THE THIRD REVIEW OF COMMUNITY TREATMENT ORDERS

Final Report

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ABBREVIATIONS AND GLOSSARY

ACT	Assertive community treatment
CAMH	Centre for Addiction and Mental Health
CCB	Consent and Capacity Board
CDS - MH	Common Data Set/Mental Health
CTO	Community treatment order
CTO-IR	Community Treatment Order Information Record
Forms	Form 1: Application by Physician for Psychiatric Assessment
	Form 33: Notice to Patient under Subsection 59(1) of the Act and under Clause 15(1)(a) and 15.1(a) of Regulation 741
	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
MHA	*Mental Health Act*
MoH	Ministry of Health
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

REPORT SUMMARY

Community Treatment Orders

A community treatment order (CTO) is issued by a physician to enable a person with a serious mental disorder who has experienced repeated psychiatric hospitalizations to be provided with a comprehensive plan of community based treatment that is less restrictive than being detained in a psychiatric facility. While living in the community, CTO clients agree to follow a community treatment plan.

The criteria for a physician to issue or renew a CTO involve several steps, including determining whether the person or his or her substitute decision maker consents to the community treatment plan =, establishing a community treatment plan, and ensuring the person receives rights advice, all prior to signing the CTO. Once signed, a CTO is in effect for not more than six months and can be renewed for a period of six months at any time before its expiry and within one month after expiry. Once the CTO has expired or has been terminated, the parties may enter into a subsequent community treatment plan if the criteria set out in the *Mental Health Act* are met.

The Third Review of CTOs

The Ontario *Mental Health Act, R.S.O. 1990 (MHA)* at s. 33.9 requires that the use of CTOs be reviewed at specified intervals. Section 33.9(1) states that the Minister shall establish a process to review the following matters;:

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

Under the direction of the Ministry of Health (MoH), and with project oversight from the Provincial System Support Program at the Centre for Addiction and Mental Health, R.A. Malatest & Associates conducted a review of CTOs in Ontario. This report arises from the third review of CTOs and largely replicates the earlier (2007 and 2012) reviews.

Several sources of information were used to inform the third review of CTOs, including:

- A review of academic and publicly-available literature pertaining to CTOs;
- Analysis of administrative data;

- Interviews and focus groups with 34 stakeholders, including health professionals, CTO coordinators, mental health advocates, clients, their family members, friends and substitute decision-makers (SDMs); and,
- An online survey of 306 stakeholders.

There are several limitations to this report that should be kept in mind when considering the review's findings:

- Limited participation of clients, families and advocacy groups across the province;
- Limited voices from groups representing diverse populations, including Indigenous, Francophone, northern and ethno-cultural communities; and,
- Lack of accurate data directly reporting the number of CTOs issued, reissued or renewed.

Changes to the CTO environment since the last review

- *A growing number of CTOs are issued, reissued and renewed*

The available data indicate that the number of CTOs (including first issue, renewal after six months, and reissue after a lapse) in Ontario has increased since 2012. The continued growth is likely driven by mental health professionals' increased awareness and comfort in using CTOs. However, it could also be partly due the need to free-up hospital beds and the use of CTOs to gain priority access to services for clients.

- *The system supporting CTOs may become increasingly under strain*

As the numbers of CTOs continue to grow system-wide, so have the caseloads of organizations that support CTOs, such the Psychiatric Patient Advocate Office (PPAO) and the Consent and Capacity Board (CCB). For instance, while the CCB received approximately 200 applications to review a CTO in 2007, this number steadily increased to almost 1,900 applications in 2018.

The capacity of the mental health system to cope with the increasing number of CTOs has not kept up with this increase. Rather, some elements of the system have found ways to keep up with demand, while other elements are showing strain that is impacting the level of service provided to clients.

The concern is how the various elements of the system that support CTOs would cope with any further increases in the number of CTOs. To address this concern, mental health professionals and CTO coordinators have recommended streamlining the administrative burden imposed by the CTO process.

- *CTOs increasingly involve substitute decision-makers*

When a client is found not capable of consenting to a CTO, a SDM may consent to the CTO on behalf of the client. In 2018, 47% of CTO rights advice requests were for an SDM, a percentage that has increased since 2012. The data available suggest that the volume of CTO cases involving SDMs has more than doubled since the last review. The reason for this trend is unclear. It appears that the majority of CTOs issued now involve an SDM.

- *The ongoing debate around informed consent*

The debate around informed consent as it relates to accepting CTOs has quieted over the years, as many stakeholders who had concerns now accept CTOs. Many experts and mental health professionals agree that adequate safeguards exist to ensure that clients' and SDMs' rights are protected throughout the CTO process.

Yet concerns still exist about the processes of seeking consent and developing the community treatment plan. Many clients and their SDMs lack knowledge of the mental health system in general, CTOs in particular, their respective rights, and the side effects of medications often included in community treatment plans. The review heard of instances where clients or SDMs entered into a CTO, but had not given fully informed consent in that they were not aware of their right to not consent, or that they were coerced into consenting. In other cases, SDMs said they fully consented to the CTO and knew that they had the option of consenting.

Given the role of CTO coordinators in obtaining that consent, further developing the role of CTO coordinators, in terms of appropriate educational backgrounds, ongoing training needs and desired competencies, may help safeguard clients' and SDMs' best interests.

The reasons that CTOs were or were not used during the review period

- *Factors impacting clients', SDMs' and physicians' decisions to accept or recommend a CTO*

For clients who consented to a CTO, the main factors that impacted their decision include the desire to leave the hospital, to adhere to medication, to have a fallback in case their condition deteriorated, and to gain access to services. Some clients interviewed acknowledged that the CTO was in their best interest.

Factors that impacted SDMs' decision to accept a CTO include the legal authority associated with a CTO, the use of the CTO as a tool to encourage compliance among loved ones and as a means to access services. However, the review also heard that some SDMs consent to the CTO solely because the CTO is what the doctor said has to happen or has recommended. In some cases, SDMs do not sign the CTO or ask to have it revoked for various reasons, including feeling burdened with the responsibility of the CTO

on behalf of the client and concern over adding additional strain to their relationship with their loved ones. In cases where the SDM is the client's parent, some clients and SDMs commented on the need to transition to a new SDM as the parent ages. They expressed an interest in more information, structure and support to facilitate this transition.

Physicians' decisions to recommend a CTO are influenced by client factors, systemic factors and administrative factors.

- Client factors include diagnosis, client insight into their mental illness, history with the correctional system and substance use.
- Systemic factors include the availability of resources to provide continued inpatient services, and the availability of and access to community services.
- Administrative factors result from the perception that the CTO process is a burden.

➢ *Alternatives to CTOs being used to manage clients in the community*

Mental health professionals indicated that CTOs should be the last resort after other treatment options have been explored. The two most pervasive alternatives to CTOs are the assertive community treatment (ACT) team and intensive case management models, both of which provide comprehensive community-based mental health services. Although alternatives are likely to have been attempted prior to issuing a CTO, clients and SDMs have little awareness of them.

➢ *New CTOs mainly come from inpatient psychiatric facilities*

Overall, similar proportions of CTOs are issued at inpatient psychiatric facilities, through outpatient psychiatry and through ACT teams. However, virtually all first issuances of CTOs come from inpatient psychiatric facilities; although that proportion falls for CTO renewals and re-issuances, presumably as clients receive community care.

➢ *Characteristics of clients using CTOs*

CTO clients typically are in their 30s (though ages can vary from young adults to seniors), have a long history of mental health challenges, including recurring hospitalizations, and have diagnoses of schizophrenia, schizoaffective disorder or bipolar disorder. CTO clients are increasingly more likely to be male. They often are low-income individuals and participate in social and legal assistance programs (such as Ontario Works, Ontario Disability Support Program and Legal Aid Ontario). Although a majority have stable housing, a considerable proportion live in subsidized housing, in a room-and-board setting, in a hostel/shelter, in Homes for Special Care[1] or are homeless. Some clients have substance use challenges and a history with the correctional system.

[1] For more information, see www.health.gov.on.ca/en/pro/programs/hsc.

According to mental health professionals, clients from diverse populations (such as Indigenous or Francophone clients) account for a small proportion of CTO clients overall. According to their experiences, newcomers to Canada seem to be an increasingly common group being served through CTOs.

The effectiveness of CTOs during the review period

- *Services and supports used by CTO clients*

CTO clients have access to a number of services and supports, including but not limited to health professionals' services, case management, ACT teams, intensive case management and housing services. The CTO-IR data suggest that client access to these services has increased relative to the six-month period before they entered a CTO.

Some of these services were provided adequately (for instance ACT team services), whereas others were not (for instance housing). While these services are not exclusive to CTO clients and can be made available to all mental health clients in the system, CTO clients appear to be afforded priority access to services, particularly where community services and resources are limited.

- *Characteristics of the client and of the CTO may influence the effectiveness of CTOs*

Several factors can influence the effectiveness of CTOs, including client characteristics and features of the CTO. Client characteristics that influence the effectiveness of CTOs include insight into their mental illness and compliance; socio-economic, psychosocial and health factors; and history of substance use. Factors such as availability and stability of income, communication skills, and social capital (in the form of support from friends and family) increase the effectiveness of CTOs. CTOs issued in urban areas are more effective than in rural areas that have fewer CTO resources (e.g. physicians/psychiatrists, ACT team services and CTO coordinators).

CTO features that can influence their effectiveness include the content of and client inputs into the community treatment plan, as well as the relationship between the client and service providers. Should a CTO client be placed in custody, the services provided under a CTO are no longer available, which can set back the client's treatment.

CTO factors that can influence their effectiveness include the availability of community resources and services to support the community treatment plan, a client's history with the correctional system, and most notably, availability and provision of housing to CTO clients. The findings for ethno-cultural factors are unclear, but the data suggest that Indigenous communities are the least well-served by CTOs.

- *Effects of CTOs on client well-being and satisfaction*

The effectiveness of CTOs may be mixed and largely case-dependent. On the positive side, CTOs may reduce hospitalization and interactions with the correctional system. The data suggest that 93% of clients entering a CTO had at least one psychiatric hospitalization in the previous six months. However, the same data also suggest that only 13% of clients have had a psychiatric hospitalization during the six months on a CTO.

The evidence is mixed for clinical/medication outcomes, psychosocial outcomes, and outcomes for quality of life and satisfaction with care. Feelings of reduced personal agency may be an outcome for some CTO clients.

