, closer monitoring and quicker response to non-compliance and risk.' - Psychiatrist • Increased communication between those named in the community treatment plan 'Creates a more formalized treatment/recovery plan between all interested parties attached to the client and clear direction what will happen if a person undergoes a mental health crisis.' – CTO coordinator • Position that it is a less restrictive alternative to hospitalization • Belief that medication is the cornerstone of treatment for psychotic mental health consumers • Family request	• Hospitalization requirement (excludes consumers only involved in forensic system) 'We have lots of people who are released from jail that would benefit from a CTO but they can't be placed on one because they haven't been in the hospital in three years.'- Psychiatrist • Time and effort to issue and manage CTO (paperwork and hearings) 'They are effective, but difficult to renew! This defeats the purpose. They have become a big time drain on psychiatrists without commensurate pay.' - Psychiatrist • Lack of support services 'The caution is that when we are seeing a patient we believe will benefit, that meets all the criteria, we don't have any services that will monitor the CTO patient properly in the community.' - Physician • Availability of CTO coordinators and case managers 'There's a CTO coordinator who brings these things together and that personality is very important. If she's not doing her job bringing people together, no CTO gets done.' - Physician • Lack of knowledge 'Some physicians were scared off initially by the formality of the process and dealing with the review board.' - Physician • Some only issue to consumers that have capacity to consent 'I only issue CTOs to consumers that can consent. I view it as a contract that improves my therapeutic alliance.' - Psychiatrist • Others only issue to consumers with SDM 'It's toothless if the consumer consents because they can withdraw their consent at any time.' - Psychiatrist • Reluctance of family 'It is challenging when the team sees the benefits of a CTO but the family are afraid of possibly having the police involved.' – Inpatient health worker

5.2 Alternatives to CTOs

A CTO is a mechanism to enforce adherence to a community treatment plan. Potential alternatives include voluntary mental health support services, in-patient care or intensive case management. In the survey, respondents were asked what alternatives there were to CTOs and their responses are shown in Table 5-4. In interviews, CTOs were used in conjunction with intensive case management and also used when intensive case management was not available or until it became available.

Table 5-4: Alternatives to CTOs

Alternatives to CTOs (open-ended reply)	Consumers	Family and Friends	Service Providers
No other options	62%	65%	6%
Voluntary mental health support services	13%	5%	27%
ACT Team	4%	5%	18%
Community outreach	2%	5%	7%
Injections	2%	0%	4%
Peer support	2%	0%	3%
Hospital	0%	0%	8%
Forensic psychiatrists	0%	0%	7%
Involuntary intervention or psychiatric services	0%	0%	5%
Family support and caregivers	0%	0%	5%
Housing	0%	0%	3%
Leave of absence	0%	0%	2%
Total	**47**	**20**	**344**

Source: Online survey

5.3 Gaps in the Use of CTOs

For review participants who felt that CTOs were not being used enough, the most common reason was the reluctance of many psychiatrists to use CTOs. Health professionals who used CTOs felt that there was a lack of information available for their colleagues about CTOs as a treatment option and many felt that more consumers could benefit from CTOs if health professionals were more aware of how to use CTOs.

We talked to a number of health professionals who felt that people with the potential to benefit from CTOs were missing out because there was not the capacity to support them, both CTO coordinator and case manager capacity and the availability of services in the community.

> *That's the gap that we see in any type of individual that has mental health addiction issues is that generally, when they are housed in custody because of a criminal offence, they are not getting access to the care they really need and when released, there really isn't much of a program for them to go to for that continued monitoring. – Stakeholder*

Stakeholders also identified specific consumer populations that they felt had the potential to benefit from CTOs but were missing out because they did not fit the CTO criteria. Some felt the criteria

concerning hospitalization and length of stay should be modified. Some felt that CTOs should be an option for consumers on their first hospital admission or after their first episode, if a CTO would prevent an otherwise inevitable readmission. For consumers who had been in and out of the justice system rather than been admitted to hospital, the CTO was cited as a mechanism which could help prevent future criminal offences, but was not available. It is important to note that this group did not include consumers who were under the jurisdiction of the Ontario Review Board.

While not necessarily due to CTO criteria, it was also observed that a lower number of youth and elderly were issued CTOs. However, in some health regions, special programs from youth and geriatric consumers were in place and supported the use of CTOs.

5.4 Potential for Misuse of CTOs

The number of CTOs issued in Ontario is steadily increasing. The reason for this increase is not likely due to an increase in the consumer population meeting the requirements of the CTO, but rather an increasing knowledge, understanding and comfort with CTOs. With this increase in comfort comes the risk of straying from the original purpose of the CTO and influencing a broadened scope for the legislation. The use and approach to CTOs varies across the province and there are also varying opinions about whether CTOs are being used too broadly or being under- or over-used.

> *Some physicians appear to believe almost every patient requires a CTO. The CTO has become a convenient means of controlling people. That was not the original purpose.*
> *–Survey respondent (occupation unknown)*

SECTION 6: THE EFFECTIVENESS OF CTOs DURING THE REVIEW PERIOD

A CTO mandates adherence to a community treatment plan. Therefore the effectiveness of a CTO is closely linked to the quality of the community treatment plan associated with the CTO and the availability to of services and supports for inclusion in the community treatment plan.

Effects on Consumer Well-Being and Satisfaction

As with use of CTOs, there were a range of views about the effects of CTOs on consumer well-being and satisfaction. Adherence to an effective community treatment plan improved the well-being of most consumers. However, for others with severe side-effects, well-being was not improved to the same extent.

The Effectiveness of the Process

The implementation of CTOs varied across the province; in particular, the roles of CTO coordinators and case managers included different responsibilities and levels of interaction with consumers and community services.

There seemed to be variation in the consumer groups to whom CTOs were issued. From some we heard that CTOs were increasingly being used as a preventive measure rather than as a last resort. An essential element of the CTO process is that consumers or their SDM provide informed consent. Since the first review, there appears to have been a movement away from consumer consent to being issued a CTO towards SDM consent. While almost one-half of the consumers responding to the survey were not concerned about the amount of choice they had under a CTO or their rights under a CTO, a similar number were concerned.

As with other processes associated with CTOs, methods for addressing non-adherence to the CTO differed across the province and depended on the CTO team. Only slightly more than one-quarter of survey respondents considered that methods for dealing with non-adherence to a CTO were satisfactory.

Discharge from a CTO

There was limited data available on the duration of CTOs; however, some CTOs were renewed multiple times over a period of years. In the survey, only one-quarter of respondents agreed that CTO consumers maintained their gains after the CTO expired. Some CTO stakeholders suggested that CTO or CTO renewals should last for a longer period. There was considerable variation among health professionals on when to discharge an individual from their CTO and no standard processes were in place.

Factors Impacting on the Effectiveness of CTOs

Factors impacting on the effectiveness of CTOs included the quality of community treatment plans and access to services. CTOs were reported as effective in increasing communication between health professionals and in linking consumers with services. However, access to services including access to case management was a key factor limiting the use of CTOs and many stakeholders felt that CTOs were not available to all who could benefit. Across all groups in the survey, more than half agreed that the lack of availability of income support and housing limited the effectiveness of CTOs (and of care for mental health consumers not on a CTO).

In this review the effectiveness of CTOs has been assessed by considering the following:

- The effects CTOs have on consumer well-being and satisfaction;
- The effectiveness of the process for issuing CTOs and consistency of the process with the intention of the legislation and the legislated criteria;
- The discharge planning process for a CTO consumer; and
- Factors impacting on the effectiveness of CTOs including the services and supports CTO consumers are receiving.

6.1 The Effects of CTOs on Consumer Well-being and Satisfaction

Opinions about the effectiveness of CTOs in improving the lives of consumers were numerous and varied. Perspectives also varied in complexity with many recognizing tensions around coercion, civil rights, recovery and improved quality of life.

6.1.1 Consumer perspectives

Considering feedback from CTO consumers who participated in the study, wanting to get out of hospital played an undeniable role in their consenting to the CTO. Some consumers were willing to adhere to their medication, others did not recognize that they needed medication or did not consider that the benefits of the medication outweighed the side-effects they were experiencing.

I don't want the CTO because I don't like medication. I see the benefit of community involvement but the choice of taking medication is key. – Consumer on first CTO

While staying out of hospital remained the key motivating factor for some continuing to accept a CTO, others began to experience other benefits as well, although some still did not agree with the principle of compulsory care. Benefits mentioned by consumers included feeling better, feeling in control of their life, sleeping better, taking control of their physical health, and pursuing interests and goals.

Some CTO consumers felt the structure and schedule provided by the CTO helped by getting them out of the house and into the community. Similarly, it was mentioned directly by consumers and also by service providers that the appointments often served as an opportunity for consumers to socialize. Particularly for consumers with few family members and friends, regular visits with members of their CTO team were something to look forward to.

Other consumers expressed more moderate satisfaction with the affects of the CTO. They did not identify any significant improvement in their life, but recognized that the CTO had helped them maintain their treatment plan.

Many consumers who responded to the survey (72%) agreed they felt better as a result of the CTO, 66% reported an improved quality of life, 57% were more satisfied with their CTO than other treatment options, and 62% felt CTOs were the best option for their situation compared with other treatment options. Views were compared for consumers on their first CTO with those who had been issued with two or more CTOs (Table 6-1).

Table 6-1: Consumers' Views on Their Experience with a CTO

Consumers (n=47)	One CTO (n=20)			2 or more CTOs (n=27)		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
I felt better as a result of the CTO	80%	10%	5%	67%	19%	15%
My quality of life improved	70%	15%	10%	63%	15%	10%
I am/was more satisfied with my CTO than with other treatment options I have experienced	55%	35%	5%	59%	22%	15%
CTOs were the best option for my situation	60%	20%	15%	63%	15%	22%

Note: Percentages may not add up to 100 as some respondents replied "No answer/Don't Know."

6.1.2 Family and friends

Feedback from family and friends about the effectiveness of CTOs was almost always positive. Their first impressions of the CTO were relief and happiness, in the knowledge that their loved-ones were being taken care of. While many recognized aspects of coercion and freedom, they felt that improvements in their loved-one's well-being outweighed the negatives. Mostly, families felt that the CTO facilitated the rebuilding of relationships with their loved-ones and their recovery. They felt that there was a need to educate relatives and friends of people with mental illness about the CTO so that they could be used as early as possible in order to be preventative. The metaphorical 'revolving door' may be difficult for family, friends and consumers. Because the CTO helped address this problem, it was not perceived as something that reduced freedom as the consumer was able to be in the community.

> *It is hard having your child hate you because they are in hospital. They hate you less when on a CTO because it allows them to come home and calm down. - SDM*

In responding to the survey, 70% of family and friends reported improvements in the health and 70% reported improvements in the quality of life of their family member or friend, 85% were more satisfied with the CTO than other treatment options, and 85% agreed a CTO was the best option for their loved-one (Table 6-2).

Table 6-2: Family, Friends and SDMs' Views on Their Experiences with a CTO

Family and Friends(n=20)	Agree	Neutral	Disagree
Their health improved as a result of the CTO	70%	0%	15%
Their quality of life improved	70%	15%	10%
I am/was more satisfied with the CTO than with other treatment options my family member/ friend has experienced	85%	10%	0%
CTOs were the best option for my family member/ friend's situation	85%	5%	5%

Note: Percentages may not add up to 100 as some respondents replied "No answer/Don't Know."

SDMs also noted that the CTO provides consumers with structure and some SDMs who were relatives felt that this was welcomed by consumers. In one case, one participant noted that their loved-one had changed his/her views of the CTO and was now responsible with his/her medication. Others commented that the CTO helped keep their loved-ones compliant with their treatment plans because of the presence of the CTO; or because of fear that they may regress again.

6.1.3 Consumer Advocacy Groups

While some participants representing consumer advocacy groups and other consumer driven agencies recognized some benefits to CTOs, they warned against the wide-spread use of CTOs as a 'band aid' while not addressing long-term issues for consumers. Some of these participants mentioned that families have adopted the notion that the CTO is the solution and will eliminate all their challenges. In addition to issues around coercion and infringement of civil rights, some mentioned that forced treatment was not a long term solution to engaging people in their recovery.

Others felt that while some positive outcomes resulted from CTOs, they did not outweigh the fundamental principle of civil liberty. One example that was used frequently was the limitation put on consumers around traveling, or even relocating to another community.

Some participants felt strongly that if the necessary resources to properly care for severely ill consumers were in place, CTOs would not be necessary.

6.1.4 CTO Coordinators/Case Managers, Psychiatrists

> *We've had mothers come in that are just overwhelmed with having their child back for family dinners.-CTO coordinator/case manager*

There was wide appreciation among CTO coordinators, case managers and physicians of the benefits of CTOs on the quality of life of the consumer. Interviewed health professionals held the view that consumers' well-being improved when consumers adhered to treatment plans, which almost always included medication. When consumers stopped taking their medication their health and well-being rapidly deteriorated as well as their awareness that they were unwell. Besides adherence to medication, participants described many positive outcomes for consumers on CTOs such as stable housing, reduction in criminal acts, substantial reduction in hospital admissions, connections with the community, stable housing, reengagement with employment and education and improved physical health. An outcome frequently mentioned was that CTOs permitted consumers to work on and repair their relationships.

> *The closing of Long Team Care mental health beds in Ontario has been a huge mistake for many patients who are now struggling for safe housing in the community. There is a need for them and CTOs are not an adequate alternative to them. – Community health worker*

Health professionals noted that these changes did not occur within a short timeframe and sometimes took years on a CTO to accomplish.

6.1.5 Other Stakeholders

Members of Ontario Police services who participated in the review noted the main advantage of CTOs was that they could link a consumer with health care services much more easily than when there was no CTO in place.

6.1.6 Overview of Stakeholders Perceptions of the Effectiveness of CTOs

In the survey, respondents were asked about the extent they agreed or disagreed with statements about the effectiveness of CTOs (Table 6-3). With the exception of consumer groups/ peer supporters, there were high levels of agreement by survey respondents that CTOs had a positive effect on the quality of life of consumers (65%), were effective in addressing the 'revolving door' between hospital and community (65%), had reduced hospital admissions rates (64%), and that CTOs were effective in reducing the risk of serious harm to people in the community (57%).

Table 6-3: The Percentage who Agreed with Statements About the Effectiveness of CTOs

Statements	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
The CTO program is effectively serving the following communities[1]:							
Multi-cultural communities	40%	48%	35%	26%	22%	17%	28%
Rural communities	25%	39%	18%	19%	15%	17%	20%
Francophone communities	15%	26%	10%	16%	7%	12%	15%
Aboriginal communities	8%	9%	8%	6%	11%	7%	7%
CTOs have a positive impact on the quality of life of the consumer	78%	91%	78%	62%	15%	71%	65%
CTOs are an effective way of addressing the 'revolving door' between the hospital and the community	73%	91%	75%	62%	22%	71%	65%
CTOs have reduced hospital readmission rates	85%	87%	68%	63%	26%	52%	64%
CTOs are effective in reducing the risk of serious harm to people in the community	55%	78%	60%	61%	19%	55%	57%
CTOs should be a last resort when other treatment options have been explored	38%	35%	55%	57%	63%	36%	51%
CTOs have better outcomes than other community treatment options[2]	60%	65%	53%	36%	7%	38%	41%
CTO clients maintain their gains after the CTO expires[2]	20%	48%	30%	29%	7%	17%	26%
Did not agree with any statement above	*3%*	*0%*	*8%*	*6%*	*15%*	*10%*	*6%*
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

[1] 32-53% of respondents replied "No answer/Don't know" for community questions (approximately one-third for multi-cultural and rural communities; approximately ½ for francophone and Aboriginal communities).
[2] 15% of respondents replied "No answer/Don't know" for these questions.

> *They believe the voices are a gift and they are communicating with spirits. I don't see any reason to try and convince them otherwise. We say "so are these spirits causing you distress and if so how do we help you?" – Service provider*

There was uncertainty about the extent to which CTOs effectively served Aboriginal, multi-cultural, rural and Francophone communities in Ontario. Few survey respondents agreed these communities were served effectively by CTOs but many did not know. Challenges around approaching the CTO, and mental health care in general, with consumers of different cultural backgrounds were mentioned. Health professionals said that because of different beliefs and concepts of wellness, having the consumer and their family acknowledge a mental illness was often a challenge. Many health professionals noted that getting agreement to an approach to treatment was the priority, rather than accepting mental illness. It was mentioned as important to provide culturally sensitive care and, for Aboriginal consumers in particular, to be open to a holistic approach to a treatment plan.

Another point mentioned was the practical issue of having to have documents translated for consumers or SDMs along with interpreters to guide them along the process of the CTO.

6.2 The Effectiveness of the Process

6.2.1 The Role of the CTO Coordinator

> *Our CTO coordinator is retiring and we are currently in the recruiting process which creates a lot of anxiety on the psychiatrists. Who is going to be recruited? Do they have the skill set? Do they have the proper knowledge? It's a very sophisticated position that requires people with high clinical expertise to do the job appropriately otherwise there will be a lot of issues with the board. The board has very high expectations of the documentation. – Psychiatrist*

The number of CTOs a CTO coordinator oversaw varied significantly and reflected CTO coordinators' different roles and responsibilities. Some CTO coordinators were full-time in the position, while others had shared responsibilities for other roles in the LHIN. The amount of contact CTO coordinators had with consumers also varied. Some knew all their CTO consumers whereas others seemed to solely have a coordination role.

Many review participants mentioned the importance of the CTO coordinator role in ensuring the effectiveness of CTOs overall and processes around issuances and renewals. CTO coordinators were responsible for ensuring all parties were informed and that all documentation was completed.

Based on administrative data available, it is estimated that in 2011 a CTO coordinator oversaw, on average, almost 50 CTOs (issues and renewals). The data also confirmed that some coordinators worked across LHIN borders, sometimes with consumers in up to five LHINs. It was generally these coordinators whose CTO counts were highest. One such CTO coordinator oversaw 169 CTOs in 2011 (Table 6-4).

Table 6-4: Number of CTOs Issued and Renewed per CTO Coordinator (2011)

	Average	Std. Dev.	Median	Min	Max	Total
CTOs Issued	20.2	24.1	12.0	0	112	1,130
CTOs Renewed	28.7	34.3	18.0	0	143	1,607
Total	**48.9**	**48.4**	**30.5**	**1**	**169**	**2,737**

Source: PPAO 2011. Coordinator statistics for 56 coordinators responsible for 2737 (of 3171) CTOs recorded by PPAO, or approximately 86% of all CTOs in 2011.
Note: Although some coordinators had zero issues and others had zero renewals, no coordinator had zero CTOs in both categories.

