October 2011
Community Treatment Orders and Other Changes to the Mental Health Act

Overview of Lecture

- Introduction of Guest Speaker:
  Gale Melligan, RN, BA, CPMHN(C)
  CTO Coordinator, St. Joseph’s Healthcare Hamilton
- Mental Health Act – Key Forms and Process
- Role of Consent & Capacity Boards
- Treatment and Capacity
  - Role of Substitute Decision Maker
  - Role of Health Care Consent Act
- Community Treatment Orders
  - Purpose, Criteria, Community Treatment Plans

Mental Health Act (revisions Dec 2000)

- Why was the Mental Health Act (MHA) changed?
  - Social pressure
  - Political pressure
  - Inquests
  - Professional frustration & misunderstanding

  WHAT WAS CHANGED?
  - Committal criteria
  - Changes for police
  - Apprehension criteria
  - Introduction of Community Treatment Orders (CTOs)
  - All changes interact/impact each other
Legal forms under MHA that are utilized to bring an individual with a serious mental illness (SMI) to hospital for assessment

- Based on behaviors and risk factors
  - Past, present & future test – Serious harm test
  - New criteria with Box B – based on past history of SMI where treatment has helped in the past and there is a Substitute Decision Maker (SDM) in place

Form 1 – Application for Psychiatric Assessment
- Issued by physician – must have seen client in past 7 days
- Valid for 7 days
- Enables police to take client for assessment
- Once in facility a Form 1 is valid for 72 hours
- Removal of the “imminent” wording

Form 2 – Order of a Justice of the Peace (JP) for Psychiatric Assessment
- Similar changes to Form 1 with new Box B criteria
- Issued by JP – anyone can seek a Form 2
- Form 2 taken to police
- Valid for 7 days
- Assessment only

Forms 3 & 4
- Similar changes as with Form 1 & Form 2 with the:
  - Addition of Box B criteria and
  - Removal of “imminent”
- To use Box B – must meet all criteria
- Language stronger here as physician must have more than reasonable cause regarding risk & behavior – now have a clinical opinion regarding risk
Form 3 – Certificate of Involuntary Admission
- Valid for 2 weeks
- Client provided with rights advice by Psychiatric Patient Advocate Office (PPAO)
- Right to apply to CCB to determine if criteria met

Form 4 – Certificate of Renewal
- 1st - valid for 4 weeks
- 2nd - valid for 2 months
- 3rd etc - valid for 3 months
- Can be renewed at expiry
- Rights advice provided each time
- Right to Consent & Capacity Board (CCB) Hearing each time
- Mandatory CCB Hearing with each 4th renewal

Protection of Rights
- Systems of checks in place with:
  - Physician who signed Form 1 cannot issue Form 3
  - Apprehension under Form 2 – must have Form 1 issued – cannot make involuntary
  - Notice to clients, when committal forms issued or renewed
  - Rights advice for all committal forms
  - Ongoing access to Psychiatric Patient Advocate Office (PPAO)
  - Access to Legal Aid
  - Right to a Consent & Capacity Board (CCB) Hearing each time Form 3 or Form 4 issued
  - Onus on physician
  - Right to appeal CCB outcome

Consent & Capacity Board
- An independent Tribunal affiliated with Ministry of Health & Long Term Care (MOHLTC)
  - Panel consists of: Psychiatrist, lawyer and community member
  - Client has right to Hearing within 7 days of making application
  - Decision must be provided within 72 hrs of completion of Hearing
  - Onus of proof on physician
  - Hearings under Mental Health Act, Substitute Decisions Act, Health Care Consent Act, Long Term Care Act
Police Apprehension

- **Section 17** of Mental Health Act (MHA) pertains to Police
- Can act on professional judgment, if person acting in manner that in a normal person would be disorderly
- **NEW LAW** – removes requirement for personal observation
  - Can now use 3rd party information
  - Removal of “imminent” criteria
  - Form 1, Form 2 & Form 47 – these are issued to Police for apprehension of clients under MHA

Treatment & Capacity

- Apprehension & admission do NOT guarantee treatment
- Treatment under [*Health Care Consent Act*](#)
- Treatment cannot begin until have valid consent
- Consent is treatment specific & must be informed
- Emergency treatment without consent

**Incapacity to Consent to Treatment**

- Client assessed by physician
  - Not able to understand treatment
  - Not able to appreciate consequences of decision or lack of decision
  - Not able to assess alternatives to proposed treatment
  - **Treatment is a moving target and must be continually assessed**
  - Client must know they are being assessed
  - Notice to client, rights advice and right to CCB Hearing for those found incapable to consent to treatment

Substitute Decision Maker (SDM) for Treatment

- Ranking List: guardian, attorney for personal care, representative appointed by CCB, spouse, children and parents, siblings, other relatives, friends
- Same rules apply – must be informed consent & treatment specific
- SDM must be willing & able to act in this role – if not, access Public Guardian & Trustee
Amendments to
*Health Care Consent Act (Dec 2000)*

- Changes made to HCCA to reflect changes in MHA
- Treatment now includes **Community Treatment Plan**
- Can apply to Consent & Capacity Board (CCB) for directions regarding incapable persons wishes, or to depart from wishes
- Can apply to CCB to remove a Substitute Decision Maker (SDM)
- Applications to CCB for CTO hearing now includes incapacity review