When hearing from clients and family members, many reported that CTOs are easy to follow and are effective. Several also commented that CTOs provide more stability, improvements in symptoms, and general health. Some interviewees noted that positive consequences of the CTO extended to other members of the household, who experienced less stress and better sleep.

- *CTOs are frequently renewed for the same client*

Many clients have their CTOs renewed multiple times. One in seven CTO clients (14%) surveyed in 2019 has been issued 5 or more CTOs. In some cases, clients reported that they will be on a CTO for the rest of their lives.

- *CTOs lack a formal discharge planning process*

There is no standard discharge planning process for CTO clients. Although there appear to be norms, physicians have discretion when it comes to the process of discharging a CTO client. Although physicians and CTO coordinators attempt to ensure continuity of care after clients are discharged from a CTO, SDMs expressed concerns about the aftermath of a discharge, when the supports to the client are discontinued, increasing the likelihood of relapse.

Methods used to evaluate the outcome of any treatment used under CTOs

- *What client outcomes are being measured?*

Client outcomes that are the most frequently evaluated in the literature relate to hospital and service utilization, and include number of psychiatric visits, number and length of readmissions, time to readmission, and type of health and community services utilized. Findings from this review's primary research confirm that hospital and service utilization are the most frequently measured outcomes in Ontario. The CTO-IR gathers information on some client outcomes, including:

- Number of psychiatric hospitalizations in the past six months. If the CTO is a first issue, this will measure psychiatric hospitalizations before a CTO is issued, and if the CTO is renewed or reissued, this will measure psychiatric hospitalizations while the CTO is in effect;
- Client services used in the previous six months;
- Services to be included in the community treatment plan; and
- Client involvement with the legal system during the previous six months.

Many stakeholders consulted as part of this review acknowledged that hospital and service utilization rates are poor outcome measures, as they do not portray the full picture of the impact of the CTO on the client. They further noted that, despite CTOs being available for almost 19 years, little is being done to measure client outcomes in a consistent way, both within health facilities and in the community by the MoH.

- *How are client outcomes being measured?*

The information systems designed to collect data on client outcomes contain gaps. Some client outcome measures are collected and compiled in the CTO-IR. The common feeling among mental health professionals was that the MoH does not express an interest in collecting, analyzing or disseminating data on an aggregate level.

The CTO-IR system is an attempt to collect such data, but considerable gaps in the data are apparent. Despite the best efforts of MoH staff, two months were required to prepare CTO-IR data for analysis. Moreover, the CTO-IR data appears incomplete when compared with data from other sources. It is estimated that the CTO-IR contains a record for approximately 38% of CTO issues, renewals and reissues.

- *Differences in client outcomes by client socio-demographic, geographic, or ethno-cultural factors*

Client outcomes can be measured by some socio-demographic and geographic factors using the CTO-IR data. The CTO-IR gathers information on some client socio-demographics (e.g. age, sex, family background, and housing type). Clients' geographic location could be inferred from the name and address of the organization/agency with which the issuing physician is affiliated. However, the CTO-IR form does not collect any information pertaining to the ethnic, racial or cultural background of the client.

Recommendations to Improve CTOs

Given the growing number of CTOs being issued and the perception that each is an administrative burden, the following recommendations to improve CTOs often revolve around balancing efficiency with protecting the best interests of clients:.

1. *Lengthen the validity period for CTO renewals to a maximum of two years;*
2. *Engage stakeholders in discussions about how the CTO process could be streamlined;*
3. *Consider further defining the position of CTO coordinator;*
4. *Communicate more effectively with clients and SDMs, especially about medication side effects, and include side effect mitigation strategies in community treatment plans;*
5. *Consider the role of CTOs in the correctional context;*
6. *Establish a standardized discharge process;*
7. *Ensure the data system analyzes CTOs from a systemic perspective;*
8. *Collect ethno-cultural background information through the CTO Information Record; and*
9. *Consider culture and language needs when working with clients on CTOs and their families.*

1 BACKGROUND

1.1. Community Treatment Orders

Under the Ontario *MHA*, at section 33.1 (1), a physician may issue or renew a community treatment order for a person who suffers from a serious mental disorder if the criteria set out in subsection (4) are met. CTOs are issued for people who, as a result of his or her serious mental disorder, experience a pattern of admission to a psychiatric facility, stabilization, release and readmission.

The general process for CTOs involves several key components that are described below.[2]

1.1.1 Determining eligibility

Pursuant to s. 33.1(4) the criteria for a CTO includes a requirement that;

(a) During the previous three year period, the person has
   i) 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

has been the subject of a previous community treatment order in Ontario.

1.1.2 Determining capacity to consent

As part of the criteria for issuing or renewing an CTO, a physician may issue or renew the order if 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 (HCCA)[3]. =Capacity is determined based on an assessment by a physician and the criteria are set out in the HCCA If the physician finds the client is not capable of consenting to a CTO, the physician must give the client a certificate of incapacity, commonly known as Form 33.
Should the client wish to challenge the determination of incapacity, they have the right to a hearing before the Consent and Capacity Board (CCB). The CCB is an independent provincial tribunal whose mission is "*the fair and accessible adjudication of consent and capacity issues, balancing the rights of*

[2] This description is for illustrative purposes and provides the process in its simplest form. The process followed by a CTO client may differ in a number of ways. The CTO process is described using information from several sources, including information available on the PPAO website: www.sse.gov.on.ca/mohltc/ppao/en/Pages/InfoGuides/2016_CommunityTreatmentOrders.aspx?openMenu=smenu_InfoGuides

[3] Pursuant to s. 10(1) of the HCCA, a health practitioner who proposes treatment for a person shall not administer the treatment unless he or she is of the opinion that the person is capable with respect to the treatment and the person has given consent. If the health practitioner if of the opinion that the person is incapable and the persons substitute decision maker has given consent, then the treatment can be administered.

vulnerable individuals with public safety."[4] The hearing before the CCB can result in either a confirmation or a reversal of the physician's determination that the client is not capable of consenting. Should they not be satisfied with CCB's decision, the client or the physician can appeal CCB's decision to the Ontario Superior Court of Justice.

If a client is found not capable of consenting to a CTO, an SDM may provide consent.. The SDM is required to make decisions that reflect the client's prior capable wishes (if they are known) or the best interests of the client (if prior wishes are not known).

The physician will look at who is available, capable, and willing to act as the client's SDM. The SDM is frequently the client's spouse, parent, child, brother or sister, or someone appointed by the CCB to act as the client's representative. If there is no SDM available to make treatment decisions on behalf of the client, the Office of the Public Guardian and Trustee will act as the SDM.

1.1.3 Establishing a community treatment plan

The physician, CTO coordinator and other mental health professionals develop a community treatment plan, seeking input from the client, and the SDM, if any, as well as from anyone else named in the community treatment plan (for instance, other physicians, CTO coordinators or social workers). The MHA requires a community treatment plan to contain at least the following elements:

- A plan of treatment for the client
- Any conditions relating to the treatment or care and supervision of the CTO client;
- The obligations of the client subject to the CTO;
- The obligations of the SDM, if any;
- The name of the physician, if any, who has agreed to accept responsibility for the general supervision and management of the CTO; and,
- The names of all persons or organizations who have agreed to provide treatment or care and supervision under the plan, and their obligations.

The physician must believe that the client is able to comply with the plan and that the treatment or care and supervision required under the plan are available in the community.

[4] For more details on the mission of the CCB, see www.ccboard.on.ca/scripts/english/aboutus/index.asp.

1.1.4 Examining the client

Pursuant to section 33.1(4)(c) of the MHA, the physician must examine the client within 72-hours before entering into the community treatment plan, and believe that:

- The client is suffering from a mental disorder that requires continuing treatment or care and continuing supervision while living in the community;
- If the client is not currently a client in a psychiatric facility, they meet the criteria for the completion of an application for psychiatric assessment ("Form 1"); and
- If the client does not receive continuing treatment or care and continuing supervision in the community, they are likely, because of mental disorder, to cause serious bodily harm to themselves or to another person, or to suffer substantial mental or physical deterioration or physical impairment.
- The person is able to comply with the community treatment plan contained in the CTO and,
- The treatment or care and supervision required under the terms of the CTO are available in the community.

If the physician is satisfied that the client meets the above criteria, and their capacity to consent has been assessed, the physician signs and dates the community treatment plan. At this time, the physician also issues Form 49 (Notice of Intention to Issue or Renew a Community Treatment Order) and gives a copy of the form and the plan to the client, the SDM, if any, and the Psychiatric Patient Advocate Office (PPAO). These documents then initiate the process of rights advice to the client and the SDM.

1.1.5 Providing rights advice

Before a CTO is issued, the physician must be satisfied that the person who will be subject to the order and his or her SDM (if any) have consulted with a rights adviser and have been advised of their legal rights pursuant to s. 33.1 (4)(e) of the MHA. The person must receive rights advice, unless they refuse. If rights advice is refused, the rights adviser shall promptly provide confirmation of that fact to the physician in the approved form. If the SDM is the Office of the Public Guardian and Trustee, they receive rights advice for first issuances of CTOs only, and not for renewals.

Once notified by the physician, the rights adviser promptly talks with the client, to discuss in a neutral and non-judgmental fashion, CTO-related issues such as:

- Capacity to consent to the CTO if the person has been found incapable;
- The requirements for issuance or renewal of a CTO;
- The client's rights and obligations under the CTO; and,
- The client's options for appealing a finding of incapacity or seeking a review of the community treatment plan.

When rights advice is given, the rights adviser issues a Form 50 (Confirmation of Rights Advice), which states whether or not a client who has been found incapable of consenting wishes to apply to the Consent and Capacity Board to appeal the finding of incapacity. Should the client wish to appeal the finding of incapacity before the CCB, the rights adviser assists the client with the application Form 48 (Application to Board to Review Community Treatment Order and Notice to Board to Schedule Mandatory Review of Community Treatment Order), as well as with obtaining legal counsel, including applying to Legal Aid Ontario if requested.

1.1.6 Completing the CTO

To complete the CTO, the client (or SDM if any), and the physician sign Form 45 (Community Treatment Order) and Form 46 (Notice of Issuance or Renewal of Community Treatment Order). The client (and SDM if any) receives copies of these forms and a blank Form 48 (Application to Review Community Treatment Order) in case they want to challenge or withdraw from the CTO (see Section 1.1.8).