6.2.2 When CTOs are Used

There seemed to be variation around when CTOs were used. There may be an increase in CTOs being issued from community based clinics. We heard in interviews that in some LHINs, CTOs were being requested by the ACT Team.

We heard from some providers that CTOs were increasingly being used as a preventive measure rather than as a last resort. In the survey, approximately two-thirds of psychiatrists and CTO coordinators did not agree that CTOs should be a last resort when other treatment options had been explored. Other in-patient health professionals (55%), ACT Team members (64%), other community health care providers (57%), and consumer groups/peer supporters (64%) were more likely to agree that CTOs should be used as a last resort.

The Ontario approach to CTOs has been to take a preventive approach. The legislation is not specific about whether CTOs are a last resort or otherwise, but it does allow for a CTO to be used to prevent deterioration.

6.2.3 What is Included in a CTO Treatment Plan

Opinions of what should be included in the community treatment plan covered by a CTO varied. Almost all CTO treatment plans included medication. Some CTO coordinators indicated that in their regions CTOs were kept very simple and only included the aspects of the community treatment plans related to administration of medication and necessary appointments. However, for other consumers, the CTO may include conditions such as ensuring service providers could safely access their residence for treatment or other appointments.

The CTO coordinator will also link the consumer with the necessary services to support their recovery; however these were not

One consumer with very severe diabetes whose control was terrible and his physical state was deteriorating. Once he was on the CTO, which pushed him and motivated him to comply with treatment, his general physical health and his own management of his diabetes improved exponentially. – Psychiatrist

My experience has been that it's less about the actual CTO and more about how few supports there are to make them successful. The CTO idea makes sense. However, how can it work properly when a strong plan cannot be presented? – In-patient health worker

I would say that the CTO is very generic to allow for the patient and the case manager to develop their own goals and plans. Also to provide a little bit of flexibility so as they recover, as they continue to improve, they have certain choices. – CTO Coordinator

necessarily included in the CTO. Other services could include a variety of items including working toward some of the consumer's life goals. Reasons for not including these in the CTO was to make adhering to the CTO as easy as possible and to not place any added pressure on aspects that were not crucial for recovery. Others involved with CTO consumers felt that treatment plans should be elaborated to include activities that would help consumers achieve their goals. It was felt that these elements were an important part of recovery as opposed to being a secondary/complementary focus. What was included in a community treatment plan was also affected by the services available in a region.

The Role of the Consumer

The extent consumers and SDMs were involved in developing their community treatment plans varied, but review participants involved in developing CTOs said that the treatment plans were always discussed with the consumers. If the consumer was deemed incapable, the plan was discussed with their SDM and in most cases, their input into what to include in the plan was encouraged. There was some mention of the type of medication and dosage being discussed with the physicians; however some also said that in many cases, it seemed physicians were not open to such negotiation.

> *Most of our CTOs are issued out of the hospital and I would often go down and visit the patient on the ward and review the common things that would be included on a CTO in general. Then we have a case conference with SDM, family members and the patient. We would look at a draft and it would be adjusted at that point. It would include a crisis plan, and the consequences of not complying like the form 47. – CTO Coordinator*

Most consumers (80%) and family/friends and SDM (75%) responding to the survey were satisfied with the treatment plan delivered through their CTO (Table 6-5). One element of the CTO that many consumers said they liked was feeling they were part of a team. This approach was also mentioned by a few other stakeholders directly involved with CTOs. Approaching the CTO with the perspective that it was a team effort where all members were accountable and not just the consumer, was mentioned as really helping to make consumers understand the benefits of being issued a CTO and reducing feelings of coercion associated with the legislation.

Table 6-5: Satisfaction with Treatment Plans

Consumers (n=47)	One CTO			2 or more CTOs		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
I am/was satisfied with the treatment plan being delivered through my CTO	80%	5%	10%	82%	7%	11%
Total Numbers	**16**	**1**	**2**	**22**	**2**	**3**
Family and Friends (n=20)	**Agree**	**Neutral**	**Disagree**			
I am/was satisfied with the treatment plan being delivered through their CTO	75%	10%	10%			
Total Numbers	**15**	**2**	**2**			

Note: One consumer (with one CTO) and one family or friend replied "No answer / Don't Know."

Despite satisfaction with treatment plans, not all consumers who took part in focus groups recalled their CTO being discussed with them. One said he/she had expected to be more involved in the process or provided with more information about the CTO, but felt like there was no choice, no input and said he/she was just asked to sign the form.

For the second one, I didn't have any say what so ever. I thought it would be an open discussion, but it was just signing paperwork. – CTO consumer

6.3 Renewals, Reissues and Removal of CTOs

6.3.1 Duration of CTOs

CTO were not renewed for one-third of Toronto CTO consumers. When looking at just those who were deemed a threat to themselves or others, the proportion of CTO consumers for whom CTO were not renewed dropped to 17% (Table 6-6).

Table 6-6: The Number of CTO Renewals for Toronto CTO Consumers (2005/06 to 2010/11)

Number of Renewals	% of All Consumers (n=377)	% of Consumers deemed a threat to self or others (n=48)
None	33%	17%
1 to 2	24%	44%
2 to 5	24%	21%
6 or more	19%	19%

Source: Data provided by and Toronto Source.

However, the data in Table 6-6 do not reflect consumers whose CTO expired before their physician was able to renew it. We heard in interviews that some CTO lapsed for more than a month and were therefore considered a reissue rather than a renewal. As there is a mandatory review every second CTO renewal this is a loophole that some may be using to avoid CCB hearings. The actual proportion of CTO consumers continuing with CTOs may be larger than the data presented here suggest.

With a hearing every six-months, my daughter is learning what to say and not to say each time.- SDM quote

Discussions with mental health professionals and other stakeholders found that the time a consumer would be on a CTO could vary from one to two years, up to 10 years. Opinions on how long a consumer should be on a CTO varied, but there was substantial agreement that a minimum of one to two years was required to see any consistent stability. For this reason, many felt that the term of the CTO (six months) was too short and most agreed that one year was a more appropriate time frame. A longer duration was also felt to alleviate the workload associated with renewal.

The couple of clients who are issued multiple Form 47s do not try to leave or hide when the police arrive. They are fully aware that this is their hold out, their pride, their statement of independence. That they are not going to comply and they are going to wait for the police. – CTO coordinator/case manager

Despite being very positive about their experiences with CTOs, the SDMs we talked to felt the CTO duration was too short and described the uncertainty they felt as the CTO approached the end date, especially

in situations where the consumer resisted the CTO. They also discussed not knowing "where to draw the line" with respect to their family member's right to refuse treatment.

6.3.2 Non-Adherence to a CTO

As with other processes associated with CTOs, methods for addressing non-adherence to the CTO differed across the province and depended on the CTO team. While some would immediately issue a Form 47 when a CTO consumer strayed from their treatment plan, others would attempt to reason with the consumer and provide them with the opportunity to recommit to the CTO before issuing the Form 47 as a last resort. This resulted in variation in the number of Form 47s issued per region.

In my opinion CTOs are not as effective as they could be. There is a certain toothlessness in the legislation, especially when the person involved in the CTO has no real appreciation of the CTO- Survey respondent (Occupation unknown)

Consumers not adhering to the treatment plan were a reality faced by those involved in the CTO; however it was not felt that the problem was prominent. Consumers not complying with their CTOs were often the same ones that repeatedly challenged it.

For others, it took only one incidence of being issued the Form 47 for adherence to not be an issue. Most agreed that failure to adhere most commonly occurred shortly after a CTO was issued or renewed.

Just over one-quarter (28%) of survey respondents considered that methods for engaging with consumers who did not adhere to a CTO were satisfactory (Table 6-7). Psychiatrists, consumer groups and peer supporters, and rights advisers were least likely to agree that methods were satisfactory. One of the challenges was locating consumers who moved away from the district and consumers who could not be located because they were homeless.

Table 6-7: Agreement with the Satisfaction of Methods for Dealing with Non-Compliance

Statements Agreed With	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
The methods for dealing with non-compliance are satisfactory	15%	44%	38%	33%	0%	24%	28%
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

6.3.3 The Discharge Planning Process

Formally, when a CTO term was ending and a physician wished to renew, a Form 46 would be issued and a physician would conduct an assessment under Form 1. There were no standard processes for ending a CTO. The more important discussion was whether to end or renew the CTO and how these decisions were made.

It's a tough call to know when to end a CTO because some people go on and do really well, and others

There is a difference from being on a CTO and suddenly being off the CTO. How do you make it a smaller step towards being able to make some of those decisions of being able to exercise your own care. – ACT Team member

The dilemma concerning ending CTOs was whether consumers would continue with recovery or whether they would become unwell again and return to the hospital. Feedback from mental

health service providers indicated challenges in knowing whether a particular consumer would do well without the CTO. Due to this uncertainty, CTOs were most often renewed. In response to the survey (Table 6-3 above), with the exception of CTO coordinators, the majority of health professionals did not think that consumers would retain the gains they had made after their CTO was removed.

There was some discussion around creating a bridging system to help consumers transition from being on the CTO to being independent in the community, which was expected to assist continued recovery.

Interviewed stakeholders said that some consumers did not want to be taken off the CTO because of fear of losing the supports they had been receiving. Other consumers we spoke to said they would like to have timelines and goals included in the CTO to work toward discharge. Having no indication of when they could possibly be discharged from the CTO, despite its six month duration, was of concern to consumers.

According to the Toronto data, there may be a trend towards CTOs ending due to withdrawal. The proportion of Toronto CTOs being discharged for that reason increased from 10% from 2005/6 to 2007/08 to about half from 2008/9 to 2010/11. Discharges occurring due to completion without referral have fallen from 39% in 2005/06 to 6% in 2010/11 (Table 6-8).

Table 6-8: Discharge Reason for Toronto CTO Consumers (2005/06-2010/11)

Discharge Reason	2005/06 (n=31)	2006/07 (n=47)	2007/08 (n=34)	2008/09 (n=58)	2009/10 (n=68)	2010/11 (n=51)
Completion with Referral[16]	29%	28%	12%	21%	26%	29%
Completion without referral	6%	0%	15%	29%	35%	39%
Withdrawal[17]	48%	62%	44%	10%	10%	10%
Relocation	13%	6%	15%	14%	13%	10%
Death	0%	4%	6%	7%	3%	2%
Suicide	3%	0%	0%	0%	0%	0%
Other	0%	0%	6%	12%	12%	10%

Source: Data provided by and Toronto Source.

[16] Service being referred to not specified.
[17] Withdrawal must be provided by individual consenting to CTO (can be consumer or SDM)

6.3.4 Are the Safeguards in Place Working Adequately

An essential element of the CTO process is that consumers or their SDM provide informed consent. Consent and coercion was a frequently discussed topic in interviews and in open-ended responses to the survey. However, a well informed consent process is difficult as coercion is implicitly part of the CTO process because consumers generally want to leave hospital and the CTO provides them with a mechanism for doing so. The safeguards in place include the provision of rights advice and the CCB. Slightly less than one-half of respondents to the survey (43%) agreed that the legal safeguards in place were adequate.

Sometimes psychiatrists forget that people have the right to be mentally ill as long as they are not harming themselves or others. I think they revert to meds too quickly. I think that's often a problem. –Stakeholder

Table 6-8: Survey Respondents Perceptions about Safeguards

Statements	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
The legal safeguards in the legislation are appropriate	53%	70%	55%	40%	7%	41%	43%
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

Of the CTO consumers who responded to the survey, 57% were not concerned about the amount of choice they had when issued a CTO, however 15% were concerned and 21% very concerned (Table 6-9). Slightly less than one-half of the CTO consumers (45%) were either concerned (26%) or very concerned (19%) about their rights under a CTO.

Table 6-9: Survey Respondents Perceptions about Their Rights Under a CTO

Consumers (n=47)	One CTO (n=20)			2 or more CTOs (n=27)		
	Not Concerned	Concerned	Very Concerned	Not Concerned	Concerned	Very Concerned
The amount of choice I had when issued a CTO	45%	30%	15%	67%	4%	26%
My rights under a CTO	45%	25%	20%	56%	26%	19%
Family and Friends (n=20)	**Not Concerned**	**Concerned**	**Very Concerned**			
The amount of choice my family member/ friend had when issued a CTO	60%	15%	65%			
My family member/ friend's rights under a CTO	65%	10%	5%			

Note: Percentages may not add up to 100 as some respondents replied "No answer/Don't Know."

Some SDMs felt that CTOs infringed on personal rights because consumers wanted to be released from hospital. Many family members or friends who responded to the survey (75%) were not concerned about the amount of choice their family member or friend had when issued a CTO or about their family member or friend's rights under a CTO (75%). One aspect of the consent process that may be

particularly challenging is the degree of control that a parent who is a SDM has over the life of a young adult issued a CTO, when that young adult has been trying to seek independence from their parent. Separating the parenting role from the SDM role may allow relationships to be built or re-built more effectively.

When we talked to consumer groups and peer supporters, their comments related primarily to the risk of coercion, the general lack of information provided to consumers and their families about CTOs and the importance of using an appropriate approach when suggesting a CTO.

6.3.5 Rights Advice

The rights advice services are a mechanism by which consumers' and SDMs' rights are safeguarded. Before a CTO is issued or renewed the consumer, and their SDM (if any) must receive information about their rights concerning the order. Generally, stakeholders felt that the rights advice being provided was timely and complete. It was acknowledged that the provision of rights advice was an essential component of CTOs, especially for individuals consenting to their own CTO and non-PGT SDMs. One coordinator noted that the process was becoming more efficient now that PGT SDMs were only required to receive rights advice when a CTO was initiated and not for renewals.

The PPAO records the number of requests their offices receive for rights advice. These data showed that the number of requests for rights advice had increased in tandem with the growth of CTOs (Table 6-10). The growth of CTOs has been supported largely by community based rights advice services, rather than PPAO field offices or facility-approved rights advisers. Community based rights advice accounted for only 28% of all CTO rights services in 2001. In 2011, they accounted for 88%.

Table 6-10: Rights Advice Requests for CTOs (Issued and Renewed) by Service (2001-2011)

Year	Community Based Rights Advice			PPAO Field Offices			Facility-Approved Rights Advisers		
	Issue	Renewal	Total	Issue	Renewal	Total	Issue	Renewal	Total
2001	65	0	65	40	3	43	19	108	127
2002	22	84	106	47	12	59	58	8	66
2003	298	230	528	79	12	91	42	8	50
2004	425	275	700	127	16	143	52	3	55
2005	448	392	840	156	20	176			
2006	552	526	1,078	211	22	233			
2007	627	713	1,340	192	51	243			
2008	658	874	1,532	217	37	254			
2009	810	1,074	1,884	282	32	314			
2010	948	1,387	2,335	361	57	418			
2011	1,147	1,642	2,789	309	56	365	14	11	25

Source: 2005-2011 data from PPAO; 2001-2004 data from Dreezer and Dreezer Report.

To be effective, rights advice must be delivered in a timely fashion. PPAO data also record the response time to requests for rights advice. Comparing the PPAO database to the findings of the first review showed that rights advice may now be occurring in a more timely fashion as the proportion of rights

services being delivered more than a week after the request had fallen from 31% in 2002-2004 to 14% in 2011.

The response time appeared to vary by LHIN. For instance, Toronto Central was the only LHIN where the majority of requests took more than three days. The North West on the other hand was able to provide rights advice to 83% of requests within one to three days (Table 6-11).

Table 6-11: PPAO Response Time to Requests for Rights Advice

LHIN	All Request for Rights Advice		
	1-3 days	4-7 days	?7 days
Central	54%	26%	21%
Central East	51%	32%	17%
Central West	64%	24%	12%
Champlain	59%	24%	17%
Erie St.Clair	65%	25%	10%
Hamilton Niagara Haldimand Brant	69%	21%	9%
Mississauga Halton	51%	35%	14%
North East	66%	24%	10%
North Simcoe Muskoka	64%	28%	8%
North West	83%	11%	6%
South East	72%	19%	9%
South West	60%	27%	12%
Toronto Central	38%	35%	27%
Waterloo Wellington	68%	23%	9%
Ontario, 2011	59%	27%	14%
Ontario, (2002-2004)	*52%*	*17%*	*31%*

Source: 2011 data from PPAO; 2002-2004 data from first Review.

In the survey most health professionals agreed that the rights of CTO consumers were adequately protected as part of the CTO process. In contrast, few consumer groups/peer supporters (7%) and rights advisers (25%) agreed that consumers' rights were adequately protected. Over all survey respondents, 48% agreed that the rights advice process worked well (Table 6-12).

Table 6-12: Survey Respondents Perceptions about Safeguards

Statements	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
The rights of CTO consumers are adequately protected	83%	74%	75%	60%	7%	55%	60%
The Rights Advice process works well	58%	61%	58%	44%	33%	50%	48%
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

From interviews it appeared that the majority of rights advice for CTOs issued to in-patients was delivered in-person in a mental health facility. If this was not an option the rights adviser would attempt to contact the individual (or their SDM) by telephone. Some CTO coordinators found this to be a problem as many of their consumers did not have a telephone. SDMs who were relatives had varying experiences with rights advice. Some described it as not valuable and very brief; while others described it as informative. This appeared to be dependent on the person who provided the rights advice to them.

Other concerns included the difficulty that some consumers had in interacting with strangers and the stress that this could cause. A lack of rights advisers who spoke languages other than English and the resulting delay in the provision of rights was also a concern. Finally, although only a few hospitals had opted out of PPAO rights advice and hired their own rights advisers, this was seen as a potential conflict of interest.

Since 2005, the legislation regarding rights advice for consumers consenting to their own CTO has been amended. Previously, a Form 50 could not be issued until the consumer had been directly contacted and had refused rights advice. Now, rights advisers have to make their best effort to contact the consumer, but if they are not able to, the CTO may still be issued.

6.3.6 The Consent and Capacity Board (CCB)

The CCB is an independent administrative tribunal governed by the *Health Care and Consent Act*, composed of psychiatrists, lawyers and members of the general public. As it applies to CTOs, their mandate is to rule exclusively on whether an individual qualifies under the legislated criteria of a CTO.

The CCB reported an increase of 24% in applications in 2011/12 over the previous year. Table 6-13 below shows the applications received by the CCB in 2011 by LHIN. It shows that 74% of these were mandatory reviews (required every second time CTO is renewed) and the remainder were patient initiated and other forms of reviews. It also shows that the number of applications varied by LHIN, even when the size of the LHINs was taken into consideration. Due to the limited sample sizes, it is hard to tell whether the makeup of applications by type varied by LHIN.