---

Community Treatment Orders (CTOs)

- New law in Ontario as of Dec 2000
- Controversial
- Similar laws uses around the world
- Also called “Outpatient Committal”

**Why CTOs?**

- Political & social pressure
- Inquests recommendations
- Lack of continuity regarding treatment
- Deinstitutionalization
- Increased criminalization of the mentally ill

---

CTO: Purpose

- “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”
- A treatment option for those who stop treatment after discharge and decompensate in the community
- Meant for revolving door clients
CTO: Criteria

- Past 3 years – previous CTO, or 30 days hospitalization, or 2 or more admissions
- Community Treatment Plan (CTP) development
- Assessment before entering into CTP
  i.e., person is suffering from SMI and needs treatment, meets Form 1 criteria if not in a psychiatric facility, without treatment will meet committal criteria, able to comply with the plan and treatment, care and supervision are available

Community Treatment Plans

- Constitutes treatment under HCCA
- Obligations of client
- Obligations of health care providers
- Who is the most responsible physician
- Names of those who have agreed to provide treatment and supervision
- Must be reasonable and attainable
- Clients and service providers must be clear on obligations and accountability
  This is not a wish list – services must be available & willing

Crucial for client to understand obligations & what to expect; and for service providers to know what they are accountable for

NOT JUST A PIECE OF PAPER

CTO: Details

- CTO issued by a physician
- Last for 6 months
- Can be renewed at expiry
- Right to a CCB review with every CTO issued
- Mandatory CCB review every 2nd renewal
- Rights advice with every CTO issued – client can refuse
- Rights advice prior to issuance – Bill 16 · 2010 – revised MHA that can issue/renew CTO if best efforts made to provide rights advice to client unsuccessful
- Rights advice to SDM
Non compliance with a CTO

Form 47 – Order for Examination
- Issued by physician if not complying with terms of CTP after efforts made to assist client
- Issued without seeing client
- Issued to Police and valid for 30 days
- Taken for Examination – admit if needed
- Much controversy around Form 47 - clarified 2010 Bill 16 changes to MHA CTO is not terminated with issuance of Form 47

Termination of a CTO
- Admission does not terminate a CTO
- May issue a Form 1, Form 3, Form 4 while on a CTO
- Person or SDM can request termination – client must be examined by physician to determine if they are able to live in the community without the CTO - if person fails to attend for examination, physician can issue a Form 47

Role of CTO Coordinator
- Provincial funding to assist with implementation of new legislation – CTO Coordinators and CTO Case Managers
- Education
- Assist with CCB hearings
- policies & Protocols
- Bring parties together – CTO Planning Meetings
- Working with Substitute Decision Makers
- CTO “expert” - must know the legal nuts & bolts
- Assist with MHA mandatory legislative review of CTOs – after 3rd year and q 5 years
- Data submission to MOHLTC

CTO: Realities
- Provides a new treatment option – but NOT forced treatment
- Provides clear communication to all parties
- Good discharge planning
- Opportunity to move on with life
- Inclusion of families in care of relative
- Accountability of mental health service professionals
- Use varies across the province
- Still misunderstood & controversial
- A balance of needs – those of the clients and those of society and economic realities
CTO: Who are the clients?
- Meant for revolving door clients – those with years of history
- Must have SMI – Axis 1 diagnosis
- Used today for many younger clients – why wait!
- Issues of substance abuse over 70% with CTO clients
- More males than female
- Ages 16 to 85
- Most in Hamilton incapable to consent – 88%
- Many have legal issues due to SMI
- Most CTOs renewed at expiry – many for years

CTO: Do They Work?
- Does provide options for challenging clients
- Not magic
- Opportunity to develop community supports for client
- Development of therapeutic relationship
- Opportunity for families to stay involved
- Many clients able to achieve goals of staying out of hospital, getting own apartment, job, improved relationships, etc.
- Communication loop for professionals
- Accountability in community

CTOs in Hamilton
- Initial reluctance to utilize CTOs
- 5 years to issue initial 100 CTOs
- 2011/12 will issue/new over 200 CTOs
- # of CTOs issued now over 800
- Over 100 clients on CTOs with a variety of community agencies – ACTT, Case Management, clinics
- Now seen as the standard of care for those clients who meet CTO criteria
Across the province & next steps

- Provincially – numbers vary region to region
- Initial buy in some areas to CTOs i.e. London
- Other areas now more accepting and CTO utilization is increasing across the province
- Provincially mandated review of CTOs
- Research – this has increased around the world with mixed outcomes
- Many useful sites on internet for CTO information
- Some research has shown decreased hospitalization, decrease LOS, decrease criminalization
- Research has shown that clients find it stigmatizing, coercive and inhibiting, while others find it a safety net
- Need to continue research to enable changes/best practices in treatment options and find the correct balance

Questions & thank you

Contact Information
Gale Melligan
CTO Coordinator
St. Joseph’s Healthcare Hamilton
905-388-2511 ext 36321
gmelliga@stjoes.ca