1.1.7 Enforcing a CTO

Once the CTO is complete, the client is responsible for adhering to the conditions of their community treatment plan. If the client fails to comply with their community treatment plan (e.g. misses appointments or does not take medication), and the physician has attempted to help the client adhere to their plan, then the physician can issue a Form 47 (Order for Examination). The Form 47 allows the police to bring the client to the hospital, clinic or wherever the physician is located, for the physician who issued the order to examine the client with respect to the CTO.

1.1.8 Challenging a CTO or withdrawing consent

The client or the SDM, if any, may apply to the CCB using Form 48 (Part 2) to determine whether the criteria for issuing the CTO have been met. A rights adviser may assist the client or SDM, if any, with completing the Form. If the CCB determines that any of the criteria for issuing a CTO are not met at the time of the CCB hearing, the CTO will be revoked.

If not challenged, or if confirmed after the hearing before the CCB, the CTO is effective for up to six months. At any time after the CTO is issued, the client or the SDM, if any, have the right to retain and instruct counsel about the CTO; can ask the physician to review the client's condition and necessity for the CTO; and can change their mind and withdraw their consent to the CTO. The physician can also change their decision about the need for the CTO. If the CTO is no longer necessary, the physician must terminate it, and notify the client and anyone who is involved in that CTO.

If the client or the SDM, if any, withdraws their consent to the CTO, the physician must attempt to examine the client's condition within 72 hours. During that time, the physician is responsible for taking reasonable steps to locate the client or their SDM. Once they have located the client, the physician will examine them to determine if they are able to live in the community without the CTO. If the physician

determines that the client cannot live in the community, and the client or their SDM has revoked their consent to the CTO, the physician can complete a Form 1 (Application for Psychiatric Assessment) to have the client detained in a psychiatric facility for assessment.

1.1.9 Renewing and reissuing a CTO

A CTO is effective for six months, after which it expires or is renewed. A CTO can be renewed as many times as needed, as long as the client remains eligible for a CTO, with each renewal lasting up to six months. The CTO renewal is usually started a few months before the CTO is set to expire since the renewal process can be long and a new CTO must be issued if it has not been renewed within one month of its expiry.

To renew a CTO, the client, SDM (if any), the physician and CTO coordinator repeat most of the steps and forms involved in the process of issuing a CTO, as described above. Renewal includes adjusting the community treatment plan as necessary, and providing rights advice, along with completing the required CTO forms. It is worth noting that every second CTO renewal triggers a deemed application for review by the CCB.

1.2. The Third Review of CTOs

Section 33.9 of the MHA requires a review of CTOs every five years. The Provincial System Support Program at the Centre for Addiction and Mental Health, at the request of the MoH, issued a request for proposals for the third review of CTOs. R.A. Malatest and Associates was the successful proponent. The first review was completed in 2007 by Dreezer & Dreezer and the second in 2012 by R.A. Malatest & Associates Ltd. As with the previous reviews, the results of the third review will be made publicly available.

1.2.1 Review questions

The third review largely replicates the earlier reviews in that it answers the review questions under three specific areas:

- The reasons that CTOs were or were not used as a means of treating clients during the review period:
    - What factors impact clients', physicians' and SDMs' decisions to use or accept a CTO?
    - What alternatives to CTOs are being used to manage clients in the community?
    - What are the characteristics of clients using CTOs?
    - Where are CTOs originating?

- The effectiveness of CTOs during the review period:

- What effects do CTOs have on client well-being and satisfaction?
- What services and supports are CTO clients receiving?
- What are the factors which influence the effectiveness of CTOs?
- Is there a standard discharge planning process for a CTO client?
- How many times, on average, are CTOs renewed for the same client?
- Does the effectiveness of CTOs differ by client socio-demographic, geographic, or ethno-cultural factors?

- The methods used to evaluate the outcomes of any treatment used under CTOs:
  - What client outcomes are being measured?
  - How are client outcomes being measured?
  - Are differences in client outcomes being measured by client socio-demographic, geographic, or ethno-cultural factors?

1.2.2 Defining the review's scope

In answering these questions, the 2019 review has been informed by a number of lines of evidence including:

- A review of recent academic and publicly available literature on this topic;
- A review of administrative data maintained by the MoH, the PPAO and the CCB; and,
- Consultations with stakeholders using focus groups, expert interviews and an online survey.

The review collected feedback from a wide array of stakeholders including government officials, representatives of the CCB and the PPAO, academic researchers, mental health professionals, mental health advocates, clients and their family members, friends and SDMs.

The following activities were not within the scope of the 2019 review:

- Funding of community mental health services or supports;
- Involuntary committal criteria in the MHA, review of *Personal Health Information Health Protection Act, 2004,* or review of the *Health Care Consent Act*;
- The activities of the CCB, the PPAO, or the Ontario Review Board;

- Legislation, regulations and policies not related to the CTO program; and
- CTOs and similar programs in jurisdictions outside of Ontario.[5]

[5] For the review of the literature, this activity is given a particular consideration that is described in Section 2.2.1.

2 METHODS

This section outlines the methods used for the review, including governance of the review, sources of evidence and considerations relevant to the review.

2.1. Governance of the Review

The third review of CTOs was conducted by R.A. Malatest & Associates Ltd. The MoH provided the review's funding and defined the scope of the review, including the review questions, the budget and timelines. The Provincial System Support Program at the Centre for Addiction and Mental Health provided oversight to the work of R.A. Malatest & Associates Ltd. Thus the Provincial System Support Program acted as a neutral intermediary between R.A. Malatest & Associates Ltd. and the MoH to ensure an appropriate level of independence for the review.

2.2. Lines of Evidence

The review was informed by examining relevant literature and administrative data, and by consulting stakeholders through focus groups, individual interviews and an online survey.

2.2.1. Reviewing relevant literature

The project team reviewed available literature with a focus on considering literature published after May 2012, as publications prior to that date were included in the 2012 review. The literature review included evidence-based academic and publicly available literature that helped answer the questions guiding this review, in particular research evaluating the effectiveness of CTOs. The project team undertook a literature search on PubMed and PubMed Central in March 2019, using the following key terms set out below.

Search Terms for the 2019 review

- Community treatment order
- CTO
- involuntary outpatient commitment
- compulsory treatment
- Brian's law

The literature search identified 37 studies meeting the aforementioned exclusion and inclusion criteria, including a wide variety of research methods (such as meta-analyses, randomized controlled trials, systematic reviews, mirror image studies, and qualitative studies). The bibliography presented in Appendix E lists the literature reviewed.

It is worth noting that, though the review of CTOs focuses on Ontario, the scope of the literature review included literature from other Canadian provinces and international jurisdictions. The objective of the review was not to review CTOs and similar programs in jurisdictions outside of Ontario, nor to systematically compare CTOs in Ontario with their counterparts in other jurisdictions. Instead, the findings of the literature review appear throughout the document and were used to compare the primary findings of this review to the findings of other studies.

Despite CTOs being in place in almost all Canadian jurisdictions, there is relatively little research on their effectiveness in Canada. Rather, the bulk of CTO research evaluates CTOs and similar mechanisms in international jurisdictions, including the United States, the United Kingdom, and Australia. Although differences exist, the CTOs or similar mechanisms implemented in other jurisdictions are comparable to Ontario's approach to CTOs. Thus this literature review shed light on CTOs by looking for evidence of their effectiveness in similar contexts beyond Ontario.

2.2.2. Reviewing administrative data

A single, definitive record of all CTOs issued, renewed and reissued does not exist. MoH representatives indicated that the data from the Common Data Set/Mental Health, which was a source of CTO counts and demographic data used for the 2012 review, is no longer collected at the provincial level. The 2019 review analyzed administrative data from three sources to determine trends in the total number of CTOs issued, renewed and reissued and to determine the attributes of CTOs, such as client characteristics.

Data from the MoH, the PPAO and the CCB were examined, taking into consideration the limitations of each. Data were considered appropriate sources for the 2019 review if they demonstrated:

- Year-over-year consistency within data sources: the review examined each data source to investigate whether they tended to report consistent data year-over-year. Sources reporting relatively consistent trends, rather than unexplained fluctuations, were considered to be appropriate sources;
- Consistency with trends identified by other lines of evidence: data sources that showed similar findings as other data sources or qualitative findings were considered appropriate; and,
- Consistency with previous evaluation: data that was able to replicate the findings reported in the 2012 review were considered appropriate.

With no single database being without limitations, the 2019 review employed a combination of datasets, based on which appeared to be best suited for a particular analysis. The details of the data sources for this study are presented below.

Sources of Data for the Review

MoH data: The MoH maintains two data sources that were considered for this review: the CTO Information Record (CTO-IR) and Ontario Health insurance Plan (OHIP) claims database. The CTO-IR is an information record that is to be completed every time a CTO is issued, reissued or renewed in Ontario. The CTO-IR gathers specific data about the individual to whom the CTO is issued, renewed or reissued to track client characteristics, such as age, gender, housing status, psychiatric diagnosis, involvement in the legal system and previous hospitalizations. Data in the CTO-IR can only be used for the purpose of the legislated reviews.

The CTO-IR database contained a total of 2,608 CTO records for the calendar year 2018,[6] a number lower than would be expected when compared with other data sources. As the PPAO data suggest 6,796 CTO rights advice requests in 2018, it is likely that the CTO-IR data only contain a fraction of all CTO records.[7] The finding that CTO-IR data is incomplete is supported by two observations of CTO-IR data. First, the data are not consistent year over year. For instance, the CTO-IR database contains almost no records for 2015 or 2016. Second, some areas of the province appear to be under-represented in the data. For instance, according to PPAO data, Central Ontario accounts for 16% of all requests for CTO rights advice, yet it only represents 0.4% of records the CTO-IR. The reason for this under-reporting is unclear.

Although perhaps incomplete, the 2018 CTO-IR data appears consistent with other sources on other measures. For example, the gender of clients is consistent with OHIP data and the diagnoses of clients are consistent with the 2012 review. As such, while the CTO-IR may only contain a proportion of all records, the cases it contains allows for a relatively accurate depiction of CTOs as a whole, although the degree to which it is representative cannot be confirmed.

The MoH also provided fiscal year data from OHIP, which represents billings from physicians to the provincial healthcare insurance system. The 2012 review indicated that this source was under-reported, possibly because psychiatrists and general physicians who issue CTOs do not directly bill OHIP for services related to CTOs. For example, the OHIP data shows that in 2017/18, there were approximately 650 unique clients throughout Ontario that received 1,690 billable doctor visits about CTOs, including 238 for CTO initiations and 513 for CTO reissues; numbers lower than any other data source provided for the 2012 or the 2019 review. As such, the OHIP data was not considered to be a reliable source of administrative data for estimating the number of CTOs in Ontario. Nonetheless, it was used in limited ways to support trends observed in other sources.