Table 6-13: Applications to the Consent and Capacity Board (2011)

LHIN	Applications	Mandatory	F48i	F48r	Other	Deemed Incapable	F48A
Central	38	47%	34%	13%	5%	156	15
Central East	13	46%	31%	23%	0%	71	3
Central West	43	74%	16%	9%	0%	120	8
Champlain	96	68%	19%	13%	1%	302	22
Erie St.Clair	55	87%	5%	5%	2%	112	6
Hamilton Niagara Haldimand Brant	130	83%	5%	12%	1%	245	18
Mississauga Halton	55	60%	29%	11%	0%	178	10
North East	51	80%	10%	10%	0%	124	9
North Simcoe Muskoka	24	75%	4%	21%	0%	61	5
North West	4	50%	0%	50%	0%	10	0
South East	4	25%	25%	50%	0%	13	3
South West	127	91%	0%	7%	2%	301	10
Toronto Central	77	48%	27%	18%	6%	225	24
Waterloo Wellington	43	88%	2%	9%	0%	98	4
2011 Total	**760**	**74%**	**13%**	**12%**	**2%**	**2016**	**137**

Source: PPAO.
Definitions: F48i is review of CTO issuance, F48r is review of CTO renewal, and F48A is review of treatment incapacity.

While some stakeholders noted that the CCB process worked well, other comments regarding the CCB were not favorable. There was a tension between some health professionals who perceived that the frequency of appearances before the Board was unnecessarily high and the need to ensure that consumer's rights were protected. It is important that consumers have a chance to appear before the Board and we did hear of concerns that without receiving adequate advice about their rights consumers may be being asked to sign waivers saying they did not want to appear. Comments made about the Board included problems with communication and organization, the adversarial nature, and that the CCB may, at times, "lack common sense". Some also felt that their scope was too narrow and that it should be expanded to include clinical components of the community treatment plan. In response to the survey, 31% agreed that the CCB process was satisfactory for all stakeholders (Table 6-14). Dissatisfaction was not necessarily directed at the CCB but at the rules the CCB must work within.

Table 6-14: Survey Respondents Perceptions about Safeguards

Statements	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
The Consent and Capacity Board process is satisfactory for all stakeholders[1]	38%	26%	33%	34%	15%	26%	31%
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

[1]13% of respondents replied "No answer/don't know."

CTO coordinators relayed that consumers found the CCB process to be stressful. As the process was seen to be adversarial in nature, some clients felt that self-advocating may further the perception that they were non-compliant and in some cases felt it may "anger" their psychiatrist and as a result cause their release from hospital to be delayed. Others felt that it was an exercise in futility and that the decision had been predetermined. CTO coordinators also mentioned that the new process of sending out CCB information to consumers who had declined a hearing had caused confusion and increased stress for consumers.

The data below provided by regional stakeholders showed that CTOs were rarely revoked in the jurisdictions for which data were available (Table 6-15).

Table 6-15: Disposition of Consent and Capacity Board for Selected Regions (2005-2010)

LHIN/City	Disposition	2005	2006	2007	2008	2009	2010
Champlain	CTO Confirmed	3	4	7	18	20	23
	CTO Revoked	0	0	0	0	0	0
	Withdrawn/Dismissed	0	0	0	2	3	0
	Incapacity Revoked	0	0	0	0	1	0
London (part of South West)	CTO Confirmed		37	40	64	70	89
	CTO Revoked		0	2	0	0	1
	No Jurisdiction (Invalid)		1	5	2	2	2
	Withdrawn		2	3	5	1	7
Mississauga Halton	CTO Confirmed			5	15		
	CTO Revoked			1	1		
Algoma (part of North East)	CTO Confirmed	0	2	4	10	18	27
	CTO Revoked	0	0	0	0	0	0

Source: Champlain Source, London Source, Mississauga Halton Source and Algoma Source. Data for Champlain, Mississauga Halton and Algoma is for fiscal year (e.g. 2005/06, 2006/07).

Family and friends who were SDMs said that the frequency of the hearings in front of the Board brought uncertainty and given their satisfaction with the CTO, this may not be unexpected. Some SDMs who were relatives indicated that each time they appeared in front of the Board, their loved-one essentially learned what to say and what not to say.

The physicians initiating CTOs also found CCB hearings to be stressful and noted that the hearing process was a long one that could take up to a day to complete. This made it difficult for physicians with multiple consumers on CTOs and could deter physicians from issuing further CTOs to individuals they felt would benefit from them. Physicians also reported receiving inadequate notice of an appeal to the CCB, in some cases only having hours to prepare. Finally, physicians shared the concern of some consumers that the adversarial nature of the CCB hearings had a detrimental effect on the therapeutic alliance that they were striving to achieve with the individual. We also heard from physicians that the compensation provided to them for CCB hearings was inadequate.

Some suggestions on how to improve the CCB process were to increase compensation for physicians attending hearings, to have lawyers review files to determine if a hearing should be held and to hold hearings less frequently for individuals who had already had several renewals.

One area of the CTO legislation which was criticized during the review was that relating to the appeal process. Under the legislation, a consumer receives rights advice when they receive a Form 49. However, they are not entitled to apply to the CCB until after the CTO has been issued. Rights advice is not required after the Form 45 has been issued and it may be difficult for consumers to proceed with an application to the Board at that time due to challenges in contacting lawyers, the CCB or rights advisers.

6.4 Factors Impacting on the Effectiveness of CTOs

CTOs are not a treatment modality. Effective CTOs require a comprehensive community care plan and the availability of the services recommended in the plan. Community treatment plans have been discussed previously. Other factors which seemed to have the most impact on the effectiveness of CTOs related to the access consumers had to the services and supports that could be delivered under a CTO and to the knowledge of the health professionals involved in the process.

6.4.1 Services and Supports Received by CTO Consumers

Review participants agreed that the main factor impacting on the effectiveness of a CTO was whether the necessary supports and services were in place to facilitate success. It was clear from discussions with participants that, whether included in the CTO or not, supports were crucial to recovery.

> *There are 5,000 people on the waiting list for supportive housing in Toronto. Somebody who is struggling is so vulnerable and marginalized. Focusing on medicinal compliance will do nothing for their situation. Housing and healthcare are lacking.- Stakeholder*

Consumers who responded to the survey were asked about the services and supports they had received in the last year (Table 6-16). Those newly issued with CTOs were more likely to have accessed hospital inpatient services or community mental health programs. Those on their second or subsequent CTO were more likely to have received care from the ACT Team, a doctor outside of a hospital or from family or friends. It is important to note that these differences may just be an effect of small numbers.

Table 6-16: Services and Supports Received by Consumers in the Last Year

Service or support	One CTO	Two or more CTOs	Total
Community mental health program	80%	48%	62%
Doctor's care outside of a hospital	45%	63%	55%
Care from family or friends	45%	59%	53%
Hospital outpatient	45%	44%	45%
Hospital inpatient	50%	37%	43%
Social service program (e.g. help with housing or employment)	25%	30%	28%
ACT Team	5%	26%	17%
Hospital leave of absence	5%	0%	2%
No care outside of the care under the CTO	*0%*	*4%*	*2%*
Total Numbers	**20**	**27**	**47**

Survey respondents were also asked about the availability of services in their community (Table 6-17). While most consumers were satisfied with the services that were being provided to them, 55% of consumers with newly issued CTOs and 30% on a second or subsequent CTO were concerned, or very concerned, about the availability of services in their community. In discussions with both consumers and SDM we heard that one of the advantages of a CTO was that they were now linked into services. While most (85%) family and friends of CTO consumers were satisfied with the services being provided as part of their family member/friend's treatment plan, many family and friends of CTO consumers were also concerned (30%) or very concerned (35%) about the availability of needed services in their community.

Table 6-17: Services and Supports Received by Consumers in the Last Year

Consumers (n=47)	One CTO (n=20)			2 or more CTOs (n=27)		
	Not Concerned	Concerned	Very Concerned	Not Concerned	Concerned	Very Concerned
The availability services I need in my community	35%	45%	10%	59%	15%	15%
I am/was satisfied with the services being provided to me as part of my treatment plan	85%	10%	5%	82%	7%	7%
Family and Friends (n=20)	**Not Concerned**	**Concerned**	**Very Concerned**			
The availability of needed services in my community	25%	30%	80%			
I am/was satisfied with the services being provided to them as part of their treatment plan	80%	35%	5%			

Note: Percentages may not add up to 100 as some respondents replied "No answer/Don't Know."

The services and supports for mental health consumers varied by type and availability depending on the community. Some areas had very basic or limited services and others had an integrated community of service providers. Regardless of the region, there was consensus that services overall were lacking. While just being out in the community was seen as a benefit of the CTO, stakeholders felt that this would be short lived if supports were not available to keep consumers in the community.

With limited mental health resources available it is often difficult to support these higher risk individuals that need much support (daily visits) to be successful.- Community health worker

In response to the survey, lack of housing and access to services were identified most frequently as limiting the effectiveness of CTOs (Table 6-18).

Table 6-18: Factors Limiting CTOs

Statements Agreed With	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
The lack of availability of income support and housing limits the effectiveness of CTOs	50%	44%	58%	58%	70%	55%	56%
CTO coordinators and case managers have adequate access to services for clients	30%	26%	20%	24%	11%	26%	24%
CTOs are being used as a way to get to the front of the resource line	10%	9%	18%	17%	30%	21%	17%
CTOs take needed resources away from non-CTO clients	10%	9%	8%	9%	26%	5%	10%
Did not agree with any statement above	*30%*	*26%*	*20%*	*21%*	*19%*	*24%*	*22%*
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

Many CTO consumers were on waiting lists to receive case management and other needed services. CTO consumers who required intensive case management were often left to wait for ACT Teams to become available. Increases in the numbers of CTOs without corresponding increases in mental health human resources was reported to have created tension around the level of care that could be provided. It was felt that funding should reflect the increase in CTO use. The lack of available community services was said to make the jobs of CTO coordinators and case managers even more challenging as they were left to continuously try to secure services for the consumer or left to work around the services that were available.

Some housing programs are afraid to provide housing support to the CTO client because they think that the CTO will only last for six months. After 6 months, the client may not agree to renew the CTO. They are reluctant to provide housing because they think it is going to be short term. – Coordinator/Case Manager

For many, housing was the number one support influencing CTO effectiveness and concerns about its availability were prominent. Housing

shortages were noted in many areas and where housing was available, other challenges made it difficult for CTO clients to access housing.

In addition to the lack of services, the first review reported there was preferential access to available community services and that CTOs were being used to jump queues. There was substantial disagreement with this notion among a large group of stakeholders, particularly CTO coordinators and case managers. They were of the opinion that all mental health consumers had equal access to available services. There was some agreement however that the CTO made access easier, specifically when linked to a case manager who could introduce and link the consumer to the services. Some felt that all mental health consumers had access to the same services, but that those on CTOs were a higher priority for services.

Resources may seem to be more abundant for CTO consumers, but they are often the most in need, often by definition: severity of illness, multiple hospital entries, lack of adherence, disadvantaged groups. – Survey participant - Psychiatrist

When CTOs first started, there was a great amount of education for doctors, healthcare professionals, families and community workers. I think it needs to be refreshed. I find many of the community mental health providers do not have a clue of the program and what it can offer and how they need to participate as well. – Community health

6.4.2 Health Professionals

Another factor influencing the effectiveness of CTOs was communication among service providers, CTO coordinators and case managers, physicians and with consumers. While some regions appreciated the integrated services they were a part of and appreciated the collaboration around the CTO, communication was something that could often be improved. Interviewed stakeholders said that more collaboration between CTO coordinators could further benefit the CTO by developing standard practices that could be executed in all LHINs. Thay also frequently mentioned that more education about CTOs was required to increase broad understanding of the tool and how and when it could be effective.

Of note is that 61% of respondents to the survey (and 87% of CTO coordinators) felt that CTOs had increased communication and understanding among service providers (Table 6-19).

Table 6-19: Percentage Agreeing with Statements about CTOs

Statements	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
CTOs increase communication and understanding among service providers	68%	87%	63%	63%	19%	57%	61%
Physicians are adequately educated and informed about CTOs and related issues[1]	15%	30%	30%	24%	4%	21%	22%
All individuals who could benefit from a CTO have access to one [1]	13%	4%	23%	16%	7%	7%	14%
Did not agree with any statement above	*25%*	*4%*	*23%*	*24%*	*70%*	*33%*	*27%*
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

[1] 11-13% of respondents replied no answer/don't know, versus rates of <5% for the other questions in this table.

SECTION 7: METHODS USED TO EVALUATE THE OUTCOME OF ANY TREATMENT USED UNDER CTOs

Clinical judgement was the primary method used to evaluate the outcomes for CTO consumers. Administrative data provided some information about the outcomes of treatment used under CTOs. Improving the quality of administrative data would help in assessing the effectiveness of CTOs in Ontario. The introduction of the Ontario Common Assessment of Need Tool (OCAN) has the potential to provide a means for collecting information about outcomes for CTO consumers, allowing a more accurate assessment of the strengths and weaknesses of the process.

7.1 What Consumer Outcomes are being Measured in Ontario

Sound administrative data being recorded in a single database would facilitate the measurement of outcomes resulting from CTOs. The types of analyses that a sound database could allow would greatly inform the MOHTLC on the nature and state of CTOs. For instance, case by case analyses could show the time consumers need to be on a CTO before desired outcomes are realized. Longitudinal studies could show how CTOs are improving over time in being able to support positive outcomes for consumers, their friends and family, and the mental health care system. Exploratory studies could demonstrate the outcomes that are associated with certain elements of CTOs, for instance whether the consumer or a SDM consents.

However, the nature of the data that are being collected may not readily contribute to an understanding of outcomes. Certainly some data that were provided do record before and during measures of aspects of consumers' lives. The Toronto database holds information about consumers upon entering the CTO (the baseline) and at a later time (the most recent information, either current as of the date of data extraction or the date of discharge). Dimensions of lifestyle being recorded include:

- Residence situation (alone, spouse, parents, etc);
- Residence type (private house, municipal housing, boarding house, etc);
- Living support (independent, support, supervised, etc.);
- Employment status (sheltered workshop, employed on own, sporadic employment, etc);
- Academic participation (attending high school, attending college/university, not in school);
- Primary income source (disability income, employment insurance, employment); and
- Hospital visits and days (in the two years prior to CTO issue as baseline and from the time of issue to current/or date of discharge).

As each CTO case is different, it is difficult to conclude whether all CTO consumers moving from a certain lifestyle prior to the CTO to another during the CTO was a positive or negative change. As such, many of these dimensions measure change in a CTO consumers' lifestyle but do not form clear outcomes. Perhaps the only measures that could clearly demonstrate positive outcomes are the number of hospitalizations and hospitalization days since the CTO; however these data do not appear to be recorded and/or entered into the database for the vast majority of cases.

And finally these data only report information during the CTO (providing information at the outset and current/discharge date). It does not provide any measure of the consumer's lifestyle at a point in time after the CTO. Thus the data that are recorded can be best viewed as an output of the CTO, rather than an outcome of it. It is important to understand whether the beneficial outcomes of CTOs remain after discharge or whether CTOs are best viewed as ongoing mental health maintenance.

And of course, when one considers the many factors at play that could impact these dimensions, causality will always be an issue in understanding any of these measures. That is true of all measures of mental health outcomes, however.

In addition to outcome measures recorded within the Toronto database, consumer-driven or 'softer measures' of consumers' well-being may be recorded using the Ontario Common Assessment of Need (OCAN). OCAN asks individuals to set goals (e.g. stabilized housing, education, and employment) and records their achievements. It also asks clients about their well-being, for instance recording their satisfaction with life and sense of safety in their community. OCAN is currently being rolled out by LHIN through the CCIM but has not been provincially mandated.

A single database, recording when CTOs are being used, what services are included in community treatment plans, and consumer outcomes, may contribute to reducing concerns about the use of CTOs. At present, the outcomes of CTOs are not being readily recorded. And as such, this review has been unable to assess from existing administrative data the impact of CTOs on consumers, their friends and family, and the mental health care system.

7.2 How Consumer Outcomes are being Measured

There appears to be variation in how and when CTOs are documented across Ontario. The means by which information on CTOs is gathered varies between regions and differing stakeholders. As there does not appear to be a consistent standard to how information on consumers are being collected and compiled, consumer outcomes are not being adequately recorded.

Data are not being collected in a rigorous manner, nor compiled in a centralized database. Further, databases are often not comparable from one region or stakeholder to another. The lack of a central measure of consumer outcomes is significantly impairing the ability of the MOHLTC, practitioners and researchers to measure CTO consumer outcomes.

SECTION 8: DISCUSSION AND RECOMMENDATIONS

This section of the report provides an overview of the review's findings, discusses the implications of the findings in the context of the review questions, and provides recommendations.

8.1 Use of CTOs

A lack of robust administrative data about the number of CTOs issued, reissued and renewed provided a challenge for the review. Although some data were available from the MOHLTC Common Dataset (CDS) and from CTO-OHIP billing records, data were frequently conflicting and/or incomplete. Data for some LHINs or parts of LHINs were also provided to us by CTO coordinators and other stakeholders, and data were also received from the PPAO and the CCB. Data were not available from all LHINs as data recording by CTO coordinators was inconsistent with some recording data and sending it to the Ministry, others recording data but keeping it locally and others collecting information in an informal manner.

The number of CTOs issued, reissued and renewed has steadily increased since 2001. In 2003, at the end of the last review the number of CTOs recorded in the CDS was 459. In 2010, 3,270 were recorded in the MOHLTC Common Dataset (CDS)[18] and 1,210 in OHIP data (down from 2,014 in 2008).

Most CTOs were issued within mental health case management services (54%) or ACT Teams (17%).[19] Detailed data from LHINs provided some insight into the profile of consumers issued CTOs. CTOs were most commonly issued to people with schizophrenia or schizoaffective disorder (82%) or bipolar disorder (13%). Many people issued CTOs also had problems with addiction and substance abuse. Based on the Toronto data, people on CTOs were on average less educated when compared to the Toronto population as a whole. The majority of CTOs were issued to people under 45 years, with those aged over 45 years more likely to be females. On admission, the majority (84%) were supported financially by disability supports, employment insurance or by family, and 37% lived with family or friends.

8.2 The Reasons That CTOs Were or Were Not Used During the Review Period

After talking to consumers and reviewing the survey data we identified four themes with respect to CTO consumers' reasons for agreeing to or not agreeing to a CTO. These themes were consistent with the opinions reported in the first review. It is important to note that consumer opinions and feelings about CTOs are not mutually exclusive and may change over the duration of a CTO.

- Some consumers were very positive about their experiences with a CTO. Overall they felt their well-being had increased since being issued a CTO and they were satisfied. They said that since they had been issued a CTO their quality of life had greatly improved; that they could now see a future for themselves; and that they had reengaged with family, friends and possibly with employment. Many acknowledged that their CTO ensured they adhered to their community treatment plan and in particular to their medication. Some reported that feeling they were linked in with services and were part of a CTO team was important. Consumers in this group generally consented to their own CTO.

[18] Includes issues, reissues and renewals

[19] The data demonstrate considerable variation between years so a three-year average was used.

- Some consumers felt they were fully recovered and therefore did not need any medication, but adhered to their treatment plan because of the CTO and often to keep family or friends happy. They were not necessarily resistant or resentful about having a CTO. Their CTOs were usually issued with the consent of an SDM.
- Some consumers resented the system and their CTO but felt that their quality of life had improved since being on a CTO so would continue taking their medication and acknowledged the CTO assisted them to do so. Some consumers who felt this way had provided their own consent and others had consent provided by a SDM.
- Some consumers resented being on a CTO because of the enforcement aspect and perceptions that being on a CTO made them feel like "criminals". Some reported that they would stop taking their medication as soon as their CTO finished, often because of the adverse side-effects they were experiencing from their medication. Most had consent provided by a SDM.

From the perspective of relatives and friends (including relatives who were SDM), the CTO ensured preventive support for consumers. It provided a means for a quick response at the first signs of struggle or relapse; it provided assurance that in the case of non-adherence to treatment, the consumer would be taken to a mental health practitioner (and not into to custody); and it provided an opportunity for SDMs who were relatives to be a part of the process. Overall, relatives and friends said the CTO provided them with relief and comfort in knowing that there was someone available when they needed them.

The main reasons that consumers and SDMs resisted CTOs were due to undesirable side effects from prescribed medication and the mandatory nature of a CTO. However, without the CTO, many recognized there would also be hardship. Relatives who were SDMs felt that the CTO helped keep their loved-one out of hospital and adhering to their medication. Together this helped bring stability to their family member's life. As a result, SDMs felt that while the CTO may not be perfect, it was still worthwhile.

Most of the health professionals we talked to used CTOs to some extent. Some used them infrequently and only with consenting consumers, and described their use of a CTO as a mutual contract where they undertook to provide services and support if the consumer undertook to adhere to their recommendations. Other health professionals used CTOs more frequently and some advocated for the use of CTOs for all discharges of patients with severe mental illness. Health professionals who used CTOs did so because: they believed that CTOs were an effective arrangement; that CTOs were effective in ensuring consumers adhered to their community treatment plans and in particular adhered to their prescribed medication; that CTOs ensured that consumers did not fall through the cracks and get lost to the system; and that consumers were linked into the resources they needed in the community.

In the survey, across all groups, the factors most often considered to be very important in supporting or encouraging the use of CTOs in Ontario were: reducing the frequency of hospitalizations (76%); ensuring a team supported community treatment plan (76%); safety in the community (71%); addressing treatment non-compliance (70%); access to additional resources such as case management (68%) and the availability of CTO coordinators and case managers (60%). It is important to note that increased access to services and case management seemed to be more about coordination and linkages between providers than about queue jumping, which was raised as an issue in the first review. This was

supported by 68% of the 40 psychiatrists who responded to the survey agreeing that CTOs were effective in increasing communication and understanding among service providers.

Health professionals we talked to explained that the following limited the use of CTOs by themselves and their colleagues: the time and effort required throughout the CTO process; lack of necessary supporting services; and lack of knowledge about CTOs. Their views were consistent with survey responses where the factors most often reported as very important in limiting the use of CTOs in Ontario were: insufficient community resources available for CTO clients (46%); level of knowledge and/or experience with CTOs (43%); the availability of CTO coordinators/case managers (42%), workload concerns regarding issuing a CTO, the legal review process and/or supervising a client (40% of all respondents and 45% of psychiatrists); and refusal of consent by a SDM (39%). Of note is that 41% of consumer groups/ peer supporters felt the lack of scientific evidence was very important in limiting the use of CTOs.

8.3 The Effectiveness of CTOs during the Review Period

CTOs have been the subject of a number of studies both in Ontario, in other Canadian jurisdictions and internationally. Dreezer and Dreezer provided an extensive review of the literature in the first review that has been updated as part of the current review. There is limited empirical data from RCTs (the 'gold-standard' for evidence) about the effectiveness of CTOs. Although there have been two meta-analyses of CTO trials neither provided robust evidence that CTOs are more or less effective than comparable care without a CTO. Methodological and ethical issues mean there is unlikely to be robust empirical evidence about the impact of CTOs. However, there are findings from other types of studies that CTOs improve outcomes for some patients. In this review the effectiveness of CTOs has been assessed by considering:

- The effects CTOs have on consumer well-being and satisfaction;
- The effectiveness of the process for issuing CTOs and consistency of the process with the intention of the legislation and the legislated criteria;
- The discharge planning process for a CTO consumer; and
- Factors impacting on the effectiveness of CTOs including the services and supports CTO consumers are receiving.

8.3.1 Effects on Consumer Well-Being and Satisfaction

Interviewed health professionals held the view that consumer well-being improved when consumers adhered to treatment plans, which almost always included medication. When consumers stopped taking their medication their health and well-being rapidly deteriorated as well as their awareness that they were unwell.

Some consumers were willing to adhere to their medication, others did not recognize that they needed medication or did not consider that the benefits of the medication outweighed the side-effects they were experiencing. Some, who did continue with medication, said they recognized the improvement in their lives, whether it was improvements to their general quality of life, being able to pursue goals or the positive relationships built with their health care support workers and others in their lives.

Most consumers who responded to the survey (72%) agreed they felt better as a result of the CTO, 66% reported an improved quality of life, 57% were more satisfied with their CTO than other treatment options, and 62% felt CTOs were the best option for their situation compared with other treatment options.

The family, friends and SDMs we were able to engage with as part of the review were almost uniformly positive about CTOs. They commented on the improvements they observed in their loved-one's quality of life, and improvements to their own well-being by reducing their levels of worry about their loved-one. In response to the survey, 70% of family and friends reported improvements in the health and 70% in the quality of life of their family member or friend, 85% were more satisfied with the CTO than other treatment options, and 85% agreed that CTOs were the best option for their loved-one.

With the exception of consumer groups/ peer supporters, there were high levels of agreement by survey respondents that CTOs had a positive effect on the quality of life of consumers (65%), were effective in addressing the revolving door between hospital and community (65%), had reduced hospital admissions rates (64%), and were effective in reducing the risk of serious harm to people in the community (57%).

Few responding to the survey agreed that CTOs were effectively serving Aboriginal communities, rural communities, Francophone and multi-cultural communities. However, many did not feel they had sufficient knowledge to respond to this question, highlighting the importance of a focus on cultural competencies as part of continuing medical education.

8.3.2 The Effectiveness of the Process

CTO Administration

CTOs are coordinated by CTO coordinators who are usually employed by hospitals. The implementation of the CTO legislation does vary between LHINs. In particular, depending on the LHIN, the roles of CTO coordinators and case managers included different responsibilities and levels of interaction with consumers and community services. The approach to the community treatment plan also differed depending on the preferences of the coordinators and psychiatrists. Some preferred a community treatment plan that only prescribed medication administration and others included a wider range of requirements such as adhering to certain schedules and community services.

While the CTO coordinator role differed slightly across health regions, feedback from review participants confirmed the importance of the CTO coordinator when considering the effectiveness of CTOs. Approaches and processes may be different, but the presence of a dedicated CTO coordinator affected how well those processes worked and helped ensure accountability of all parties involved in the CTO. We heard from some psychiatrists that they would not use CTOs if it was not for the positive support and advocacy for CTOs provided by the CTO coordinator in their LHIN.

There is no central process for providing program standards for CTOs or to allow information sharing between coordinators, psychiatrists and other health professionals across the province. This lack of central coordination may underpin some of the regional variation in practice identified during the review.

For programs such as the CTO, which impact on a relatively small proportion of the population, there is need to establish and maintain consistent program standards. While it is the role of professional groups

to set clinical standards, the MOHLTC may have an important role in setting province wide program standards that will help ensure consistent practice between LHINs.

When CTOs Were Used

There seemed to be variation in the consumer groups to whom CTOs were issued. From some we heard that CTOs were increasingly being used as a preventive measure rather than as a last resort. In the survey, approximately two-thirds of psychiatrists and CTO coordinators did not agree that CTOs should be a last resort when other treatment options had been explored. Other in-patient health professionals (55%), ACT Team members (64%), other community health care providers (57%), and consumer groups/peer supporters (63%) were more likely to agree that CTOs should be used as a last resort.

The Ontario approach to CTOs has been to take a preventive approach. The legislation is not specific about whether CTOs are a last resort or otherwise, but it does allow for a CTO to be used to prevent deterioration.

Consent and Coercion

An essential element of the CTO process is that consumers or their SDM provide informed consent. Consent and coercion were frequently discussed in interviews and in open-ended responses to the survey. In the survey most health professionals agreed that the rights of CTO consumers were adequately protected as part of the CTO process. In contrast, few consumer groups/peer supporters (7%) and rights advisers (25%) agreed that consumers' rights were adequately protected. Over all survey respondents, 48% agreed that the Rights Advice process worked well, 43% that the legal safeguards in place were adequate and 31% that the CCB process was satisfactory for all stakeholders.

However, a robust consent process is difficult as coercion is implicitly part of the CTO process because consumers generally want to leave hospital and the CTO provides them with a mechanism for doing so. Of the CTO consumers who responded to the survey, 57% were not concerned about the amount of choice they had when issued a CTO, however 15% were concerned and 21% very concerned. Slightly less than one-half of the CTO consumers (45%) were either concerned (26%) or very concerned (19%) about their rights under a CTO. In contrast, many family members or friends who responded (75%) were not concerned about the amount of choice their family member or friend had when issued a CTO or about their family member or friend's rights under a CTO (75%).

When we talked to consumer groups and peer supporters, their comments related primarily to the risk of coercion, the general lack of information provided to consumers and their families about CTOs and the importance of using an appropriate approach when suggesting a CTO.

Since the first review there appeared to have been a movement away from consumer consent to being issued a CTO towards SDM consent, which is more in line with the expectations of the legislation. Based on PPAO data, the number of CTOs (issues and renewals) consented to by the consumer has decreased from 41% between 2001 and 2003, to 28% in 2011. It is not clear whether this process was being driven by a change in the scope of CTOs being issued to include more consumers not capable of providing consent, changes in the way in which capacity to provide consent were assessed or to changes in the way data were collected or recorded.

In discussions with psychiatrists we heard opinions that ranged from the viewpoint that consumers who could not provide consent should not receive a CTO as they did not fit the criteria for compliance with the CTO, to views that all consumers should have SDMs otherwise a CTO was not needed as the consumer was capable of making their own decision about whether or not to adhere to a treatment plan.

Non-adherence to a CTO

As with other processes associated with CTOs, methods for addressing non-adherence to the CTO differed across regions and depended on the CTO team. While some immediately issued a Form 47 when a CTO consumer strayed from their treatment plan, others attempted to reason with the consumer and provide them the opportunity to recommit to the CTO before issuing the Form 47 as a last resort.

Nearly three-quarters of survey respondents considered that methods for dealing with non-adherence to a CTO were not satisfactory. Psychiatrists, consumer groups and peer supporters, and rights advisers were least likely to agree that methods were satisfactory. One of the challenges was locating consumers who moved away from the district and consumers who could not be located because they were homeless.

8.3.3 Discharge from a CTO

There are only limited data available on the duration of CTOs. Administrative data from Toronto, indicated that 33% of CTOs were not reissued, 24% of consumers had one to two reissues and the remainder more than two. In discussions with health professionals, the generally held view was that six-months was not long enough to allow a consumer to stabilize on the community treatment plan and that most CTOs were renewed for at least another six-month period. There were reports of CTOs that were renewed multiple times over a period of years. In the survey, only one-quarter (26%) of respondents agreed that CTO consumers maintained their gains after the CTO expired. A belief that CTOs were only effective if they were kept in place is likely to contribute to CTO reissues.

Through discussions with CTO stakeholders and open-ended answers to the survey questions, we heard that the duration of a CTO that is being renewed was too short. Many suggested that CTOs being renewed should last for a year, rather than six months. Some family members felt that the CTO was necessary as a long-term solution and found the review process stressful out of fear that the CTO would not be renewed and that they would lose the support it provided. Physicians and other service providers found the administrative burden of reviews to be high and the frequency at which they occurred limited the amount of time they could spend in their practice. Some also noted that this burden discouraged them from issuing more CTOs. Consumers commented on their uncertainty about the duration of their CTO and that they did not understand the process to end a CTO.

In interviews, it was also clear that there was considerable variation in opinion about when to discharge a consumer from a CTO and the process for doing so. This is another area that would benefit from guidelines and further dissemination of information. More research is required to understand the process of discharge from a CTO and what happens to clients, their family, friends and SDM.

Given that two-thirds of CTOs are reissued, there is an associated administrative burden for reissuing CTOs that could potentially be reduced. However, in considering any changes to the current legislated duration of a CTO of six months the need to balance the additional administrative burden of CTO renewal against consumers' rights must also taken into account.

8.4 Factors Impacting on the Effectiveness of CTOs

Community Treatment Plans

A CTO provides a mechanism by which a consumer is mandated to adhere to a community treatment plan. The most commonly used treatment plans for schizophrenia and bipolar disorders included medication. However, medication alone is not as effective as when it is combined with other treatment and services such as cognitive behavioural therapy, intensive case management and a range of social supports. The quality of the community treatment plan being delivered as part of a CTO was therefore a major factor impacting on the effectiveness of a CTO. We heard through the review that there was considerable variation in the content of community treatment plans ranging from medication alone to comprehensive and detailed plans including a range of different supports. Assessing the quality of the community treatment plans was outside of the scope of this review. However, the reported variation in the quality of treatment plans may be clinically appropriate and may relate to different levels of access to services as well as what consumers are willing or not willing to consent to. Some psychiatrists reported that they do not like to make the social supports mandatory so do not include them in the treatment plan under the CTO. Others debated about whether it was appropriate to include treatment for other health issues, such as taking insulin for diabetes, in a community treatment plan. It is important that there is sufficient knowledge about what constitutes an effective treatment plan and what should be included in a treatment plan, and this may be an appropriate topic for continuing medical education.

Access to CTOs

Access to CTOs was identified as an issue with only 14% of survey respondents agreeing that all individuals who could benefit from a CTO had access to one. Reasons behind this result included limited use of CTOs by health professionals for the reasons discussed earlier. There were also people who met the criteria and could benefit from a CTO, but whose social circumstances were beyond the scope of what the CTO could influence (for example homeless people can be difficult for service providers to locate).The CTO is not designed to repair the gaps in social programming, so people in these circumstances remain beyond the reach of a CTO.

Access to Services

Access to services was a key factor impacting on the effectiveness of CTOs. While most consumers who took part in the survey (83%) were satisfied with the services being provided as part of the treatment plan delivered through their CTO, one-quarter (27%) were concerned about the availability of services in their community and 13% were very concerned. While most (80%) family and friends of CTO consumers were satisfied with the services being provided as part of their family member/friends treatment plan, many family and friends of CTO consumers were also concerned (30%) or very concerned (35%) about the availability of needed services in their community.

Across all groups in the survey, 56% agreed that the lack of availability of income support and housing was reported to limit the effectiveness of CTOs. Based on administrative data from Toronto, only 8% of CTO consumers had independent incomes so income support and subsidized housing are crucial for this group.

While some surveyed stakeholders felt that CTOs took resources away from non-CTO clients, this was not a widely held view. In the first review, the use of CTOs to "get to the front of the resource line" was reported as an issue. In the current review, we were not able to estimate the extent to which the increase in the number of CTOs has moved resources away from consumers without CTOs. CTO coordinators reported that CTO consumers were also being placed on waiting lists for case management support and other services along with other consumers. It seemed that a general lack of services was more the issue with only 23% of survey respondents agreeing that CTO coordinators and case managers have adequate access to services for clients. This change may reflect the increased funding allocation by the MOHLTC that increased community based mental health services in the years between the reviews.

Inadequate Education and Information about CTOs

One factor suggested in interviews as limiting access to CTOs was that many physicians were not adequately educated and informed about CTOs and related issues, and this was supported in the survey with few respondents (22%) agreeing that levels of education and information were adequate.

We also found that consumers needed more information about CTOs, and in particular the process for discharge from a CTO.

8.5 Methods Used to Evaluate the Outcome of any Treatment Used Under CTOs

Clinical judgement was the primary method used to evaluate the outcomes for CTO consumers. Administrative data provided some information about the outcomes of treatment used under CTOs. Some data bases recorded information about consumer's living situation and employment. It is likely that individual medical records also recorded information about outcomes but examining these was out of scope for the review for privacy reasons. Improving the quality of administrative data would help in assessing the effectiveness of CTOs in Ontario, although it is recognised that this information would be descriptive rather than empirical.

8.6 Summary

The number of CTOs issued, reissued and renewed has been steadily increasing since the legislation was passed in 2000. It is not clear if this increase was the result of increased awareness or acceptance of CTOs among health professionals, or of an expansion in the profile of consumers for whom CTOs were used. Administrative data to monitor the number of CTOs and the duration of CTOs was limited.

The effectiveness of CTOs was linked to the quality of the community treatment plan the CTO had been issued to deliver and to access to the services required for effective care. There was evidence of variation in what was included in community treatment plans, and the CTO processes between LHINs. While the legislated criteria for issuing a CTO were clear, the translation of those criteria into practice was not set out in program guidelines or in best practice standards and it seemed that there were different interpretations and standards in different LHINs. While we saw some excellent examples of

effective practice and dedicated health care providers, we also heard of examples where the CTO process was not working as well.

It was clear that for some consumers and their families and friends, CTOs had improved consumer well-being and quality of life and consumers told us since having their CTO they could see they have a future. For health professionals, CTOs provided an effective mechanism for communication between service providers and a way to link clients to services. CTOs provided health professionals with confidence that a CTO consumer could receive the support they required to live in the community.

However, CTOs are restrictive and do impact on the rights of the consumers issued a CTO. While a number of safeguards are in place to protect those rights there are two challenges to ensuring adequate protection of consumer's rights:

- Effective assessment of a consumer's capacity to decline medication in a paradigm where consumers declining medication are considered to lack sufficient insight into their condition to make this treatment choice. Many consumers when reflecting back after their condition has stabilized believe that being forced to take medication was the right choice for them, others do not.
- Gaining informed consent when the alternative is continued inpatient care.