[6] Malatest received anonymous record-level data and compiled it based on calendar year.
[7] Albeit the PPAO data have inconsistencies of their own. See below for more detail.

PPAO data: Rights advice must be offered to a client before entering a CTO. The PPAO maintains a dataset that records each time it receives a request for rights advice by calendaryear, including cases where a third party provided the rights advice.[8]

However, the PPAO measures requests for rights advice and not the issue, renewal and reissue of CTOs in the province. While there is likely a high degree of correspondence between requests and issuances, there are limitations in using the PPAO's requests for rights advice as an estimate of the total number of CTOs in Ontario. In particular, a number of factors complicate the use of PPAO data in measuring the issue, renewal and reissue of CTOs in the province:

- As rights advice can be refused, requests for rights advice might not lead to rights advice being provided. Further, a client, or their SDM, may opt not to enter into a CTO after receiving rights advice. It is unclear how often these possibilities occur;
- The PPAO provides rights advice to both clients and SDMs. Since the recipient of the requested rights advice is also recorded in the data, filters may be applied to focus on either group;
- A CTO may involve multiple SDMs. In 2018, the PPAO issued CTO rights advice to 258 SDMs who were designated as second or third SDMs for the same CTO; and,
- The PPAO combines first issues of CTOs and reissues of CTOs as "issues". In this report, requests for rights advice as measured by PPAO data combine first issue and reissue of CTOs (but not renewals, which are reported separately).

Since the PPAO data does not allow for an accurate count of CTOs, it cannot be used to calculate the proportion of CTOs involving SDMs. However, by examining the proportion of rights advice requests for SDMs relative to all requests, one may estimate the degree of SDM involvement. However, this analysis is only an estimate for two reasons. First, a CTO may be issued through more than one SDM. Second, SDMs who are from the office of the Public Guardian and Trustee are only required to receive rights advice when a CTO is issued, and not when renewed or reissued. Therefore, the ratio of CTOs provided to clients and the number of SDMs involved is not always one-to-one. Despite these limitations, PPAO data appear to provide the most sound data for examining some key trends among CTOs.

CCB data: The CCB is a tribunal that adjudicates challenges to CTOs and is able to overturn issuance of CTOs and findings of client incapacity. CCB reviews are required every second time a CTO is renewed or when a client challenges a finding of incapacity. Given that the CCB is not involved in all CTOs, it is not possible to use their data to measure the number of CTOs. However, the data were reviewed by calendar year to examine whether the same trend with respect to CTO issuances increasing was present. It was also used to show how that trend is impacting the work being done by the CCB.

[8]The PPAO records this data when it receives a request for rights advice. In most but not all cases, the request is accompanied by a Form 49.

Given the strengths and weakness of each data source, this review uses data from PPAO, CTO-IR and CCB (albeit with the limitations detailed above) to answer different review questions:

- PPAO data was used to understand trends in the number of CTOs issued, reissued and renewed in the province and the proportion of CTOs that involve SDMs. This is the same source that was used to calculate these proportions in the 2012 review;
- CTO-IR data was used to understand characteristics of CTO clients and some outcome measures. CTO-IR data was not used in any aspect of the previous reviews;
- OHIP data was used to determine consistency with data from the previous review, as it is the only data source that is common between the 2012 and 2019 reviews; and
- CCB data was used to show changes in CTO activity at that organization.

Where the 2019 review uses different data sources than the 2012 review, direct comparisons should be made with caution.

2.2.3. Interviewing experts

Individual interviews were conducted with ten stakeholders from eight stakeholder groups, as is detailed in Table 1.

Table 1. Expert Groups Interviewed

Stakeholder group	Count
Psychiatric Patient Advocate Office	2
Mental health advocates	2
Ministry of Health	1
Consent and Capacity Board	1
Ontario Review Board	1
Academic researcher	1
Law enforcement	1
Legal professional	1
Total	**10**

The purpose of the expert interviews was to gather their unique insights into CTOs, including their views and experiences with respect to the three main areas of the review questions:

- The reasons that CTOs were or were not used as a means of treating clients;
- The effectiveness of CTOs; and,
- The method used to evaluate the outcomes of any treatment used under CTOs.

The project team developed a standard interview guide (see a copy in APPENDIX A) structured according to the review areas and questions. Different versions of the standard interview guide were developed to accommodate the responsibilities and experiences of some stakeholders invited to participate. All invited experts received a copy of their specific guide in advance of their interview.

The experts were recruited through various means, including through

- The help of CTO coordinators;
- Contact information of professionals involved with CTOs through the Centre for Addiction and Mental Health;
- Contact lists from the 2012 review; and,
- Information available online about mental health advocacy groups.

Two project team members conducted the interviews over the phone; typically, one led the interview and the other took notes. The interviews lasted between 45 and 90 minutes, and were recorded with the participant's verbal consent. Interview notes were summarized and the project team members listened to the recordings to detail the summaries and identify compelling quotations.

2.2.4. Interviewing clients, family/friends/SDMs

Twenty-two interviews, including 10 with clients and12 with SDMs, were held over the telephone at a date and time that was convenient for the participant. Participants were based across Ontario, including in Hamilton, Kawartha Lakes, London, Ottawa, Peterborough and the Greater Toronto Area. These 22 participants were recruited with the help of the CTO coordinators, case managers and ACT team members, who asked their clients and their family members/friends/SDMs on behalf of the review.[9]

At the beginning of each interview, the interviewer informed the participant of the purpose of the research, the types of questions that would be asked of the participant during the interview, the confidentiality of their participation, and the reporting of the findings. After answering any questions, the interviewer obtained verbal consent to conduct the interview. Interviews were audio recorded to ensure accuracy of recall. An incentive of $50 was offered to each participant. Interviews were semi-structured and followed an interview guide, but allowed for probing questions where needed. Interviews typically lasted 20 to 90 minutes, depending on the participant's responses.

[9] CTO coordinators provided additional contacts for the review. An unknown number of CTO clients, family, friends and SDMs were approached by CTO coordinators in this regard. Given the nature of this recruiting method, the response rate is unknown.

2.2.5. Conducting focus groups with mental health professionals

Two focus groups were held with mental health professionals via teleconference. The first focus group was attended by seven CTO coordinators, from six locations across Ontario (London, North Bay, Peterborough, Timmins, Thunder Bay, and Windsor). Participants were recruited from a list of CTO coordinators provided by the MoH for this purpose.

The second focus group was attended by six mental health professionals including psychiatrists, nurse managers, and ACT team managers. All participants worked at one of three hospitals in Ontario (one in Hamilton and two in the Greater Toronto Area). Participants were recruited with the help of CTO coordinators and through a list of professionals involved with CTOs through the Centre for Addiction and Mental Health.

Each focus group lasted between one-and-a-half to two hours and was audio recorded for accuracy of recall. Participants provided verbal consent to participate in the discussion and to be audio recorded. Participants were called and emailed to remind them about their participation.

2.2.6. Conducting an online survey

An online survey offered many more people the opportunity to provide feedback on CTOs. The survey questionnaire drew from the questions and statements used in the 2012 review to provide continuity. A copy of the survey questionnaire is presented in APPENDIX . The survey requested information about:

- The effects CTOs have on clients, family, friends or SDMs well-being and satisfaction;
- The factors that impact the decisions to use CTOs; and,
- The ways CTOs are managed and administered.

The link to the online form was shared with 71 individuals affiliated with 63 organizations connected to mental health issues. Each contact was encouraged to disseminate the link through their networks with anyone involved with CTOs in some capacity or by mentioning it on their newsletters.

The survey was completed by a total of 306 respondents representing a range of stakeholders, as shown in Table 2 below.

Table 2. Survey Completions by Type of Respondent and the Number of Areas of Ontario that are Represented

Type of Respondent	2019		2012	
	Total Completions	Areas Represented by Respondents	Total Completions	Areas Represented by Respondents
Clients and family/friends/SDMs	**64**	**9**	**81**	**n/a**
Client	30	4	47	9
Family/friend, substitute decision maker	34	7	34	9
Mental Health Professionals	**222**	**15**	**278**	**n/a**
Psychiatrist	52	12	40	10
CTO coordinator	29	15	23	10
CTO case manager	23	7	28	11
ACT team member	30	9	11	7
Community mental health worker	59	10	133	13
Inpatient mental health worker	26	8	40	10
Mental health researcher	3	2	3	n/a
Other Stakeholders	**20**	**11**	**52**	**n/a**
Lawyer or rights adviser	10	6	3	n/a
Client advocate	3	2	27	11
Government	1	1	4	n/a
Police representative	4	2	0	0
Other	2	1	6	0
Total	**306**	**15**	**411**	**14**

Source: Review of Community Treatment Order Survey, Question 1 (2019).

The majority (65%) of respondents from the professional groups (including psychiatrists, CTO coordinators and community mental health workers) had experience with issuing at least one CTO. Those who reported having signed a CTO for a client generally had experience signing multiple CTOs, with 80% reporting that they had signed more than five CTOs.

The survey was open to all stakeholders from April 11, 2019 to June 10, 2019. To ensure that sufficient voices of clients and families were heard, the survey was reopened from December 9 to 18, 2019, which allowed the number of clients and families included in the review to reach 64.

2.2.7. Analyzing collected data

Qualitative data from interviews with experts, focus groups, and interviews with clients, family/friends/SDMs were analyzed thematically using a deductive approach, whereby data were grouped and analyzed according to the review questions.[10]

Data from the online survey and administrative data were analyzed descriptively by producing frequency tables for each question. Where possible, the administrative data were analyzed to understand trends over time. Survey data were cross-tabulated against respondent categories and were contrasted against comparable questions from the 2012 survey. For the purposes of analysis, the respondents were grouped as indicated in Table 3.

Table 3. Survey Respondents by Stakeholder Group

Professional Group[11]	Count
Client/friend/family/SDM	64
Psychiatrist	52
CTO coordinator	52
Community mental health worker	89
Inpatient mental health worker	26
Other	23
Total	**306**

2.3. Limitations of the Review

Despite the best efforts of the review to mitigate the weaknesses in each line of evidence, key limitations remain and should be kept in mind when digesting the review's findings.

Limited feedback from clients: Attempts to encourage clients to provide feedback were only somewhat successful. Despite efforts to promote the survey to health professionals, encouraging them to share the link to the survey with CTO clients, a total of 30 clients from a limited number of geographic regions completed the online survey. A total of ten interviews with clients were also conducted. Therefore it is important to note that the perspective of CTO clients captured by the survey and interviews may not be representative of all CTO clients.

[10] Four researchers were responsible for analyzing the data. One analyzed interviews with experts; one analyzed the survey; and two analyzed the focus groups and interviews with clients, friends, family and SDMs.

[11] To obtain this distribution, the CTO coordinator and CTO case manager categories have been combined into one. The community mental health worker category includes the ACT team member. The mental health worker category remained unchanged. All other professional groups are now collapsed in the other category.

Limited feedback from advocacy groups: Some mental health advocates expressed concern about not being given enough time to prepare a response for the review. This challenge was mitigated by conducting individual interviews with two representatives of advocacy groups. Only three advocates completed the survey. The project team could not engage as many client advocate groups as desired. It is acknowledged that the review could have benefited to a greater extent from engaging as many advocacy groups as initially planned.

Limited input from groups representing diverse populations: The review attempted to engage service providers working with Francophone, Indigenous, northern and remote communities. However, those efforts were not productive. The survey does contain some questions about the ability of CTOs to serve some groups, but it would have been desirable to collect direct qualitative data on their experiences. Hence, the review somewhat fails to present findings specific to Francophone, Indigenous, northern and remote communities.

Data containing limitations: The data source used in the 2012 review was not available for the 2019 review,[12] and this review used data sources in different ways than the previous review. As such, direct comparisons between the findings of the 2019 review and the findings of the 2007 and 2012 reviews should be made with caution. The 2019 review used the PPAO's requests for CTO rights advice to understand trends among the number of CTOs issued, renewed and reissued in the province and among the proportion of CTO rights advice requests for SDMs. CTO-IR data was used to report on the characteristics of CTO clients. As both PPAO data and CTO-IR data have limitations (see Section 2.2.2), the reader is reminded that the review sought general trends for its findings and specific figures should be considered estimates. Given these limitations, the data analyzed for this review may not be entirely accurate; yet the review is able to stand behind its findings as a reasonable depiction of the province's experiences with CTOs since 2012.

[12] The 2012 review largely used the Common Data Set maintained by the MoH.

3 THE REVIEW'S FINDINGS

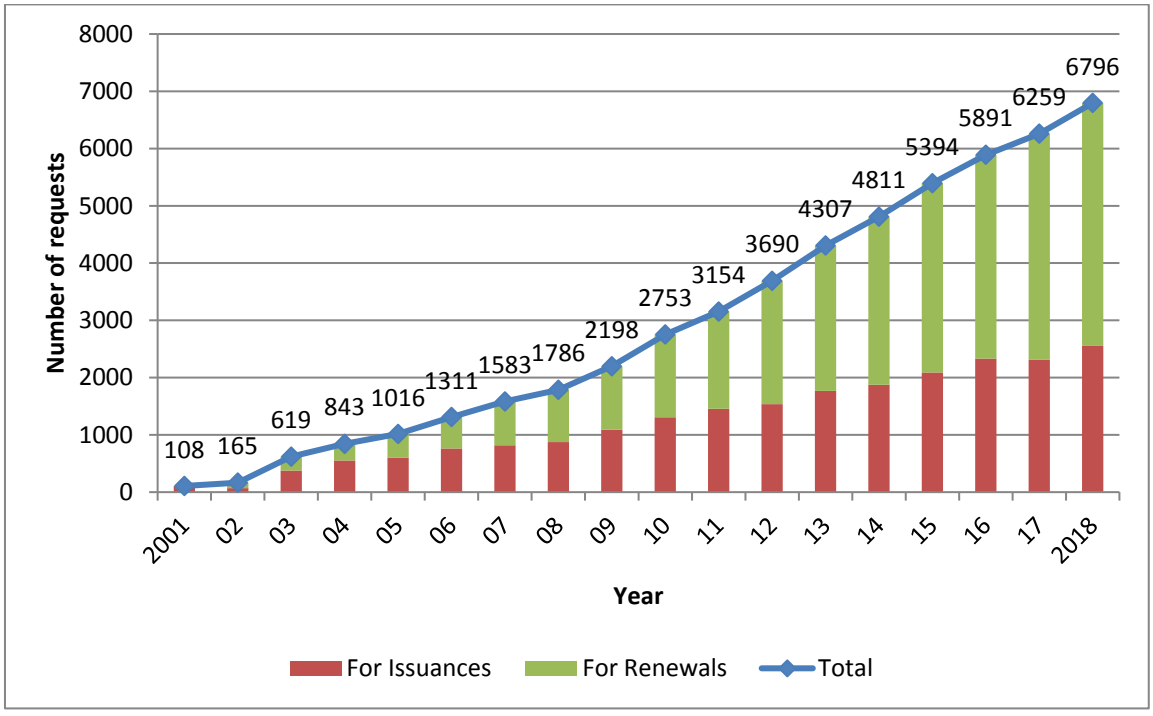
3.1. Changes to the CTO Environment since the Last Review

3.1.1. The growing number of CTOs issued, reissued and renewed

> "Increase in CTOs issued by agencies and hospitals has exponentially grown."
>
> *(CTO coordinator)*

The review found that the number of CTOs issued, reissued and renewed in Ontario has increased substantially since 2012. Data from the PPAO and CCB aligns with experiences related by experts in interviews and by mental health professionals in focus groups. Although accurate data on the number of CTOs issued, reissued and renewed in Ontario is not available, PPAO data shed light on this trend. [13] The PPAO received 6,796 requests for CTO rights advice for clients in 2018. In 2012, the PPAO received 3,690 requests for clients (see Figure 1). The PPAO data aligns with the trends observed in the 2007 and 2012 reviews, albeit from a different source. When taken together, these data show that Ontario continues to experience a long-term trend towards increasing use of CTOs.

Figure 1. Annual Number of CTO Rights Advice Requests to PPAO in Ontario



Source: PPAO. *Due to PPAO data, in this table, issues include reissues.

[13] See Section 2.2.2 describing administrative data and Section 2.3 regarding limitations of the data.

Clients that enter a CTO tend to stay on a CTO, which means that the numbers will continue to increase even if the number of new CTOs issued remains the same (see Section 3.3.5). As the numbers are expected to continue to grow over the coming years, it is important to consider the reasons why CTOs are being issued in increasing numbers. Experts and mental health professionals stated that an important reason has been increased awareness and comfort using CTOs among Ontario's physicians.

However, experts and mental health professionals also provided reasons for the growth in CTOs in Ontario that give cause for concern. Given that CTOs involve restricting client's rights, the following reasons for issuing CTOs should be carefully examined and balanced against the rights of CTO clients:

- Two experts and some mental health professionals indicated that CTOs are issued to free-up beds in hospitals or psychiatric wards;
- Some mental health professionals indicated that they issue CTOs so that clients can receive access to services sooner than if they were not on a CTO. Advocates indicate that a client should not have to enter a CTO to receive services faster (see Section 3.2.1); and
- The growth in CTOs has coincided with a growth in the use of SDMs to consent to CTOs. Currently it appears that the majority of CTOs issued, renewed or reissued involve SDMs. The relationship between the growth of CTOs and growing use of SDMs is an important issue that warrants further scrutiny (see Section 3.1.3).

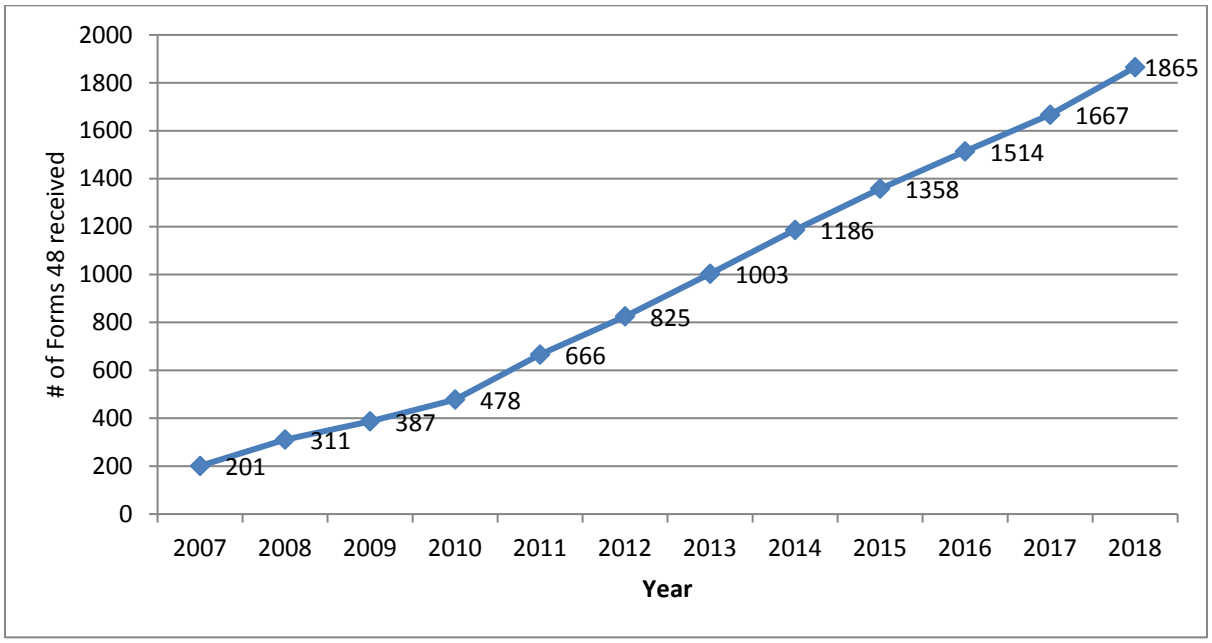
Thus, the growth in CTOs may be caused by a combination of growing awareness of and acceptance by practitioners as an appropriate treatment mechanism, as well as their growing attractiveness as a as a tool to cope with systemic strains.

3.1.2. The system's capacity to cope with continued growth

The review found that the increasing use of CTOs has not been met with a lockstep increase in the capacity of the system that supports them. While some elements of the system have found ways to keep up with increasing demand, other elements are showing strain and this strain is impacting the level of service provided to clients. The concern is how the various elements of the system that supports CTOs would be able to respond should the number of CTOs issued, reissued or renewed increase further.