Information gathered for this review suggests that stakeholders did not think the appropriate balance between mandating CTOs because of the clear benefits to some consumers, and protecting the rights of all consumers has been reached.

All groups we spoke to as part of the review asked for more education and information about CTOs: about the process; and/or about when CTOs should be used and when they were effective.

8.7 Comparison of key findings with the First Review

A table comparing the findings from the current review to the first review is appended (Appendix B). Since the Dreezer and Dreezer report was submitted some aspects of CTO implementation and use have changed. In the last seven years CTO use has increased and there is a variation in the practice of implementing CTOs.

There have also been minor changes, or points of clarification, to the legislation. Consumers who are brought back into the hospital on a Form 47 no longer require a new CTO to be issued and may be released on the same CTO once they are able to comply with their community treatment plan. Rights advice is also no longer required to be given to PGT SDMs for each renewal of a CTO, only when it is first issued.

In contrast to the Dreezer and Dreezer report, the use of CTOs to get to the front of the service line was not as frequently reported. In fact, some health care practitioners noted that consumers may wait for a CTO until services became available. Instead the advantage of CTOs was seen to be in linking services together and in improving communication between health professionals and service providers.

Finally, it has been over a decade since the legislation was introduced. Training and information was provided when legislation was approved. In the meantime, many positions have seen staff turnover and

new jobs have been created. There is a need to provide a central source of information available to physicians, CTO coordinators and case managers, service providers and consumers and for those administering services to be trained in best practices on a regular basis.

8.8 Recommendations:

1. Mental health care providers and consumers should continue to have access to CTOs.

It is clear from this review and from the first review that CTOs are effective for some consumers and that for these consumers and for their friends and families, CTOs make a tremendous positive impact on their well-being. We saw some excellent examples of effective practice and heard from some consumers about the difference their CTO had made to their lives. We also heard from health professionals about the advantages of CTOs in facilitating good outcomes for consumers as they moved from in-patient care to the community.

2. The MOHLTC should support further research to understand what it is about CTOs that underpin their effectiveness.

In responses to the survey and from information shared during interviews it seems that the reasons why CTOs are considered to be effective are not just because of the mandated adherence to treatment plans. While we are not recommending that further attempts be made to gather evidence through randomized controlled trials because of the methodological and ethical challenges, there is value in carrying out further research using other study designs including qualitative studies such as observational studies and further analysis of medical records and administrative data.

We recommend the MOHLTC convene a group to develop a research agenda for CTOs. Examples of topics that warrant further understanding include:

- What constitutes 'best practice' for CTOs?
- What is included in community treatment plans and why?
- Which consumers have the potential to benefit from CTOs and how do CTO consumers differ from/ are similar to ACT Team consumers?
- What aspects of CTOs contribute/ do not contribute to improved outcomes for consumers?
- Would the same level of effectiveness be achieved if consumers had increased access to case management and if mental health services were more effectively linked?
- Are CTOs equally effective for people from different ethnic groups?
- Are there differences in access to mental health services for people from different ethnic groups?
- What factors determine the duration of a CTO and the successful transition from a CTO?
- What is the role of the CTO in improving coordination between health professionals and service providers?

3 .The MOHLTC should continue to work with service providers and the LHINs to ensure that robust central data are available to track, at a minimum, the numbers of CTOs being issued, who they are issued by and the profile of consumers issued a CTO.

Robust administrative data are an essential and cost-effective source of information for an evaluation or review. Although efforts were made following the first review to set up a process for collecting data from the LHIN this has not been effective. CTO coordinators were unclear about what they were expected to do with respect to data collection. Potential ways to make most effective use of administrative data include using separate functional centres for CTOs. The roll out of OCAN provides an opportunity to collect data about consumer outcomes.

4. The MOHLTC should lead the development of province wide program standards.

While it is the role of professional groups to set clinical standards, for programs such as the CTO which impact on a relatively small proportion of the population and which may be seen as process related, the MOHLTC has an important role in working with the professional groups and other key stakeholders (CTO coordinators, case managers and psychiatrists) to develop program standards. Program standards should cover the whole CTO process and include roles and responsibilities, staffing ratios, consent processes, community treatment plans, and discharge processes. Once program standards have been developed, it will be important to provide opportunities for disseminating the standards to CTO coordinators, case managers and psychiatrists. An approach to be considered is creating a reference group or 'community of practice' as has been done in the early psychosis area.

5. Increased education about and awareness of CTOs is required and the MOHLTC could work with professional and other stakeholder groups to develop and disseminate information and educational material about CTOs.

Increased education and/or information was requested by stakeholders to the review.

For consumers and their family and friends:

- Review existing pamphlets, websites and other information sources to ensure that information about CTOs is available in a range of languages, appropriate for the audiences and is disseminated and readily available.

For health care professionals education and information has the potential to increase the use of CTOs and to ensure they are used appropriately. Education could be incorporated into undergraduate training for health professionals, delivered as part of existing continuing medical education programs and could cover topics such as;

- The CTO legislation and the requirements that must be met before a consumer is issued a CTO;
- What makes an effective community treatment plan;
- Education about other options for care;
- Cultural competency in mental health care provision; and
- Information about discharging a consumer from a CTO.

Information for consumers is also required to inform them of the CTOs processes and their rights. Assessment of existing information was beyond the scope of this review. It may be that the information is already available and that dissemination is the issue.

6. The MOHLTC should consider whether a review of the safeguards in place for consumers is warranted.

While a number of safeguards are in place to protect the rights of consumers who are issued with CTOs information gathered for this review suggests that the appropriate balance between mandating CTOs because of the clear benefits to some consumers and protecting the rights of all consumers has not yet been reached. The review indicated that the issuance and in particular the CTO renewal process could be challenging for all stakeholders. For consumers and SDMs who were happy to have the CTO renewed the CCB process seemed stressful and unnecessary; for health professionals the process was time consuming and a deterrent to issuing CTOs. Conversely, consumers who did not want their CTO to be renewed felt disempowered and some said there was no point in challenging the process. There is no easy answer that will ensure the safeguards are in place but that the administrative burden on all parties is not overly cumbersome. A review of the Rights Advice process and the CCB was out of scope for this review but we recommend that a working group be set up to consider the challenges outlined above. The review of safeguards could also be incorporated into the terms of reference for the group set up to develop program standards.

APPENDIX A: ONTARIO LEGISLATION

Ontario Legislation – *Mental Health Act*

Purpose 33.1 (3):

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 re-admitted to a psychiatric facility.

Criteria 33.1(4):

A physician may issue or renew a community treatment order under this section if,

(a) during the previous three-year period, the person,

(i) has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period, or

(ii) has been the subject of a previous community treatment order under this section;

(b) the person or his or her substitute decision- maker, the physician who is considering issuing or renewing the community treatment order and any other health practitioner or person involved in the person's treatment or care and supervision have developed a community treatment plan for the person;

(c) within the 72-hour period before entering into the community treatment plan, the physician has examined the person and is of the opinion, based on the examination and any other relevant facts communicated to the physician, that,

(i) the person is suffering from mental disorder such that he or she needs continuing treatment or care and continuing supervision while living in the community,

(ii) the person meets the criteria for the completion of an application for psychiatric assessment under subsection 15 (1) or (1.1) where the person is not currently a patient in a psychiatric facility,

(iii) if the person does not receive continuing treatment or care and continuing supervision while living in the community, he or she is likely, because of mental disorder, to cause serious bodily harm to himself or herself or to another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person,

(iv) the person is able to comply with the community treatment plan contained in the community treatment order, and

(v) the treatment or care and supervision required under the terms of the community treatment order are available in the community;

(d) the physician has consulted with the health practitioners or other persons proposed to be named in the community treatment plan;

(e) subject to subsection (5), the physician is satisfied that the person subject to the order and his or her substitute decision-maker, if any, have consulted with a rights adviser and have been advised of their legal rights; and

(f) the person or his or her substitute decision-maker consents to the community treatment plan in accordance with the rules for consent under the Health Care Consent Act, 1996.

Community Treatment Plan (33.7):

A community treatment plan shall contain at least the following:

1. A plan of treatment for the person subject to the community treatment order.
2. Any conditions relating to the treatment or care and supervision of the person.
3. The obligations of the person subject to the community treatment order.
4. The obligations of the substitute decision-maker, if any.
5. The name of the physician, if any, who has agreed to accept responsibility for the general supervision and management of the community treatment order under subsection 33.5 (2).
6. The names of all persons or organizations who have agreed to provide treatment or care and supervision under the community treatment plan and their obligations under the plan.

Capacity (*Health Care Consent Act*)

4. (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to *understand* the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to *appreciate* the reasonably foreseeable consequences of a decision or lack of decision.

Incapacity for personal care (*Substitute Decisions Act*)

45. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

APPENDIX B: COMPARISON WITH THE FIRST REVIEW

Dreezer and Dreezer noted that there was limited empirical data to inform the review questions. Since the first review, no additional RCTs have been completed. Methodological and ethical issues mean there is unlikely to be robust empirical evidence about the impact of CTOs. Therefore, as for the first review qualitative data (including an on-line survey) and administrative data provided the source of much of the evidence for the review.
The table below provides a summary of the findings of the first review and updates these with information from the 2012 review.

Questions	Dreezer & Dreezer	R.A. Malatest Ltd.
The reasons that CTOs were or were not used during the review period		
What factors affect clients' decisions to use/accept a CTO?	<u>Reasons for accepting/using CTO:</u> • alternative to current/future hospitalization • support during low periods • access to services • pressure from health providers • incapable acquiescence • satisfaction with a previous CTO. <u>Reasons for not using/accepting CTOs included:</u> • a lack of insight into their situation • autonomy • dissatisfaction with a substitute decision-maker	<u>Reasons for accepting/using CTO:</u> • support • access to services • improvement of quality of life while on CTO • opportunity for social interaction • alternative to hospitalization • family pressure to continue with treatment <u>Reasons for not using/accepting CTOs included:</u> • lack of autonomy/coercive • prefer not to take medication • lack of insight • stigma
What factors affect substitute decision-makers' decisions to use/accept a CTO?	<u>Reasons for accepting/using CTO:</u> • recommended by the health care team • no alternative • increases SDM role in process • provides SDM with leverage • they agree with the concept of outpatient committal • positive experience with a previous CTO • perception of increased availability of resources <u>Reasons for not using/accepting CTOs included:</u> • a belief that CTOs are an affront to the dignity of the subject person • concern about the potential for a rupture in their personal relationship with the individual under a CTO	<u>Reasons for accepting/using CTO:</u> • Preventative support • Rapid assistance in times of relapse • See improvement in quality of life • Positive perception of previous CTO • access to services • Ability to be involved in care of loved-one • Relief and comfort of not being only one responsible for care • Keeps loved-one in community • Ensures adherence to medication • Benefits outweigh negatives <u>Reasons for not using/accepting CTOs included:</u> • Negative perception of previous CTO

	• their perception about whether the client is willing/able to comply • less than satisfactory experience with the mental health system • the decision-making rules in the Health Care Consent Act • unwillingness to assume the responsibility	• Dissatisfaction with medication prescribed • Mandatory nature of treatment
What factors affect physicians' decisions to use a CTO?	<u>Factors that promote use</u> • Process related • access to resources • the availability and assistance of the CTO coordinator • being a salaried physician. • Effectiveness • belief in the efficacy of CTOs • Ideological • belief in the righteousness of CTOs • Other factors • family insistence <u>Factors that limit use:</u> • Criteria/legislation • the requirement that the patient meet the Mental Health Act's Form 1 criteria • length of CTO (too short) • the requirement for prior hospitalization • Process related • concerns with the enforcement process • negative experience with Consent and Capacity Board process and hearings • complexity and amount of time required to institute a CTO • concerns regarding legal liability • lack of compensation • lack of mentoring and encouragement • a perceived "lack of teeth" • clients being discharged from hospital prior to a CTO being put in place	<u>Factors that promote use</u> • Process related • ability to enforce adherence to medication • links consumers to services • provides additional support to consumers • championing of CTOs by other physicians or their CTO coordinator • Effectiveness • have seen positive outcomes for previous CTOs • see CTO as a two way contract • prevents consumers from slipping through the cracks that exist in voluntary outpatient treatment • increase communication between those named in community treatment plan • Ideological • position that it is a less restrictive alternative to hospitalization • belief that medication is the cornerstone of treatment for psychotic mental health consumers • Other factors • family request <u>Factors that limit use:</u> • Criteria/legislation • hospitalization requirement (excludes consumers only involved in forensic system) • Process related • Time and effort to issue and manage CTO (paperwork and

	• lack of access to physician for community follow-up • Clinical practice • lack of suitable candidates • lack of knowledge about and familiarity with CTOs • a belief that CTOs are redundant given the range of treatment modalities available • capable clients refusing consent • preserve rapport with consumer • previous CTO has failed • Effectiveness • lack of a belief in the efficacy of CTOs • Ideological • a belief that CTOs are or may be a violation of the rights of their patients • Other factors • regional disparity of resources	hearings) • Lack of support services • Availability of CTO coordinators and case managers • Clinical practice • Lack of knowledge • Effectiveness • Toothless if consumer is consenting • Ideological • some only issue to consumers that have capacity to consent • others only issue to consumers with SDM • Other factors • Reluctance of family
What are the characteristics of clients using CTOs?	• just over half of CTO clients are male and just under half are female. • approximately 70 per cent are aged 21 to 50 • approximately 70% are diagnosed as suffering from schizophrenia and about 30% suffer from schizoaffective disorder or bipolar disorder • individuals who are seen as likely to comply with their CTO • approximately half are considered to be capable of consenting to their own treatment	• Primarily issued for consumers diagnosed with schizophrenia/schizoaffective disorder • History of hospitalization • Unwilling to adhere to medication • 60% male • Majority under 45 • 72% lack capacity to consent • From Toronto CTO consumers • Percentage CTO by ethnicity generally represents city's population • Primary language: 73% English • Lower educational achievement then city's workforce • 65% on disability support
What alternatives to CTOs are being used to manage clients in the community?	• Assertive Community Treatment (ACT) Teams • comprehensive case management • criminal justice system • consumer-run businesses • drop-in centres that provide peer support	• Assertive Community Treatment (ACT) Teams • Voluntary mental health services • Involuntary inpatient treatment • Forensic system • Family/caregiver/peer support

	• LOAs	• Leave of absence • Long-acting injections
Where are the CTOs originating?	• CTOs are almost exclusively originating in Schedule 1 psychiatric facilities. • A small number of family physicians in the community have initiated CTOs • Some ACT teams have initiated CTOs • CTO usage is uneven across the province	• Data only available for Toronto and Ottawa Region • More than half from Hospital for inpatients • Also from: outpatient facilities, community mental health organizations
The effectiveness of CTOs during the review period		
What effect do CTOs have on client well-being and satisfaction?	• Many CTO clients experienced substantial improvement in a number of spheres, including: • stability • staying in the community • personal support and attention • continued treatment during periods of severely diminished insight • ability to find stable housing, • education and reintegrate into the community • Many family members reported substantial improvement in the CTO client and a related improvement in the problems that the illness creates for the family. • Some clients and advocates feel that any benefits are outweighed by the loss of personal autonomy and control. • Most physicians saw a benefit.	• No additional quantitative data. Information based on reports from: • Consumers: • some saw it as a positive in gaining a level of stability that they could not achieve on their own • some felt they did not need it • some were strongly against it • Family members: • family members saw it as positive by increasing stability of the consumer and improving their quality of life • Health professionals: • Most saw it as positive • Some felt it was overused, other felt it was underused • Some noted that it was coercive
What services and supports are CTO clients receiving?	• A range of in- and outpatient services was reported. It was noted that CTOs were used to improve access to services and there were perceptions that CTOS assisted clients to “queue jump”.	• Some consumers only condition is taking medication • Community treatment plans also included: case management, supportive housing, ACT, community mental health program, medication management/clinic • Little evidence of queue jumping • Some consumers had to wait for services to be available to enter CTO
What are the factors impacting on the effectiveness of	• Unable to conclude with respect to an individual client or to a group of clients is which, if any, of the benefits of a CTO derive	• Consistent administrative data with which to evaluate legislation • Regional disparity in services

CTOs?	from the legal restraints placed upon CTO clients as opposed to the services, increased professional accountability and level of professional organization devoted to their care.	• Lack of programming for aboriginal and ethno-racial groups
Are CTOs completed for consumers when they are discharged from hospital?	• N/A	• CTOs can be issued upon discharge from a hospital • They can also be issued to individuals while they are in the community
Is there a standard discharge planning process for a CTO consumer?	• N/A	• No, this is an area in which mental health professionals require more information.
How many times, on average, are CTOs renewed for the same consumer?	• N/A	• Data only available for Toronto • 33% not renewed • 48% renewed between 1 and 5 times • 19% renewed more than 6 times
Methods used to evaluate the outcome of any treatment used under CTOs		
What consumer outcomes are being measured?	• The MOHLTC collects data on: • a CTO client's use of services during the six months before the current CTO, • on the services to be involved in the current CTO • on a CTO client's involvement with the legal system during the six months before the current CTO • type of housing occupied by a CTO client and who they live with • While a CTO client's support team monitors their progress, there is no system-wide evaluation of outcomes. • A few small local studies have attempted to measure client outcomes. They measure variables before and after CTO, as: • satisfaction • compare hospitalization rates	• There is very little centralized data on outcomes • Some LHINs record data on: • Housing • Source of income • Studies within the province have also examined: • Hospital use rates • Services accessed • CCB activity • Quality of life • Perceptions of CTOs

	• legal involvement • type of housing • income and employment.	
• How are consumer outcomes being measured?	Through monitoring of administrative data, case-file review and other survey tools the following is measured: • services • involvement with the legal system • living arrangements	Through monitoring of administrative data, case-file review and other survey tools the following is measured: • services • involvement with the legal system • living arrangements

APPENDIX C: DATA SOURCES AND MAPPING TO REGIONS

Administrative Data Sources for Second Legislated Review

Source		Overview			Characteristics of Consumers			Origin of CTO	Characteristics of CTO						Rights Advice	Consent & Capacity Board	
		Total # of CTOs	# of Issues vs. Renewals	# of Unique Consumers	Demographics	Diagnosis	Housing & Income Support		Consumer Incapable	Who provided consent	Coordinator	Community Agencies involved	Discharge Reason	Renewals per Consumer		Applications	Hearings
Provincial Data																	
CDS-MH		X						X									
CTO Information Record		X	X														
CCB																X	
PPAO		X	X					X	X	X	X				X	X	
OHIP		X	X		X			X									
LHIN Data	Sub-LHIN																
Central																	
Central East																	
Central West																	
Champlain		X	X	X	X			X				X					X
Erie St.Clair																	
Hamilton Niagara Haldimand Brant	Hamilton	X	X	X		X											
	Brant Haldimand	X	X	X													
Mississauga Halton		X	X							X							X
North East																	
North Simcoe Muskoka																	
North West																	
South East																	
South West	London				X	X											X
	Windsor	X	X		X			X									
Toronto Central	Toronto			X	X	X	X	X					X	X			
Waterloo Wellington																	

Mapping of Regions to Local Health Integration Networks (LHINs)

The Dreezer and Dreezer report regionalized their findings by seven areas commonly used in analysis of Ontario: Central East, Central South, Central West, East, North, South West, and Toronto. In 2006 the Local Health System Integration Act created fourteen Local Health Integration Networks or "LHINs" to plan, fund, and manage health care delivery in Ontario. Thus, while much provincial data is still sorted by seven regions, health data is largely sorted and compiled on a per-LHIN basis. This creates a challenge for longitudinal comparisons between the first and second legislated reviews as the 14 LHINs are not contiguous components of the seven regions. However, using maps provided by each LHIN's website and a list of counties within each region (included in the Dreezer and Dreezer Report), the following mapping was used, with qualifications footnoted:

Mapping of Regions to LHINs

2005 Region	2011 LHIN
Central East	Central Central East
Central South	Hamilton Niagara Haldimand Brant
Central West	Central West Mississauga Halton[20] Waterloo Wellington
East	Champlain[21] South East
North	North East North Simcoe Muskoka[22]
South West	Erie St. Clair South West[23]
Toronto	Toronto Central[24]

[20] The City of Burlington, geographically within Mississauga Halton and the Central West region, is administered by the Hamilton Niagara Haldimand Brant LHIN.
[21] Southern portion of Lanark county is in South East LHIN/Region.
[22] South Simcoe county is within the Central East region.
[23] Grey county is split three ways between North Simcoe Muskoka, South West, and Waterloo Wellington LHINs.
[24] Toronto Centre is roughly equal to the pre-amalgamation city of Toronto, while the region of Toronto includes the Etobicoke (Mississauga Halton LHIN), North York (Central LHIN), and Scarborough (Central East LHIN).