As the number of CTOs has grown since 2001, so has the caseload of the organizations that support CTOs, such as the PPAO and the CCB. The amount of CTO rights advice the PPAO provided to clients has grown substantially over time (see Figure 1), as has the caseload of the CCB (see Figure 2). In 2007, the CCB received 201 Form 48s (combined Part 1 – Patient Initiated and Part 2 – Mandatory Review). This has increased to 1,865 in 2018, a net growth of over 900%.

Figure 2. CTO Caseload for the CCB by Year



Source: CCB

For the CCB, CTOs are taking up a greater share of their capacity (in adjudicating first issues, renewals or reissues). According to data provided by the CCB that demonstrates its activities year over year, less than 5% of all CCB activity was related to CTOs in 2007; by 2018 it had increased to 23%, a five-fold increase (see Table 4). In addition, not only has the CCB's caseload increased, but the average amount of time spent on each case has grown, with this growth in CTO activity outpacing growth in applications. All applications to the CCB increased by 35% over five years, compared to an 86% increase in CTO activities.

The PPAO reported similar data. Although only three years of data are available, they demonstrate that CTO activities are increasing, although they appear to represent a comparatively stable proportion of all PPAO activities.

The caseloads of CTO coordinators, case managers and mental health professionals involved in CTOs have also increased. Some stakeholders, in particular CTO coordinators, described how they have been able to meet the growing demand for their services. To address these growing demands, the following have also occurred:

- Increased staff resources being devoted to administration of CTOs, by hiring new CTO coordinators and assigning other staff to support CTO activities;
- Increased productivity due to repeated exposure to the CTO process;
- Increased community resources to support a higher number of clients being issued CTOs;

- Increased engagement of physicians in the community, which redistributes the CTO workload; and,
- Increased connections to additional resources in the community such as family physicians or nurse practitioners who can manage some aspects of CTOs.

Table 4. Comparison of CTO Activity Compared to All Agency Activity

	Comparison of All Activities and CTO Activities for the CCB			Comparison of All Activities and CTO Activities for the PPAO		
	CTO Activity	All Agency Activity	% CTO Activity	CTO Activity	All Agency Activity	% CTO Activity
2007	201	4,476	4.5			
2008	311	4,504	6.9			
2009	387	4,705	8.2			
2010	478	5,091	9.4			
2011	666	5,215	12.8			
2012	825	5,794	14.2			
2013	1,003	5,962	16.8			
2014	1,186	6,615	17.9			
2015	1,358	6,845	19.8	5,394	37,152	14.5
2016	1,514	7,209	21.0	5,891	39,563	14.8
2017	1,667	7,770	21.4	6,259	41,742	15.0
2018	1,865	8,076	23.1	6,796	44,472	15.3

Source: CCB and PPAO

One CTO coordinator stated that they have implemented a number of coping strategies, such as placing the photocopier and fax machine right beside their desks to eliminate the need to leave their desk.

Although some actors in the system that supports CTOs have been able to keep up by finding ways to boost capacity, capacity has not increased for everyone, or everywhere. Four experts and many mental health professionals noted that there has been no growth in terms of human resources in their workplaces to cope with the increasing workload of administering CTOs. For instance, during the review period, the number of ACT teams has remained constant. One CTO coordinator indicated that no new resources have been added in a substantial way, which limits their ability to provide service to a large and remote area of the province. Overall, stakeholders indicated that staff involved in issuing, adjudicating and coordinating CTOs are overstretched and that greater human resource capacity would be necessary to bring caseloads down to manageable levels. Moreover, as the volume of CTOs has increased, some experts and mental health professionals reported that backlogs are growing, with response times lengthening, and an increased perception of CTOs as an administrative burden.

The issue with capacity, according to mental health professionals and CTO coordinators, is tied to efficiency. Indeed, the review heard from some mental health professionals and CTO coordinators that the problem is not merely a capacity issue, but also a process issue. If the process takes too long, or has too much administration, it makes CTOs more difficult to put in place and their workload unmanageable. A number of those who provided feedback for this review stated that the CTO process is more burdensome than it needs to be. For instance, CTO renewals require considerable paperwork, which often leads to a CTO expiring before the renewal is in place.

Several participants suggested ways to simplify the CTO process, including reducing the administrative burden associated with issuing and renewing CTOs, and lengthening the validity period of CTOs to more than six months. According to stakeholders, not only is the six-month timeframe too short from a clinical perspective, but it also is too short from an administrative perspective. Some clients and families agree that this six month time frame is too short, and would like the option to lengthen it. Others questioned whether CCB involvement was beneficial at every second review or whether rights advice was required for the Public Guardian and Trustee, who has acted as SDM many times previously.[14]

> *"Issuing and renewing a CTO every six months for (seven) years puts the six-month period into question"*
>
> *(Physician)*

3.1.3. Substitute decision-makers are increasingly involved

The review found that CTOs increasingly involve the consent of an SDM. Although accurate data on the proportion of CTOs involving the consent of an SDM is not available, PPAO data again shed light on this trend. When CTOs were first introduced in Ontario, about a third of CTO rights advice requests to the PPAO were for SDMs (for instance 32% of rights advice requests in 2002). This proportion increased to 43% in 2011 as noted in the 2012 review. That review indicated that the increase might be more consistent with the intent of the CTO legislation, as some physicians considered that if a client was able to consent to treatment, they did not need a CTO. The 2012 review also uncovered another view among some physicians; since CTOs involve changing the fundamental rights of a client, they should only be issued to those who are capable of providing their own consent.

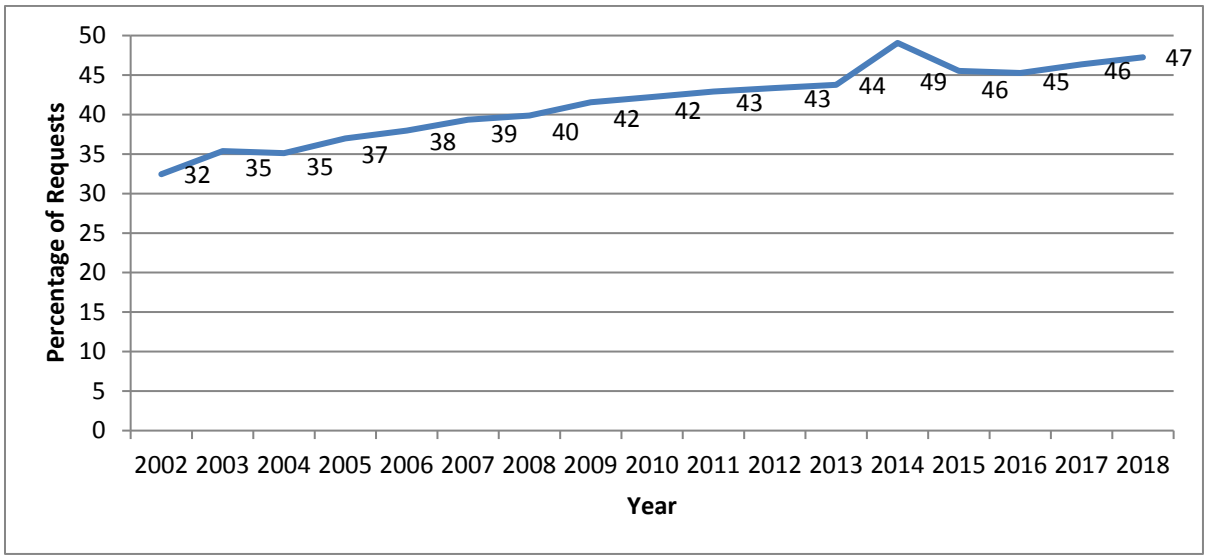
The continued growth in SDM involvement suggests that the balance may have shifted to the former view—if a client is capable of consenting to a CTO, then they do not need one. As such, the proportion

[14] Currently, the Public Guardian and Trustee needs to be provided with rights advice on the first issuance of a CTO. Under the 2010 amendments to the MHA, subsection 33.1 (5), rights advice need not be provided to the Public Guardian and Trustee for CTO renewals.

of SDMs involved in CTOs for which the PPAO receives CTO rights advice requests has increased even further; in 2018, 47% of rights advice requests were for an SDM (see Figure 3). [15]

Should this proportion reach 50%, it would mean that as many rights advice requests were made for SDMs as for clients, which would suggest that almost all CTOs are issued with the involvement of an SDM. Given the current figure of 47%, it appears that at least the majority of CTOs are issued through the consent of an SDM.[16] Further, when this growth is considered alongside the growth in CTOs outright, the volume of CTO rights advice requests received by the PPAO for SDMs has more than doubled since the last review, from 2,825 requests in 2012 to 6,086 requests in 2018.

Figure 3. Percentage of CTO Rights Advice Requests for SDMs



Source: PPAO data.

It is unclear whether the increasing use of SDMs is a result of a shift in the nature of clients being considered for CTOs, a shift among mental health workers in the reasons for issuing CTOs, or a combination of both factors. It is possible that the increasing acceptance of CTOs has led to physicians considering clients who are not capable of consenting to CTOs, hence the increasing prevalence of CTOs involving SDMs. Or given the amount of administration that stakeholders associate with CTOs, another possible explanation is that SDMs are increasingly involved because these CTOs may be easier to administer than with a client alone.

[15] In 2018, the PPAO received 12,882 rights advice requests, of which 6796 were for clients who would be subject to CTO and 6,085 rights advice requests for SDMs. This means 90% of CTOs for which the PPAO received rights requests involve SDMs.
[16] Consult Section 2.2.2 and 2.3 regarding some the interpretation of PPAO rights advice data.

More research may be required to understand the reasons for the increasing involvement of SDMs in CTOs. In particular, research is necessary to determine whether SDMs are being increasingly involved to expedite implementation. In addition, the role of SDMs in CTO renewals should be reconsidered. For example, if a client with an SDM is complying with the community treatment plan (for instance, by taking their prescribed medication) they might be able to consent to subsequent CTO renewals without an SDM.

The use of SDMs in consenting to a CTO varies across the province. Table 5 below compares CTO rights advice request data from 2018 among 14 areas of the province.[17] The data show that some areas of the province are already observing as many CTO rights advice requests for SDMs as for clients. For instance, the PPAO reports that 50% of CTO rights advice requests are for SDMs in Mississauga Halton. By contrast, 37% of the CTO rights advice requests from Central East are for SDMs.