APPENDIX D: STAKEHOLDERS

AN OVERVIEW OF STAKEHOLDERS AND KEY INFORMANTS INCLUDED IN THE REVIEW

Assertive Community Treatment

ACT is a client-centered, recovery-oriented mental health service intended to facilitate psychosocial rehabilitation for persons who have the most serious mental illnesses and have not benefited from traditional programs. People who have an ACT Team supporting them have often been in the hospital many times or have been homeless. Some ACT Teams focus on people with special needs, like people who have been involved in the criminal justice system, or who have a dual diagnosis (both mental illness and developmental disability) or a concurrent diagnosis (both mental illness and substance use disorder).

ACT services are individually tailored to address the preferences and goals of each client. The ACT Team is mobile and delivers services in community locations that are comfortable and convenient for clients. ACT services are delivered by a multidisciplinary team who provide treatment, rehabilitation, and support services. The team is directed by a coordinator and a psychiatrist and includes a sufficient number of staff to work in shifts to cover 24 hours per day, seven days a week.

Both ACT Teams and intensive case management services will work with the family members of their clients. They can learn more about a person's illness, strengths and goals from family members. They may also be able to teach the family about ways to support and help their family member with a mental illness. In some cases, they may be able to offer support to the family members themselves.

The Consent and Capacity Board

An independent provincial tribunal, the CCB's mission is the fair and accessible adjudication of consent and capacity issues, balancing the rights of vulnerable individuals with public safety. The CCB's key areas of activity are the adjudication of matters of capacity, consent, civil committal and substitute decision-making. Over 80 percent of applications to the CCB involve a review of a person's involuntary status in a psychiatric facility under the *Mental Health Act*, or a review under the *Health Care Consent Act* of a person's capacity to consent to or refuse treatment. The Board has the authority to hold hearings to deal with the following matters relating to the *Mental Health Act*:

- Review of involuntary status (civil committal);
- Review of a Community Treatment Order;
- Review as to whether a young person (aged 12 to 15) requires observation, care and treatment in a psychiatric facility; and
- Review of a finding of incapacity to manage property.

The Empowerment Council

The Empowerment Council (EC) is an organization funded by the Centre for Addiction and Mental Health (CAMH) to do systemic advocacy on behalf of mental health and addiction clients. Members are either people living with mental health issues and/or addiction currently or in the past. Although based at CAMH, the Council also serves people in the community. The Council provides educational events for clients, services providers and other members of the community.

Activities of the Empowerment Council:

- Consulting clients, through meetings, surveys and focus groups on numerous mental health and service delivery issues.
- Advocating for what is important to clients to whatever body is most effective for achieving clients' priorities: CAMH, the government, the courts.
- Working at effecting change at CAMH by having a meaningful voice at committees, focus groups, working groups, etc.
- Educating clients and others about client rights, from the CAMH Bill of Client Rights and freedoms protected by the Canadian Charter of Rights and Freedoms

Family Outreach and Response Program

Family Outreach and Response offers recovery-oriented mental health support services to families. Staff and volunteers are all psychiatric survivors or family members of people who experience extreme mind states often labeled as "mental illness". The program offers educational and support services to families from both a professional and a lived experience perspective. The Family Outreach and Response Program recognize the following:

- The most important tool families and friends have in supporting someone in recovery is their relationship.
- Recovery is a non-linear journey involving hope, education, self advocacy, personal responsibility, and support.
- Individuals are responsible for their own wellness. No one can recover for someone else.
- Families and friends can model attitudes that create a culture of healing.
- Families and friends can absolutely help facilitate their loved-one's recovery.

The Mental Health Legal Committee

Mental Health Legal Committee, established in 1997, is a group of lawyers and community legal workers practicing in the area of mental health law.

The committee has advocated for the rights of consumers of mental health services in many forms. The approximately 60 lawyer members appear in all of the mental health-related tribunals. The two main tribunals are:

- The Consent and Capacity Board, which is a provincial body that deals with issues relating to involuntary committal, capacity with respect to treatment, capacity to manage one's finances and other issues, including community treatment orders; and
- The Ontario Review Board.

The committee has made submissions in respect of a number of legislative initiatives, including Bill 68, which was the amendment of the Mental Health Act in 2000, which put into place community treatment orders and also expanded the involuntary commitment criteria under the Mental Health Act; also, legislation in Bill 135 that was the amendment with respect to the use of restraints in public hospitals.

The Mental Health Legal Committee has been involved in inquests into the deaths of patients in psychiatric hospitals. This year, the Committee also made submissions with respect to amendments to the Coroners Act, which ultimately were enacted, that require inquests into the deaths of persons who die while in restraint in psychiatric detention.

Ontario Federation of Community Mental Health and Addiction Programs

The objectives of the Ontario Federation of Community Mental Health and Addiction Programs are to work collaboratively with representatives of Community Mental Health and Addiction Programs in Ontario toward enhancing the community mental health and addiction system. "Community" agencies are defined as agencies that demonstrate a commitment to operate services based on values which:

- Recognize consumer/clients and their families as citizens and work to support and respect their basic human rights and dignity.
- Provide services to consumers/clients on the basis of their expressed interest, respecting their right to self- determination.
- Provide any of a broad range of individualized, needs-based services designed to promote "wellness" and generally improve the quality of life of the consumer/survivor, in partnership with the consumers/survivors themselves and other adjunctive services/supports.
- Involve consumer/survivors, families and other significant stakeholders as participants in the planning, governance, delivery and evaluation of all aspects of the service. Community-based agencies, in addition to traditional lines of accountability, are also accountable to the consumers/clients and communities they serve.
- Provide services in the least restrictive environment, using the minimum necessary intervention, while maintaining a safe environment.
- Allow easy access to consumers/clients in their own community, in a reasonably convenient location which is safe and comfortable.

The Ontario Review Board

The Ontario Review Board annually reviews the status of every person who has been found to be not criminally responsible or unfit to stand trial for criminal offences on account of a mental disorder. The Ontario Review Board is established under the *Criminal Code of Canada*. The Board is made up of judges, lawyers, psychiatrists, psychologists and public members appointed by the Lieutenant Governor in Council.

CTOs are not intended to replace the current mechanisms for dealing with those persons charged with a criminal offence who are found "not criminally responsible by reason of mental disorder" under the *Criminal Code of Canada*. Under the Criminal Code, the Ontario Review Board, an independent body, has the authority to direct a person determined to be not criminally responsible to be discharged absolutely if the person is not a significant threat to the safety of the public. Alternatively, if the Board is not satisfied that the person meets this criterion, then it may, by order, direct that a person be discharged subject to conditions or direct that the person continue to be detained in hospital.

The Psychiatric Patient Advocate Office

The Psychiatric Patient Advocate Office protects and promotes the rights and entitlements of Ontarians with mental illness through advocacy, rights advice and education. The PPAO's vision is of a society where the rights of all individuals, regardless of mental illness or disability, are respected, protected and realized.

The Psychiatric Patient Advocate Office (PPAO) was established by the Ministry of Health in 1983 to provide advocacy and rights advice services at the 10 provincial psychiatric hospitals (PPHs). Governance of the PPHs has been transferred to a number of public hospital corporations, but the PPAO continues to provide individual advocacy services to in-patients at nine of those hospitals pursuant to agreements between the Ministry of Health and Long-Term Care and the public hospital corporations. The PPAO serves patients in both the civil and forensic (not criminally responsible) mental health systems.

In 2001, the PPAO's mandate for rights advice was expanded to include all Schedule 1 psychiatric facilities in Ontario. Currently, all but three of these facilities designate the PPAO's Community-based Rights Advice Service as their rights adviser. Additionally, the PPAO was designated by the Minister of Health and Long-Term Care to be the provider of rights advice to all persons living in the community who are being considered for CTOs, and their substitute decision-makers.

Schizophrenia Society of Ontario

The Schizophrenia Society of Ontario (SSO) aims to make a positive difference in the lives of people, families and communities affected by Schizophrenia and Psychotic Illnesses. Their mandate is to support families of people with mental illness who have come in contact with the law while promoting change in mental health and justice. The SSO provides the following:

- Support: individual, group, and peer support for people whose family member has been in contact with the law;
- Education: Information, resources and training on mental health and justice issues for families and professionals.
- Advocacy: Advocacy on behalf of families as well as system-level advocacy to create change through effective public policy.

The SSO is working to assume a stronger role in education and awareness on Schizophrenia and Psychotic Illnesses, resulting in increased capacity of individuals and communities to respond to this illness; establish their niche in the provision of support services for individuals and families dealing with Schizophrenia and Psychotic Illnesses in a sustainable and equitable manner across the province; mobilize youth to take a greater role in understanding Schizophrenia and Psychotic Illnesses and championing this cause; and increase organizational reach, capacity and sustainability.

Sound Times Support Services

Sound Times is a member-driven consumer-survivor initiative providing mental health support services in downtown Toronto, Ontario, Canada. The service evolved out of social/recreational clubs run in different parts of the city by Community Resource Connections of Toronto (CRCT). These clubs merged

after CRCT conducted a consultation with consumers and survivors and a report recommended that consumers-survivors have their own organization that they manage and run for themselves.

These services are available to consumers, survivors and people experiencing mental health problems and include the following:

- Peer Support: Through a community of peers to learn ways to build supports from members who have done it.
- Basics: Finding resources for food, clothing, shelter, etc.
- Advocacy: Advocating with ODSP, OW and CPP, negotiating accommodations, rental disputes, etc. Making sure members are getting all the benefits and services they are entitled to.
- Service Co-Ordination and Referral: Helping members access new services if they want them and co-ordinating the ones they have.
- Education: Individual instruction in basic (Linux-based) computing and email, resume writing, assistance with applying and registering for Adult Education, college or university and Financial Aid applications, etc.
- Mental Health and Justice: Support and services are available for consumers and survivors who are in contact with the courts, police, probation and parole or who are in custody.
- Harm Reduction: Discussion groups, presentations and workshops, referrals to community drug and alcohol treatment programs.

APPENDIX E: QUESTIONNAIRE

Community Treatment Order Ontario Legislated Review

INTRODUCTION

R.A. Malatest and Associates Ltd. is the research and evaluation firm appointed by the Ministry of Health and Long-Term Care to conduct the 2012 legislated review of Community Treatment Orders. We hope that you can help by sharing your knowledge and experiences.

Anyone with an interest in community treatment orders is invited to take part. The survey includes some questions for you to answer and spaces for your comments.

It is very important for us to receive as many opinions as possible and we appreciate your time and effort in taking part. The survey will take approximately 10 minutes to complete. Please do not complete more than one. Responses will remain strictly confidential and will be reported in aggregate form only.

Click here for more information about the Review and the Survey.

I have read and understood the **confidentiality and use of information** associated with this survey and I accept them:

- ❍ Yes, I give my full consent to participate in this survey ..... **[PROCEED TO SURVEY]**
- ❍ No, I do not want to continue with this survey..... **[TERMINATE SURVEY]**

If you have any questions about the survey or would like to complete it over the telephone please call 1. 855-688-1137

A. INVOLVEMENT WITH COMMUNITY TREATMENT ORDERS

A1. Which of the following best describes your interest in CTOs:

- ❍ Consumer – Survivor – [skip to Part 1]
- ❍ Family/Friend (including family, friends who are substitute decision-makers [skip to Part 2]
- ❍ Substitute Decision-Maker - [all remaining options skip to Part 3]
- ❍ Psychiatrist
- ❍ Other Physician
- ❍ CTO Coordinator
- ❍ CTO Case Manager
- ❍ ACT Team
- ❍ Community Mental Health Worker
- ❍ Inpatient Mental Health Worker
- ❍ Lawyer
- ❍ Consumer Advocate
- ❍ Consent and Capacity Board Member
- ❍ Mental Health Researcher
- ❍ Government
- ❍ Student
- ❍ Police
- ❍ Other (Please Indicate): _____

B. PART 1: QUESTIONS FOR CONSUMERS

B1. How many CTOs have you been issued?

- ❍ 1
- ❍ 2-5
- ❍ More than 5

B2. When was your most recent CTO?

- ❍ I still have a CTO
- ❍ Less than 6 months ago
- ❍ 6 months ago or longer
- ❍ More than 1 year ago

B3. What services and supports have you had in the last year?

- ❍ Hospital inpatient
- ❍ Hospital outpatient
- ❍ Hospital leave of absence
- ❍ ACT Team
- ❍ Community mental health program
- ❍ Doctor's care outside of a hospital
- ❍ Social service program such as help with housing or employment
- ❍ Care from family or friends
- ❍ No care outside of the care under the community treatment order
- ❍ Other please specify

B4. Over the time you were issued with your CTO do you agree or disagree that…

	Agree	Neutral	Disagree	NA/DK
I am/was satisfied with the treatment plan being delivered through my CTO	❍	❍	❍	❍
I am/was satisfied with the services being provided to me as part of my treatment plan	❍	❍	❍	❍
I felt better as a result of the CTO	❍	❍	❍	❍
My quality of life improved	❍	❍	❍	❍
I am/was more satisfied with my CTO than with other treatment options I have experienced	❍	❍	❍	❍
CTOs were the best option for my situation	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

B5. Do you know of any other treatment options other than hospitalization and CTOs available in your community?

_____

B6. Do you have any comments to make about the effectiveness of your CTO?

_____

B7. Some people are concerned about CTOs. Are you concerned about any of the following?

	Not concerned	Concerned	Very concerned	NA/DK
The amount of choice I had when issued a CTO	❍	❍	❍	❍
My rights under a CTO	❍	❍	❍	❍
The availability services I need in my community	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

GO TO PART E

C. PART 1: QUESTIONS FOR FAMILIES, FRIENDS AND SUBSTITUTE DECISION-MAKERS

C1. Since your family member or friend has been issued with your CTO do you agree or disagree that

	Agree	Neutral	Disagree	NA/DK
I am/was satisfied with the treatment plan being delivered through their CTO	❍	❍	❍	❍
I am/was satisfied with the services being provided to them as part of their treatment plan	❍	❍	❍	❍
Their health improved as a result of the CTO	❍	❍	❍	❍
Their quality of life improved	❍	❍	❍	❍
I am/was more satisfied with the CTO than with other treatment options my family member/ friend has experienced	❍	❍	❍	❍
CTOs were the best option for my family member/ friend's situation	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

C2. Do you know of any other treatment options other than hospitalization and CTOs available in your community?

_____

C3. Do you have any comments to make about the effectiveness of CTOs?

_____

C4. Some people are concerned about CTOs. Are you concerned about any of the following?

	Not concerned	Concerned	Very concerned	NA/DK
The amount of choice my family member/ friend had when issued a CTO	❍	❍	❍	❍
My family member/ friend's rights under a CTO	❍	❍	❍	❍
The availability of needed services in my community	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

GO TO PART E

D. PART 3 – ALL OTHER GROUPS

D1. Have you signed a CTO or community treatment plan as a physician, substitute decision-maker (SDM), community mental health worker or other health practitioner?

- ❍ Yes ..... **[PROGRAMMING NOTE: PROCEED TO D2]**
- ❍ No ..... **[PROGRAMMING NOTE: PROCEED TO D3]**

D2. Please indicate how many CTOs?

- ❍ 1
- ❍ 2-5
- ❍ More than 5

D3. How important do you think the following factors are <u>in limiting the use of CTOs</u> in Ontario?

	Very important	Important	Not important	NA/DK
Level of knowledge and/or experience with CTOs	❍	❍	❍	❍
Concerns regarding infringement of patient rights	❍	❍	❍	❍
Issues related to rights advice	❍	❍	❍	❍
Workload concerns regarding issuing a CTO, the legal review process and/or supervising a CTO client	❍	❍	❍	❍
Insufficient community resources available for clients on CTOs	❍	❍	❍	❍
Concerns regarding compensation and/or liability	❍	❍	❍	❍
Potential negative impact on rapport between client and their service provider	❍	❍	❍	❍
New Leave of Absence provisions under the Mental Health Act are a simpler alternative	❍	❍	❍	❍
Refusal of consent by substitute decision-maker or client	❍	❍	❍	❍
Limited enforcement mechanisms available	❍	❍	❍	❍
CTOs are only useful for a limited client population	❍	❍	❍	❍
Lack of scientific evidence	❍	❍	❍	❍
Availability of CTO coordinators/ case managers	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

D4. How important are the following factors <u>in supporting or encouraging the use of CTOs</u> in Ontario?