Table 5. Percentage of CTO Rights Advice Requests for SDMs by Area of Ontario

Local Health Integration Network Area	Percent
Central	46%
Central East	37%
Hamilton Niagara Haldimand Brant	48%
Central West	49%
Mississauga Halton	50%
Waterloo Wellington	48%
Champlain	50%
South East	49%
North East	46%
North Simcoe Muskoka	43%
North West	51%
Erie St. Clair	46%
South West	48%
Toronto Central	49%
Total	**47%**

Source: PPAO. Reference year: 2018.

3.1.4. The ongoing debate around informed consent

The 2007 and 2012 reviews reported that various stakeholders were concerned about the validity of consent to a CTO. This debate appears to have quieted over the years as many who had concerns have

[17] Specifically, the areas respond to the province's 14 Local Health Integration Networks.

now come to accept CTOs. However, the review found that some stakeholders, in particular mental health advocacy groups, still have concerns around the lack of informed consent in accepting a CTO.

The issue of consent and coercion may be understood as a spectrum of practices, ranging from gaining informed consent through affording the client personal agency in their treatment, to coercing clients into accepting a CTO through threat of physical restraint. Two experts cited the "carrot and stick" metaphor to portray a situation where a physician simultaneously presents a less restrictive, community-based form of care (the CTO) as a reinforcement and hospitalization as a threat. While anecdotal evidence has been brought forward demonstrating both extremes, it is likely that most cases involve a degree of both consent and coercion.

Findings from the online survey suggest that clients have more concerns about their rights and choice with respect to CTOs than family members, friends and SDMs do. A plurality of clients reported that they were not concerned about their rights (43%) or the amount of choice they had under a CTO (46%). The majority of family members, friends or SDMs that responded to the online survey indicated that they were not concerned about the rights (62%) or the amount of choice offered to those under a CTO (62%). Although these responses may indicate that client rights and choice under a CTO are adequately addressed in the majority of cases, 25% of clients and 10% of family members, friends or SDMs responding to the survey indicated that they were very concerned about the amount of choice available to their loved ones (see Table 6).

Table 6. Concerns among Family, Friends and Substitute Decision Makers about CTOs

Concerns about CTO	Not concerned	Somewhat concerned	Very concerned
Clients			
My rights under a CTO	43%	25%	32%
The amount of choice I had when issued with a CTO	46%	29%	25%
Family, friends, SDM			
My family member/ friend's rights under a CTO	62%	20%	3%
The amount of choice my family member/ friend had when issued with a CTO	62%	13%	10%

Source: Review of Community Treatment Order Survey (2019), Question C4 (n = 28 Clients, n = 34 Family/friends/SDM).

Among mental health professionals that responded to the survey in 2019, there were high levels of agreement that clients are advised of their rights (91%) and that the rights of CTO clients are adequately protected (73%, see Table 7). The proportions of mental health professionals agreeing to all statements has increased between 2012 and 2019. In particular, the proportion of mental health professionals agreeing that clients are advised of their rights has increased from 48% in 2012 to 91% in 2019.

Table 7. Percentage of Mental Health Professionals Agreeing with Statements about CTOs

Statements Agreed With:	2019	2012
Clients are advised of their rights	91%	48%
The rights of CTO clients are adequately protected	73%	60%
The legal safeguards in the legislation are appropriate	57%	43%

Source: Review of Community Treatment Order Survey (2019), Question D8 (2019 n = 242, 2012 n=344)

Although many more stakeholders are comfortable with CTOs in 2019 as compared to 2012, concerns about informed consent and coercion still exist among some stakeholders. Clients and SDMs are a vulnerable group in Ontario's mental health system. Although safeguards exist to ensure that the rights of clients and SDMs are protected, grey areas in the process of seeking consent may continue to exist at their expense. As shown in Table 7, only 57% of mental health professionals responding to the survey agreed that the legal safeguards in the legislation are appropriate, albeit an increase from 43% in 2012.

The overall sentiment among clients interviewed was that they initially resisted the CTO as they had little control over the process and relied on their SDM to make decisions for them. For instance, one client said that the CTO initially made her feel as though she was being "held captive" by the CTO and did not realize that she had a choice. Lack of personal agency was described by some clients and SDMs as a drawback of the CTO, which can affect how the client perceives the benefits or disadvantages of the CTO and can impair important aspects of well-being. However, it is important to note that some clients said there were no drawbacks to the CTO, which highlights the variability in people's experience with CTOs. Again, while some clients noted they would have liked to be more involved in the development of their treatment plan, or would like greater involvement going forward, others felt very involved in these decisions.

> *"I agreed to be on the CTO before I learned that I could disagree… I just signed it because I thought I had to."*
> *(Client)*

> *"I have to force it on him: if he had his way, he wouldn't be on it."*
> *(SDM, Parent)*

Some key informants, particularly those from advocacy groups, held that many clients and SDMs lack knowledge of CTOs in particular, and mental health in general, and of how their rights interact with the mental health system. Both advocates interviewed disclosed feeling as if it was their job to provide the necessary education to family members and SDMs. They perceived education as more than providing rights advice; rather, it includes providing information about the CTO and mental illness itself. Such a knowledge gap may impede clients' and SDMs' abilities to provide informed consent.

As seen above, the majority of CTOs are issued through the consent of an SDM. Two SDMs interviewed indicated that their situation is too stressful to make decisions with appropriate consideration. Some stakeholders' concerns around informed consent and coercion extend to SDMs. Whether the consent is sought from the client or the SDM, there can be a grey area where the client's or SDM's consent might not be fully informed, or the process can be coercive for the SDM, just as it can for their loved one. For clients, most stated that they were skeptical about the CTO at first, and most often that their SDM agreed on their behalf. However, some clients said that over time they realized that the CTO was in their best interest, and did not have many problems adhering to it. Based on the interviews, SDMs for the most part, were in favor of CTOs from the outset, likely due to the mental health difficulties their loved one faced. However in some cases, clients and SDMs only agreed to the CTO because it is what the doctor recommended, or in some cases, what the doctor said had to happen.

Although physicians are ultimately responsible for the CTOs they sign, CTO coordinators play a key role in obtaining consent and developing the community treatment plan. While physicians have professional standards and multiple levels of oversight, CTO coordinators do not have the same levels of governance, a fact that might represent a gap in the system's safeguards. While some CTO coordinators have standards to follow based on their professions (e.g. social workers or nurses), there is no requirement that CTO coordinators belong to one of those professions. Of those that do belong to these professions, the standards may not apply to the unique work done by CTO coordinators. Perhaps to address this, further consideration should be given to further developing the position of CTO coordinator in terms of appropriate educational backgrounds (including areas of study and levels of attainment), ongoing training needs and desired competencies.

> *"[If a psychiatrist says,] 'Hey Bob, if you agree to a CTO because you meet criteria for it, I can discharge you; but if not, you will have to stay here...' Those times people agree to it, but I'm not sure how genuine the consent is"*
>
> *(Physician)*

3.2. The Reasons that CTOs Were or Were Not Used during the Review Period

3.2.1 What factors impact clients', physicians' and substitute decision-makers' decisions to use or accept a CTO?

The review found that the factors impacting decisions to use or accept a CTO are different for clients, SDMs and physicians. Given the likelihood that most CTOs will be renewed (see Section 3.1.1), more research should be done on the factors that impact clients', SDMs' and physicians' decisions to renew a CTO.

Factors impacting clients' decisions: Given that the majority of CTOs in Ontario are issued through SDMs, the factors impacting clients' decision to accept a CTO might be a moot point. Nevertheless, the main factors include the desire to leave the hospital, to adhere to their medication and to increase their access to services.

Several lines of evidence (including the literature,[18] expert interviews, interviews with clients and family/friends/SDMs and focus groups) show that clients view CTOs as a better alternative to hospitalization. Hence, the threat of hospitalization may lead clients to feel they have no choice but to adhere to treatment and comply with the CTO.[19]

In the published literature, clients often reported that medication adherence was the main reason for using a CTO, and see CTOs as providing a safety net, that is to say a mechanism to stabilize and improve their mental health condition.[20] Several clients interviewed reported using CTOs because it is a good "check" to stay on top of their treatment plans. They viewed the CTO as a formal reminder to take medication or to go to the hospital when required. Several clients described the CTO as straightforward and easy to follow. Some saw the CTO as an insurance policy or safety net that was there if they needed it.

> *"I either have to watch him [my son] disintegrate or medicate him with some hope for stability."*
> (SDM, parent)

> *"It's not just clients who have obligations under the CTO; it's the whole team of service providers as well. They're more likely to put more effort into providing services to a client who is on a CTO than a client who is not on a CTO."*
> (SDM, Public Guardian and Trustee)

[18] See, for instance, Canvin, Rugkåsa, Sinclair, & Burns, 2014; Francombe Pridham et al., 2018; Riley, Høyer, & Lorem, 2014.
[19] Canvin et al., 2014; Corring, O'Reilly, & Sommerdyck, 2017; Francombe Pridham et al., 2018; Pridham et al., 2016.
[20] Canvin et al., 2014; Corring et al., 2017; Stroud, Banks, & Doughty, 2015.

Another factor that influences the acceptance of a CTO is increased access to services. Since there are often long waitlists for outpatient psychiatry, the review heard that those on CTOs are often prioritized to receive these services before others, given the service provider's obligations under the CTO.[21] One client interviewed made the case that she benefited from more services and better attention since being on a CTO (as compared to before the CTO), which motivated her to stay on the CTO. Other clients commented that having priority access to a bed, or being able to get admitted to a specific hospital, gave them comfort in case something went wrong.

Factors impacting SDMs' decisions to accept a CTO: The main factors impacting SDMs' decisions to accept a CTO include establishing the legal authority associated with a CTO that they could not apply themselves, encouraging adherence to treatment, and enhancing access to services, as evidenced by interviews, focus groups and the literature. The literature also suggests that SDMs turn to CTOs because they provide a mechanism to stabilize and improve their loved ones' mental health condition, and to relieve them from being at the front line of care provision.

However, some SDMs interviewed consented because doctor recommended it or said it had to happen. According to experts interviewed, some SDMs do not consent to the CTO or ask to have it revoked for various reasons, including feeling burdened with the responsibility of the CTO and adding additional strain to their relationship with their loved ones.

Factors impacting physicians' decisions to recommend a CTO: The factors affecting physicians' decisions to recommend a CTO can be categorized into three broad domains: client factors, systemic factors and administrative factors.