	Very important	Important	Not important	NA/DK
Access to additional health resources like case management	❍	❍	❍	❍
Addressing treatment non-compliance	❍	❍	❍	❍
Reducing frequency of hospitalizations	❍	❍	❍	❍
Ensuring a team supported community treatment plan	❍	❍	❍	❍
Availability of CTO Coordinators/ case managers	❍	❍	❍	❍
Client request	❍	❍	❍	❍
Meeting legislated criteria	❍	❍	❍	❍
Safety in the community	❍	❍	❍	❍
Family or substitute decision-maker request	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

D5. What alternatives to CTOs are being used to manage consumers in your community?

_____

D6. Do you agree or disagree with the following statements about the effectiveness of CTOs?

	Agree	Neutral	Disagree	NA/DK
The CTO program is effectively serving the following communities:				
Aboriginal communities	❍	❍	❍	❍
Rural communities	❍	❍	❍	❍
Multi-cultural communities	❍	❍	❍	❍
Francophone communities	❍	❍	❍	❍
CTO clients maintain their gains after the CTO expires	❍	❍	❍	❍
CTOs have reduced hospital readmission rates	❍	❍	❍	❍
CTOs are effective in reducing the risk of serious harm to people in the community	❍	❍	❍	❍
CTOs have better outcomes than other community treatment options	❍	❍	❍	❍
CTOs have a positive impact on the quality of life of the consumer	❍	❍	❍	❍
CTOs are an effective way of addressing the 'revolving door' between the hospital and the community	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

D7. Do you have any comments to make about the effectiveness of CTOs?

_____

D8. Do you agree or disagree with the following statements about the management and administration of CTOs.

	Agree	Neutral	Disagree	NA/DK
The rights of CTO consumers are adequately protected	❍	❍	❍	❍
The Rights Advice process works well	❍	❍	❍	❍
The legal safeguards in the legislation are appropriate	❍	❍	❍	❍
All individuals who could benefit from a CTO have access to one	❍	❍	❍	❍
Physicians are adequately educated and informed about CTOs and related issues	❍	❍	❍	❍
The Consent and Capacity Board process is satisfactory for all stakeholders	❍	❍	❍	❍
CTOs increase communication and understanding among service providers	❍	❍	❍	❍
The methods for dealing with non-compliance are satisfactory	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

D9. Do you have any comments to make about CTO management and administration?

_____

D10. Do you agree or disagree with the following statements about the resources and services relating to CTOs

	Agree	Neutral	Disagree	NA/DK
CTOs take needed resources away from non-CTO clients	❍	❍	❍	❍
CTOs are being used as a way to get to the front of the resource line	❍	❍	❍	❍
CTO coordinators and case managers have adequate access to services for clients	❍	❍	❍	❍
The lack of availability of income support and housing limits the effectiveness of CTOs	❍	❍	❍	❍
CTOs should be a last resort when other treatment options have been explored	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

D11. Do you have any comments to make about resources required for effective CTOs?

_____

E. ALL GROUPS: YOUR VIEWS

E1. Please provide us with any thoughts about CTOs that have not already been covered

_____

F. ALL GROUPS: INFORMATION ABOUT YOU

F1. I am

- ❍ Male
- ❍ Female
- ❍ Other
- ❍ Decline to answer

F2. My age is:

- ❍ Under 30
- ❍ 31-60
- ❍ Over 60
- ❍ Decline to answer

What health region (LHIN) do you live in?

- ❍ South East
- ❍ Erie St. Clair
- ❍ Central
- ❍ North West
- ❍ North East
- ❍ Mississauga Halton
- ❍ Toronto Central
- ❍ North Simcoe Muskoka
- ❍ Central East
- ❍ Central West
- ❍ Champlain
- ❍ Hamilton Niagara Haldimand Brant
- ❍ South West
- ❍ Not sure/ Decline to answer

SURVEY CLOSING

[SURVEY IS SUCCESSFULLY COMPLETED]

Thank you for completing this survey. Your participation in this review is greatly appreciated.

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APPENDIX G: EVIDENCE TABLES

EVIDENCE TABLES OF PEER REVIEWED PUBLISHED LITERATURE SINCE 2005

Author	Year	Level	Design	Subjects	Study Objectives	Intervention (Provider, Duration)	Outcome Measure	Results	Study Limitations
Kisely	2011	1	Meta-analysis	Two RCTs (Steadman, 2001; Swartz, 2001)	Examine clinical and cost effectiveness of CTOs	CTO - Durham, North Caroline (12 months), New York, New York (11 months)	Hospitalization (number of admissions, length of stay), compliance, social adjustment, perceived coercion, quality of life, side effects, victimization, attrition	No significant effect of CTO on any outcome other than reduction of victimization	Non-blinded, violent participants not random (Swartz, 2001)
Burgess	2006	2	Case controlled	Individuals given CTO between 1/7/91 and 30/6/00 (n=16,216) and comparison group (n=112,211).	Effect of hospital discharge on CTO consumers and examine changes in CTOs issued over time	CTO (Victoria, Australia, range of durations)	Use of CTOs, changes of CTO over time, and effect of CTOs on readmission to hospital	Over 9 year period CTOs issued rose by 40%, no change in demographics of those receiving CTOs Higher readmission risk for consumers with first CTO Those with more than 1 CTO had a reduced risk of readmission	Pattern of care may be unique to jurisdiction, case controlled (difficult to match clinical variables), unequal group sizes, validity problems with administrative data
Frank	2005	2	Mirror Image	Mental health consumers issued a CTO between 1/7/98 and 30/6/00 (n=42)	Evaluate CTOs on subsequent time out of the hospital	CTO (Montreal, Quebec, range of durations)	Time spent out of hospital between admissions	Time to readmission was greatest right after CTO was issued. Time to readmission second largest after first readmission to the hospital after being issued a CTO	Validity problems with administrative data, pattern of care may be unique to jurisdiction, findings may represent regression to the mean

Author	Year	Level	Design	Subjects	Study Objectives	Intervention (Provider, Duration)	Outcome Measure	Results	Study Limitations
Hough	2005	2	Mirror Image	CTO consumers between 01/95 and 09/98 (n=553)	Effect of CTO on crime and violent crime rates	CTO (South Australia, 1 year)	Rate of offence and violent offences for CTO consumers	Rate of offence and violent offence significantly lower during and after CTO than before	Pattern of care may be unique to jurisdiction, findings may represent regression to the mean, validity problems with administrative data
Hunt	2007	2	Case controlled	CTO consumers (n=224), voluntary group (non-CTO)(n=92)	Compare CTO and non-CTO group on demographic and clinical variables , hospital use and continued engagement with services upon exit from case management	CTO (Toronto, Ontario, range of durations)	Hospital admissions, access to services after discharge	CTO group: reduced number of hospital admissions, reduced duration of hospital stay, less likely to voluntarily continue with services after discharge	Non-random selection, validity problems with administrative data, unbalanced group size, case controlled (difficult to match clinical variables)
Ingram	2009	2	Case controlled	Australian CTO consumers with suitable case notes (n=94)	Examination of association between CTO and reduction of problem behaviours and improved social functioning	CTO (Australia, range of durations)	Social outcomes	Significant reduction in homelessness, episodes of aggression	Validity problems with case note studies, case controlled (difficult to match clinical variables), pattern of care may be unique to jurisdiction
Kallap-iran	2010	2	Case Controlled	CTO consumers discharged from Hunter Valley Mental Health	Examine relationship between CTO and hospital	CTO (Newcastle, Australia	Hospital utilization rates	Significant reduction in admissions and bed days (when index admission included)	Small sample size, short follow up time, case controlled (difficult

Author	Year	Level	Design	Subjects	Study Objectives	Intervention (Provider, Duration)	Outcome Measure	Results	Study Limitations
				Services 06/98 (n=26-28)	utilization rate				to match clinical variables), pattern of care may be unique to jurisdiction
O'Brien	2009	2	Mirror image	CTO consumers from Royal Ottawa Mental Health Centre and the Montfort Hospital (n=84)	Effect of CTO on community engagement and supportive housing	CTO (Ottawa, Ontario, range of durations)	Number of community services accessed, housing status	Community services: increase during CTO, 80% of consumers had increase in the number of services received Housing: significant change to more supportive housing	Validity problems with administrative data, findings may represent regression to the mean
O'Brien	2005	2	Mirror Image	CTO consumers from Royal Ottawa Hospital 1/01 to 9/03 (n=25)	Evaluate effectiveness of CTO	CTO (Ottawa, Ontario, one year before and one year after CTO) issued	Hospital use rate, use of support services, housing, consent and capacity board activity	After CTO: admissions to hospital decreased, increase in range of services used, significant change in housing driven by a move to supportive housing No consumers applied to CCB upon issue or renewal of CTO (n=47)	Validity problems with administrative data, findings may represent regression to mean
Phelan	2010	2	Mirror Image	CTO consumers (n=76), discharged without CTO (n=108)	Compare individuals on CTO with those receiving a discharge. Both have access to same services.	CTO (Bronx and Queen's, New York, New York, CTO ≥ one month)	Violent behaviour, Psychotic symptoms, suicide risk, illness related social functioning, quality of life, perceived coercion, stigma (propensity scores)	CTO group: less likely to perpetrate serious violent behaviour, lower risk of suicide, better illness-related social functioning, lower feelings of stigma and coercion	Self-reported data, non-random assignment, pattern of care may be unique to jurisdiction, findings may represent regression to the mean
Segal	2009	2	Case	Individuals given	Determine if CTO	CTO (Western	Duration of hospital	Duration of hospital stay	Pattern of care may

Author	Year	Level	Design	Subjects	Study Objectives	Intervention (Provider, Duration)	Outcome Measure	Results	Study Limitations
			Controlled	CTO between 12/11/97 and 31/11/98 (n=129) and comparison group (n=117).	reduced inpatient episode durations	Australia, range of durations)	stay	shortened in the CTO group	be unique to jurisdiction, case controlled (difficult to match clinical variables), validity problems with administrative data, findings may represent regression to mean
Segal	2006 d	2	Case controlled	Individuals given CTO between 12/11/90 and 30/6/00 (n=8,897)	Determine factors for selection of patients receiving a CTO (as inpatient < 30 days)	CTO (Victoria, Australia, range of durations)	Factors significantly associated with selection for early CTO	Education greater than 11th grade level, lower likelihood of diagnosis of dementia/schizophrenia, first admission to psychiatric institute involuntary, community involvement	No information about symptom-based severity of illness, validity problems with administrative data, case controlled (difficult to match clinical variables), comparison group not randomly selected
Segal, S	2006 a	2	Case Controlled	Individuals given CTO between 12/11/90 and 30/6/00 (n=8,897) and comparison group (n=16,094).	Examine whether persons are issued a CTO upon release from hospital or while living in the community and whether CTO is a less restrictive alternative to	CTO (Victoria, Australia, range of durations)	Inpatient days, inpatient episodes, total community treatment days, treatment days per community episode.	Increase likelihood of CTO: male, younger, never married, schizophrenia, and lack of community involvement. CTO group: more inpatient days, shorter inpatient episodes	Pattern of care may be unique to jurisdiction, case controlled (difficult to match clinical variables), validity problems with administrative data, treatment and comparison

Author	Year	Level	Design	Subjects	Study Objectives	Intervention (Provider, Duration)	Outcome Measure	Results	Study Limitations
					hospitalization.				group unequally weighted
Segal, S	2006 b	2	Case Controlled	Individuals given CTO between 12/11/90 and 30/6/00 (n=591) and voluntary outpatient comparison group (n=591)	Impact of CTO on services utilized	CTO (Victoria, Australia, CTO ≥ 180 days)	Inpatient days, number of admissions, mean length of stay (days), Community treatment days	CTO group: chance of hospitalization decreased, increase in involuntary community treatment, no increase in voluntary, one less day of inpatient treatment for every six days on CTO	Pattern of care may be unique to jurisdiction, case controlled (difficult to match clinical variables), validity problems with administrative data
Segal, S	2006c	2	Case controlled	Individuals given CTO between 12/11/90 and 30/6/00 (n=8,897) and comparison group (n=16,094).	Effect of CTO on mortality risk	CTO (Victoria, Australia, range of durations)	Probability of injury and non-injury related deaths	CTO group: 13% mortality, less total deaths than expected (males - 60 more deaths than expected, females - 112 deaths less than expected), 13% reduction in probability of non-injury related death Comparison group: mortality rate 18%	Pattern of care may be unique to jurisdiction, case controlled (difficult to match clinical variables), validity problems with administrative data, treatment and comparison group unequally weighted
Corring	2010	3	Qualitat-ive- Semi-structured Interviews	CTO consumers (n=8)	Explore quality of life issues for CTO consumers	CTO (London and St. Thomas, Ontario, range of durations)	Corring Quality of Life Measure	Multiple factors factor into quality of life for CTO consumers: lack of insight, need for medication, desire for increase activity, satisfaction with stability provided by CTO	Non-random sample, small sample size, lack of context, reliability of self-reports
Gibbs	2005	3	Qualitative - Semi-structured	CTO consumers over last 2 years not readmitted to	Evaluate consumer perceptions of	CTO (Otago, New Zealand, range of	Positive and negative feelings of CTOs	Wholly favorable - 19% Generally favorable - 46% Neutral - 21%	Reliability of self-reporting, pattern of care may be

Author	Year	Level	Design	Subjects	Study Objectives	Intervention (Provider, Duration)	Outcome Measure	Results	Study Limitations
			interviews	hospital for more than 6 months (n=42)	CTOs	durations)		Generally opposed - 7% Totally opposed - 7% Positives - Safety, security, access to services, increased freedom, made them access treatment when they lacked insight Disadvantages: loss of autonomy and freedom, coerced medication compliance and unpleasant side effects, restrictions on residence and travel, stigma	unique to jurisdiction
O'Reilly	2006	3	Qualitative-Semi-structured interviews	CTO consumers (interview)(n=14), Relatives, clinicians (focus groups)	Examine opinions of CTO stakeholders	Opinions of consumers, relatives, clinicians and representative of community agencies	Lived experiences	Consumers: positive and negative feelings, coercion, necessary structure Family: CTO structure necessary Clinicians: mostly positive, lack of autonomy	Small sample size, reliability of self-reporting
Schwartz	2010	3	Qualitative - Semi-structured interviews	CTO consumers receiving treatment at the Royal Ottawa Mental Health Centre (n=6)	Evaluate consumer perceptions of CTOs	CTO (Ottawa, Ontario, CTO for 4 months to 7 years)	Perceptions of housing, employment, personal relationships, reasons for CTO, info provided by service providers, understanding of legal process, stigma, negative feeling of	Employment: 33% worked part time, 67% had no employment. Personal relationships: family view CTO favorably and saw positive change from it.	Small sample size, reliability of self-reporting

Author	Year	Level	Design	Subjects	Study Objectives	Intervention (Provider, Duration)	Outcome Measure	Results	Study Limitations
							CTO, positive feelings of CTO	Reason for CTO: Not taking medication and not engaging in self-care. Stigma: occurred in community through labels, scrutiny and isolation. Professional stigma in the form of de-personalization from diagnostic language, and paternalistic ideologies Negative feelings of CTOs: loss of autonomy and stigma of mental illness, lack of continuity in health care Positive feelings of CTOs: positive outcomes	
Schwartz	2006	3	Qualitative Interviews	CTO consumers (n=1,011)	Identify key demographic factors for issuing CTO	CTO - Chicago, Illinois; Durham, North Carolina; San Francisco, California; Worcester, Massachusetts - range of durations	Consumer's experience with leverage, social support and treatment assistance, clinical characteristics, treatment compliance, Drug Attitude Inventory Treatment satisfaction, perceived coercion, violent behaviour	CTO more common for those: not living independently, receiving assistance to comply with treatment, with a comorbid substance abuse, greater functional impairment, with a history of violent behaviour, multiple hospitalizations, more years in treatment, recent police interventions during a mental health crisis	Reliability of self-reporting, pattern of care may be unique to jurisdiction

APPENDIX H: ADDITIONAL DATA TABLES

CTOs (Issues and Renewals) by LHIN and Region, 2000-2003 and 2008/9-2010/11

	2000	2001	2002	2003	LHIN	2008/9	2009/10	2010/11
Central East		15	53	33	Central	232	229	222
					Central East	269	357	317
Central South		18	16	17	Hamilton Niagara Haldimand Brant	232	237	138
Central West	1	3	41	56	Central West	25	94	104
					Mississauga Halton	125	102	56
					Waterloo Wellington	328	94	288
East		8	44	77	Champlain	139	225	233
					South East	372	49	428
North		6	46	75	North East	213	267	281
					North Simcoe Muskoka	171	166	255
					North West	24	367	112
Southwest		17	59	87	Erie St. Clair	132	137	161
					South West	140	152	195
Toronto	7	132	240	243	Toronto Central	394	386	480
Total	**8**	**199**	**499**	**588**	**Total**	**2796**	**2862**	**3270**

Sources: CDS-MH for 2008/9 to 2010/11; Dreezer and Dreezer Report for 2000 to 2003 (figures a composite of CTO Information Record and OHIP Billing Code data).

Percentage of Mental Health Service Recipients Issued CTOs per LHIN (2008/09-10/11)

	Number of Mental Health Service Recipients				
LHIN	Total	Issued CTO	No CTO	Unknown / Declined	% of Service Recipients Issued CTO
Central	35,097	683	32,089	2,325	1.9%
Central East	90,584	943	39,936	49,705	1.0%
Central West	16,690	223	13,796	2,671	1.3%
Champlain	55,830	597	38,313	16,920	1.1%
Erie St.Clair	38,178	430	30,118	7,630	1.1%
Hamilton Niagara Haldimand Brant	64,169	607	34,134	29,428	0.9%
Mississauga Halton	26,897	283	19,431	7,183	1.1%
North East	51,075	761	27,084	23,230	1.5%
North Simcoe Muskoka	23,832	592	18,147	5,093	2.5%
North West	41,599	503	20,097	20,999	1.2%
South East	71,998	849	30,792	40,357	1.2%
South West	45,454	487	26,398	18,569	1.1%
Toronto Central	65,670	1,260	27,369	37,041	1.9%
Waterloo Wellington	54,728	710	25,992	28,026	1.3%
Ontario (2008/09-2010/11)	**681,801**	**8,928**	**383,696**	**289,177**	**1.3%**

Source: Common Data Set- Mental Health (CDS-MH).

Percentage of CTOs Issued by Functional Centres by Local Health Integration Network (2008/09-2010/11)
(Part 1 of 2)

Functional Centre	Central	Central East	Central West	Champlain	Erie St. Clair	Hamilton Niagara Haldimand Brant	Missi-ssauga Halton	Ontario
Abuse Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Assertive Community Treatment Teams	11.3%	7.8%	44.4%	30.5%	11.9%	27.5%	9.2%	16.7%
Child/Adolescent	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Clubhouses	0.0%	0.0%	0.0%	0.0%	0.0%	3.8%	0.0%	0.5%
Community Mental Health Clinic	0.0%	6.3%	0.0%	1.0%	0.0%	0.2%	0.0%	0.9%
Concurrent Disorders	0.0%	0.0%	0.4%	0.0%	0.0%	1.2%	0.0%	0.1%
Counselling and Treatment	0.0%	10.5%	0.0%	22.4%	8.6%	0.7%	0.0%	9.5%
Diversion and Court Support	5.9%	1.2%	0.9%	2.7%	2.8%	0.5%	0.0%	5.4%
Dual Diagnosis	0.4%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	1.1%
Early Intervention	0.7%	0.7%	0.0%	3.9%	3.0%	0.8%	1.8%	0.9%
Eating Disorder	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%
Forensic	0.0%	0.8%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%
Homes for Special Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Mental Health Case Management	61.6%	65.2%	17.9%	35.2%	64.4%	54.9%	79.2%	54.1%
Mental Health Crisis Intervention	3.2%	2.3%	13.0%	0.7%	3.5%	1.6%	6.7%	3.0%
Primary Day/Night Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Psycho-geriatric	0.1%	0.0%	0.0%	0.2%	0.2%	0.7%	0.0%	0.1%
Short Term Res. Crisis Support Beds	0.6%	1.1%	1.3%	0.3%	0.0%	1.6%	0.0%	0.4%
Social Rehabilitation/Recreation	11.1%	1.4%	17.0%	0.7%	0.0%	0.5%	0.0%	2.7%
Support within Housing	5.0%	2.7%	4.9%	2.5%	5.1%	5.9%	3.2%	3.7%
Vocational/Employment	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%
Total CTOs	**683**	**943**	**223**	**597**	**430**	**607**	**283**	**8,928**

Source: Common Data Set- Mental Health (CDS-MH).

Percentage of CTOs Issued by Functional Centres by Local Health Integration Network (2008/09-2010/11) (Part 2 of 2)

Functional Centre	North East	North Simcoe Muskoka	North West	South East	South West	Toronto Central	Waterloo Wellington	Ontario
Abuse Services	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Assertive Community Treatment Teams	18.5%	9.6%	2.8%	3.7%	84.4%	7.0%	9.7%	16.7%
Child/Adolescent	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Clubhouses	1.3%	0.0%	1.6%	0.0%	0.0%	0.0%	0.0%	0.5%
Community Mental Health Clinic	0.5%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.9%
Concurrent Disorders	0.1%	0.0%	0.0%	0.2%	0.4%	0.0%	0.0%	0.1%
Counselling and Treatment	2.8%	0.3%	3.8%	29.0%	2.1%	0.3%	38.3%	9.5%
Diversion and Court Support	1.1%	2.0%	17.5%	4.9%	0.4%	0.0%	34.1%	5.4%
Dual Diagnosis	0.0%	0.5%	0.0%	10.6%	0.0%	0.0%	0.0%	1.1%
Early Intervention	0.4%	1.5%	0.2%	0.0%	0.2%	1.0%	0.0%	0.9%
Eating Disorder	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Forensic	0.0%	0.0%	1.4%	0.0%	0.2%	0.2%	0.0%	0.2%
Homes for Special Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Mental Health Case Management	69.0%	74.2%	25.0%	46.4%	9.0%	84.0%	16.9%	54.1%
Mental Health Crisis Intervention	3.4%	9.3%	5.6%	2.4%	1.6%	0.5%	0.1%	3.0%
Primary Day/Night Care	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.2%
Psycho-geriatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Short Term Res. Crisis Support Beds	0.0%	1.5%	0.4%	0.1%	0.0%	0.0%	0.0%	0.4%
Social Rehabilitation/Recreation	1.4%	0.0%	31.6%	0.4%	0.8%	0.4%	0.0%	2.7%
Support within Housing	0.3%	1.0%	10.1%	2.1%	0.8%	4.1%	0.8%	3.7%
Vocational/Employment	0.0%	0.0%	0.0%	0.2%	0.0%	0.3%	0.0%	0.4%
Total CTOs	**761**	**592**	**503**	**849**	**487**	**1,260**	**710**	**8,928**

Source: Common Data Set- Mental Health (CDS-MH).

Change in Living Arrangement for Toronto CTO Consumers (2005/06-2010/11)

	Current[1] Living Arrangement						
Baseline Living Arrangement	**Children**	**Non-relatives**	**Parents**	**Relatives**	**Self**	**Spouse/ partner/ other**	**Baseline Total**
Children	**15**	0	0	0	1	0	**16**
Non-relatives	0	**33**	4	1	8	0	**46**
Parents	0	2	**68**	0	5	2	**77**
Relatives	0	1	2	**16**	3	0	**22**
Self	0	13	4	4	**135**	8	**164**
Spouse/partner	0	1	0	1	2	**22**	**26**
Current Total	**15**	**50**	**78**	**22**	**154**	**32**	**351**

Source: Data provided by and Toronto Source.
[1]Current relates to either a person's situation as of their discharge date or, if they are still a CTO consumer, as of April 1, 2012.

Change in Support for Toronto CTO Consumers (2005/06-2010/11)

	Current[1] Support					
Baseline Support	**Assisted/ supported**	**Independent**	**Supervised Facility**	**Supervised Non - Facility**	**Unknown/ declined**	**Total**
Assisted/ supported	**30**	7	0	0	0	**37**
Independent	21	**278**	7	0	12	**318**
Supervised Facility	2	7	**7**	0	0	**16**
Supervised Non - Facility	0	0	0	**2**	0	**2**
Unknown/ declined	0	3	0	0	**0**	**3**
Total	**53**	**295**	**14**	**2**	**12**	**376**

Source: Data provided by and Toronto Source.
[1]Current relates to either a person's situation as of their discharge date or, if they are still a CTO consumer, as of April 1, 2012.

Change in Primary Income Source for Toronto CTO Consumers (2005/06-2010/11)

Baseline Primary Income Source	Current[1] Primary Income Source							
	Disability support	Employ-ment insurance	Family	Indepen-dent source	No source of income	Other	*Unknown/Declined*	Total
Disability support (e.g. Ontario Disability Support Program, CPP Disability Benefits)	**232**	1	0	2	0	2	*7*	**244**
Employment insurance (e.g. EI, Private Insurance, Ontario Works)	15	**18**	0	2	0	1	*1*	**37**
Family	4	1	**24**	2	0	0	*0*	**31**
Independent source (e.g. Employment, Pension)	0	0	0	**25**	0	3	*2*	**30**
No source of income	2	0	0	0	**4**	0	*0*	**6**
Other	1	0	2	0	0	**20**	*0*	**23**
Unknown/Declined	*0*	*0*	*0*	*0*	*0*	*0*	***7***	***7***
Total	**254**	**20**	**26**	**31**	**4**	**26**	***17***	**378**

Source: Data provided by and Toronto Source.
[1]Current relates to either a person's situation as of their discharge date or, if they are still a CTO consumer, as of April 1, 2012.

Factors Supporting or Encouraging the Use of CTOs in Ontario
(Percentage of all respondents rating factors as very important)

Factors	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	All Groups
Reducing frequency of hospitalizations	80%	87%	78%	79%	48%	76%	76%
Ensuring a team supported community treatment plan	70%	74%	88%	80%	48%	79%	76%
Safety in the community	65%	52%	75%	77%	33%	81%	71%
Addressing treatment non-compliance	85%	78%	78%	74%	19%	62%	70%
Access to additional health resources like case management	63%	70%	78%	69%	48%	69%	68%
Availability of CTO Coordinators/ case managers	58%	83%	70%	59%	44%	57%	60%
Meeting legislated criteria	50%	48%	45%	47%	37%	45%	46%
Client request	33%	17%	43%	51%	48%	55%	46%
Family or substitute decision-maker request	33%	35%	48%	45%	19%	45%	41%
Considered no factor "very important."	*0%*	*4%*	*8%*	*2%*	*15%*	*7%*	*4%*
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

Factors Limiting the Use of CTOs in Ontario
(Percentage rating factors as very important)

Very important factors	Psychiatrist	CTO Coordinator	Other In-patient Health Professional	Other Community Health Care Provider	Consumer Advocate	Other	Total
Insufficient community resources available for clients on CTOs	30%	44%	50%	43%	59%	62%	46%
Level of knowledge and/or experience with CTOs	33%	39%	48%	44%	52%	45%	43%
Availability of CTO coordinators/ case managers	53%	44%	48%	40%	26%	43%	42%
Workload concerns regarding issuing a CTO, the legal review process and/or supervising a CTO client	45%	52%	48%	38%	33%	38%	40%
Refusal of consent by substitute decision-maker or client	23%	22%	40%	42%	48%	41%	39%
Limited enforcement mechanisms available	35%	9%	43%	41%	7%	29%	34%
Concerns regarding infringement of patient rights	20%	17%	23%	32%	70%	43%	33%
Issues related to rights advice	13%	26%	28%	31%	52%	41%	31%
CTOs are only useful for a limited client population	28%	17%	28%	33%	26%	29%	29%
Potential negative impact on rapport between client and their service provider	23%	9%	25%	24%	56%	36%	27%
Concerns regarding compensation and/or liability[1]	10%	22%	3%	20%	7%	26%	17%
Lack of scientific evidence[2]	3%	9%	18%	13%	41%	29%	16%
Considered no factor "very important."	*8%*	*13%*	*15%*	*10%*	*4%*	*12%*	*10%*
Total Numbers	**40**	**23**	**40**	**172**	**27**	**42**	**344**

[1]15% of respondents replied no answer/don't know.
[2]19% of respondents replied no answer/don't know.
[3]46% of respondents replied no answer/don't know.

Regional Differences in Factors Supporting or Limiting the Use of CTOs (Part 1 of 3)[25]

LHIN	N	Regional Trends in Factors Supporting or Limiting the Use of CTOs
Central	16	Respondents from Central were more likely to consider access to health resources, and less likely to consider meeting legislated criteria, as factors supporting the use of CTOs. Additionally, they were less likely to consider that CTOs are only useful for a limited population as a limiting factor. Central had an above average response rate from community health workers.
Central East	31	Respondents from Central East were notably interested in consumer-centric concerns. They were more likely to consider consent, rights advice, and negative impacts on consumers as factors limiting the use of CTOs (impact on relationships; liability). Moreover they were more likely to consider a lack of scientific evidence and that CTOs are only useful for a limited client population as limiting factors. These respondents were more likely to consider meeting legislated criteria and ensuring a team supported community treatment plan "very important" factors supporting the use of CTOs. Central East had an above average response rate from community health workers.
Central West	8	Too few cases to comment upon.
Champlain	37	Respondents from Champlain were less likely to consider access to additional health resources like case management as a factor supporting the use of CTOs. Champlain had an above average response rate from psychiatrists. Nevertheless, these respondents were particularly less likely to consider refusal of consent by substitute decision-maker or client as a factor limiting the use of CTOs.
Erie St. Clair	10	Respondents from Erie St. Clair were more likely to consider consumer-related concerns as impacting on the use of CTOs. For example, they were more likely to cite client requests, and client or substitute decision-maker consent, more impactful on whether or not to use CTOs, than safety in the community. They considered workload and CTO enforcement concerns as being more limiting compared to the average.
Hamilton Niagara Haldimand Brant	42	Respondents from Hamilton Niagara Haldimand Brant were less likely to consider addressing treatment non-compliance as a factor supporting the use of CTOs. They were also less likely to consider issues related to rights advice as limiting the use of CTOs. Hamilton Niagara Haldimand Brant had an above average response rate from CTO coordinators and ACT Team members. Nevertheless, these respondents were particularly more likely to cite workload concerns as a factor limiting the use of CTOs.
Mississauga Halton	27	Respondents from Mississauga Halton were more likely to consider reducing frequency of hospitalizations as supporting the use of CTOs, and less likely to cite family/substitute decision-maker requests as "very important" factors supporting the use of CTOs. They were also more likely to consider workload concerns as limiting the use of CTOs.

[25] Note: Answers taken from questions D3 and D4 of the service provider edition of the questionnaire. Trends are derived where percentage replied “very important” per LHIN is at least 10% greater or less than total percentage. Trends explained by respondent involvement bias (i.e. high frequency of psychiatrists in Champlain; consumer advocates in Toronto) are excluded from this report except where in excess or opposite direction of expected trend.

LHIN	N	Regional Trends in Factors Supporting or Limiting the Use of CTOs
North East	44	Respondents from North East were generally more likely to consider none of the suggested factors limiting the use of CTOs a "very important." In particular, they were less likely to cite workload, experience, or patient rights concerns as limiting factors. Additionally they were less likely to cite access to health resources, meeting legislated criteria, and family or substitute decision-maker requests for CTOs as "very important" supporting factors. North East had an above average response rate from community health workers.
North Simcoe Muskoka	19	Respondents from North Simcoe Muskoka were more likely to consider access to additional health resources, availability of CTO coordinators/case managers, and family/substitute decision-maker requests as factors supporting the use of CTOs. They were less likely to consider issues related to rights advice or that CTOs are only useful for limited client population as factors limiting the use of CTOs. North Simcoe Muskoka had an above average response rate from consumer advocates.
North West	4	Too few cases to comment upon.
South East	11	Respondents from South East were more likely to cite a lack of scientific evidence, refusal of consent, and a negative impact on rapport between client and their service provider as limiting the use of CTOs. They considered knowledge/experience with CTOs and workload concerns as less likely to limit the use of CTOs. South East had an above average response rate from inpatient health workers.
South West	32	Respondents from South West were more likely to consider ensuring a team supported community treatment plan, and safety in the community as factors supporting the use of CTOs. South West had an above average response rate from psychiatrists.
Toronto Central	26	Respondents from Toronto Central were less likely to consider workload concerns and insufficient community resources as factors limiting the use of CTOs. Additionally they were less likely to consider a potential negative impact on rapport between client and their service provider as a limiting factor. Toronto Central had an above average response rate from consumer advocates. Nevertheless, these respondents were particularly less likely to consider reducing frequency of hospitalizations as a "very important" supporting factor for using CTOs, and particularly more likely to consider consent issues a limiting factor.
Waterloo Wellington	16	Respondents from Waterloo Wellington were more likely to consider reducing frequency of hospitalizations and addressing treatment non-compliance as factor supporting the use of CTOs. They were also less likely to consider a client request as a "very important" factor supporting the use of CTOs, though were more likely to consider concerns regarding patient rights as a factor limiting use. Additionally, these respondents were more likely to cite insufficient community resources, knowledge/experience, and that CTOS are only useful for a limited client population as factors limiting the use of CTOs.

Ranking of Respondents Most Strongly Felt Statements

Statements with which Respondents Most Agreed/Disagreed				
Rank	**Direction**	**First Legislated Review**	**Direction**	**2012 Legislated Review**
1	Disagree	Mental health professionals are fully aware of the new Leave of Absence provisions	Agree	CTOs have reduced hospital readmission rates
2	Agree	There should be more research on the appropriate use and outcomes of CTOs[1]	Disagree	Mental health professionals are fully aware of the new Leave of Absence provisions
3	Disagree	Physicians are adequately educated and informed about CTOs and related issues	Disagree	CTOs take needed resources away from non-CTO clients
4	Agree	The availability of income support and housing influences the effectiveness of CTOs	Agree	CTOs have a positive impact on the quality of life of the quality of life of the consumer
5	Agree	Rights Advice should also be available after the CTO is issued[1]	Agree	CTOs are an effective way of addressing the "revolving door" between the hospital and the community
6	Agree	Compensation, liability and paperwork issues deter physicians from using CTOs	Agree	CTOs are effective in reducing the risk of serious harm to people in the community
7	Disagree	The use of CTOs has not reduced hospital readmission rates or lengths of stay for CTO clients	Agree	The rights of CTO consumers are adequately protected
8	Disagree	CTOs take needed resources away from non-CTO clients	Agree	CTOs increase communication and understanding among service providers
9	Disagree	The methods for dealing with non-compliance are satisfactory	Disagree	All individuals who could benefit from a CTO have access to one
10	Disagree	CTO treatment outcomes are being adequately evaluated[1]	Agree	The lack of availability of income support and housing limits the effectiveness of CTOs

[1]No equivalent question asked in 2012 questionnaire.

Note : The 2005 questionnaire included 35 statements which measured agreement/disagreement among all respondents. The 2012 questionnaire included 25 statements which either mirrored or reflected the content of the former questionnaire and were only asked of service providers (different sets of questions were asked of consumers, and family and friends of consumers).

Ranking of Respondents Most Divided Statements

	Statements with Greatest Division of Opinion (Standard Deviation)	
Rank	**First Legislated Review**	**2012 Legislated Review**
1	CTOs should be a last resort when other treatment options have been explored	CTOs should be a last resort when other treatment options have been explored
2	The civil rights of CTO clients are adequately protected	Physicians are adequately educated and informed about CTOs and related issues
3	CTOs are an effective way of addressing the "revolving door" between the hospital and the community	The methods for dealing with noncompliance are satisfactory
4	Rights advice provisions do not adequately protect consumers and families	CTO coordinators and case managers have adequate access to services for clients
5	The legislation appropriately balances the need for treatment, care and protection with clients' liberty interests	The Consent and Capacity Board process is satisfactory for all stakeholders
6	CTOs take needed resources away from non-CTO clients	The CTO program is effectively serving rural communities.[1]
7	CTOs keep people out of hospital[2]	The lack of availability of income support and housing limits the effectiveness of CTOs
8	CTOs "lack teeth" and are difficult to enforce	CTOs are being used as a way to get to the front of the resource line
9	CTOs increase communication and understanding among service providers	The Rights Advice process works well
10	The use of CTOs has not reduced hospital readmission rates or lengths of stay for CTO clients.[2]	The legal safeguards in the legislation are appropriate

[1]The 2005 questionnaire asked one such question: The CTO program is effectively serving the aboriginal, rural, multi-cultural, and francophone communities. The 2012 questionnaire divided this statement into four separate questions.
[2]The 2012 questionnaire asked one such question: CTOs have reduced hospital readmission rates (ranked 19th).