1) Client factors**:** Findings from the survey indicate that the majority (89%) of respondents viewed "*reducing the frequency of hospitalizations*" as a very important factor in supporting or encouraging the use of CTOs in Ontario in 2019 (see Table 8). Beyond that overarching goal, virtually all experts and mental health professionals indicated that physicians' decisions to recommend a CTO are largely affected by client characteristics such as diagnosis, client insight, history with the correctional system and substance use.

As was related by four experts interviewed as well as mental health professionals in the focus groups, physicians are more likely to recommend a CTO for clients diagnosed with severe, chronic mental health conditions such as schizophrenia, schizoaffective disorder or bipolar disorder. Yet, physicians are less likely to recommend a CTO to clients who have depression or who do not have an extensive history of hospitalization.

[21] As mentioned by three experts and three SDMs interviewed. Also see Stroud et al., 2015, page 3.

Clients' level of insight into their mental illness and likelihood of compliance with treatment exist on a continuum. On one end, clients who have full insight are more proactive in following their physician's recommendation for treatment. Therefore, they are perceived as being much less likely to need a CTO and would likely be discharged into the community without a CTO. At the other end of the spectrum are clients that physicians feel lack insight into their mental illness and are unlikely to comply with their treatments. Physicians are more likely to recommend a CTO to those in the middle of the continuum, particularly when clients have relatively low insight but high likelihood of compliance. In line with this, survey findings show that 87% of mental health professionals responding to the survey considered "*addressing treatment non-compliance*" as a very important factor in supporting or encouraging the use of CTOs in Ontario (see Table 8).

Table 8. Percentage of Respondents Rating Some Factors as Important in Encouraging the Use of CTOs in Ontario

Encouraging Factors	2019	2012
Reducing frequency of hospitalizations	89%	76%
Addressing treatment non-compliance	87%	70%
Safety in the community	81%	71%
Ensuring a team supported community treatment plan	81%	76%
Access to additional health resources like case management	68%	68%
Availability of CTO coordinators/ case managers	67%	60%
Family or substitute decision-maker request	54%	41%
Meeting legislated criteria	52%	46%
Client request	36%	46%

Source: Review of Community Treatment Order Survey (2019), Question D4 (2019 n = 242, 2012 n=344)

History with the correctional system is another factor that was said to affect a physician's decision to recommend a CTO, although the specific impact varies. On the one hand, according to the academic researcher interviewed, history with the correctional system could adversely affect a physician's decision to recommend a CTO. By way of example, the psychiatrist talked about a client who might meet the criteria for a CTO, but if the client is or would be denied access to ACT team services owing to a history with the correctional system (particularly aggravated or sexual assault), the physician would be less likely to recommend a CTO. In this case, the client would either remain in hospital or be discharged back into the community without a CTO. On the other hand, some mental health professionals in the focus groups indicated that police and judges could look at a CTO as a signal that the client has stability in the community, and possibly reduce the chances of placing the client in custody. Seen from this perspective, physicians may be more likely to recommend a CTO to help clients who are interacting with the law.

Many mental health professionals in the focus groups also pointed to client substance use as a factor that can affect a physician's decision to recommend a CTO, though in a mixed way. All those who discussed substance use agreed that it poses significant challenges to the success of a CTO, with one participant in the group indicating that issuing a CTO to someone with a history of substance use is counterproductive, as they are unlikely to comply with treatment. More generally, mental health professionals stated that substance use impacts a client's ability to successfully follow CTO instructions, makes it harder to locate a client, and increases interactions with law enforcement. One CTO coordinator stated that chronic substance use would disqualify someone from a CTO given the requirement of being able to comply with community treatment plan. Despite these concerns, mental health professionals generally indicated it was beneficial to use CTOs with clients who used substances since CTOs would increase client interaction with case managers and treatment teams. Some in the groups indicated that this regular contact and the routine it creates could help clients with a history of substance use to quit using those substances.

2) Systemic factors**:** Systemic factors that impact physicians' recommending a CTO include the availability of required resources in the community and perceptions of the administrative requirements of CTOs. For example, it has already been mentioned that some physicians recommend CTOs as a means to vacate hospital beds.

Survey findings show that 81% of mental health professionals responding to the survey considered "*ensuring a team supported community treatment plan,"* while 68% considered access to "*additional health resources like case management*" to be very important factors in supporting or encouraging the use of CTOs in 2019 (see Table 8). The availability of community resources and services affect physicians' decisions to recommend CTOs in two contrasting ways. First, physicians are more likely to recommend CTOs when outpatient resources and supporting services (such as supportive and subsidized housing, financial resources, ACT teams and nurses) are available in the community. Two experts interviewed indicated that physicians find it challenging to issue a CTO when community resources and services to support treatment are lacking. As a counterpoint to issuing CTOs to free up hospital beds, some experts and mental health professionals pointed out that there is no point in discharging a client from the hospital, owing to lack of inpatient resources, when community resources would be even more limited. This is consistent with two survey findings: first, almost half (48%) of survey respondents rated *"availability of CTO coordinators/case managers"* as an important factor in supporting or encouraging the use of CTOs in 2019. Second, 60% of survey respondents rated "*insufficient availability of community resources*" as very important in limiting the use of CTOs in 2019, and this is the most frequently mentioned factor (see Table 9).

Table 9. Percentage of Respondents Rating Some Factors as Important in Limiting the Use of CTOs

Factor limiting CTOs	2019	2012
Insufficient community resources available for clients on CTOs	60%	46%
Workload concerns regarding issuing a CTO, the legal review process and supervising a CTO client	59%	40%
Level of knowledge and experience with CTOs	47%	43%
Availability of CTO coordinators or case managers	48%	42%
Limited enforcement mechanisms available	36%	34%
Refusal of consent by substitute decision-maker or client	39%	39%
CTOs are only useful for a limited client population	37%	29%
Concerns regarding infringement of patient rights	30%	33%
Potential negative impact on the relationship between client and their service provider	26%	27%
Issues related to rights advice	26%	31%
Concerns regarding compensation and liability	21%	17%
Lack of scientific evidence	14%	16%
Leave of Absence provisions under the *Mental Health Act* are a simpler alternative	10%	n/a

Source: Review of Community Treatment Order Survey (2019), Question D3 (2019 n = 242, 2012 n=344)

Second, one expert interviewed and two mental health professionals in the focus groups indicated that there can be year-long wait lists for case management services in the community, but that clients on CTOs receive case management services immediately. Hence, physicians can issue CTOs to their clients—including those clients who would otherwise not be issued CTOs—to give them priority access to these services. This suggests that a shortage of community resources and services may increase the likelihood that physicians will recommend CTOs.

3) Administrative factors**:** Two experts interviewed and most mental health professionals in the focus groups noted that the process of issuing and renewing CTOs involves a number of administrative hurdles that may discourage physicians from issuing a CTO. This is particularly the case when they do not issue them on a regular basis, do not have sufficient support during the process, or have had negative experiences with CCB hearings. These negative experiences could include long hearings owing to minor technicalities, and instances where CTO issuances are overturned, especially when based on factors not related to medical issues. According to one doctor, physicians in private practice generally do not issue CTOs because there are too many administrative requirements to tackle on their own. About six in ten (59%) survey respondents selected "*workload concerns regarding issuing a CTO, the legal review process*

and/or supervising a client" as a factor limiting physicians' use of CTOs in 2019 (see Table 9). In addition, the impact of administrative requirements on the issuance of CTOs appears to have become more acute (59% in 2019 versus 40% in 2012).

3.2.2 What alternatives to CTOs are being used to manage clients in the community?

The review found that awareness of alternatives is mixed and varies among different groups of stakeholders. Three experts interviewed and many mental health professionals in the focus groups spoke to a number of outpatient services that are available to people in the community and that can be delivered through different approaches. One expert and some mental health professionals in the focus groups emphasized that CTOs are not a treatment in and of themselves, but rather a method of providing and coordinating community mental health care. As such, if the clients' medical and personal circumstances permit, mental health professionals are willing to coordinate service delivery without issuing a CTO.

Three experts interviewed and many mental health professionals in the focus groups pointed to other models designed to provide comprehensive community-based mental health services, such as ACT and intensive case management. In fact, CTOs, ACT and intensive case management approaches share an important feature: they offer comprehensive services targeting people with severe and chronic mental illness who have not benefited (or would not benefit) from traditional outpatient psychiatry. The online survey showed that, among survey respondents who could identify any alternative to CTOs, the most frequently mentioned alternatives were ACT teams (34%) and other forms of case management (20%), including traditional case management and intensive case management.[22]

There is often overlap between CTO treatment plans and these alternatives. CTO clients often access ACT teams and intensive case management services, and in fact, may have priority access to them. According to many mental health professionals in the focus groups, ACT and other forms of case management ought to be attempted in isolation before considering a CTO. Mental health professionals reported they were more likely to issue CTOs if a client repeatedly does not take their medication or if the client has repeated hospitalizations, despite accessing these alternative services. In fact, according to the online survey findings, 51% of mental health professionals agreed that CTOs should be a last resort when other treatment options have been explored (see Table 10).

[22] Some respondents suggested irrelevant or off-the-subject alternatives to CTOs being used to manage clients in the community. Examples of these include long-term hospitalization, and the correctional system (i.e. custody or court order).

Table 10. Percentage of Mental Health Professionals Agreeing with Statements about CTOs (Part 2.)

Statements Agreed With	2019	2012
CTOs should be a last resort when other treatment options have been explored	51%	51%

Source: Review of Community Treatment Order Survey (2019), Question D8 (2019 n = 242, 2012 n=344)

One expert also referred to the "At Home Project", as an alternative way to manage people with mental health issues in the community. The "At Home Project" was a research demonstration project, implemented in five Canadian cities including Toronto. The project aimed to provide practical, meaningful support to people experiencing mental health problems and homelessness. It followed a "housing first" approach, whereby people are housed prior to receiving mental health recovery services.

Many clients and SDMs did not know of alternatives to CTOs, and had often been through a range of community services and hospitalizations before arriving at a CTO. No clients interviewed were aware of alternatives, apart from hospitalization. SDMs also reported low levels of awareness of alternative ways to manage their loved ones in the community. A number of online survey respondents (20%) mentioned that there were no real alternatives to CTOs.[23]

It is important to note that although clients and SDMs did not see many alternatives, some SDMs and many clients saw the value of CTOs in helping them remain healthy and adhere to their treatment plans. During the interviews, several clients and SDMs discussed the long, difficult journey they have travelled and how the CTO has helped stabilize the 'ups and downs' and 'revolving doors'.

3.2.3 What are the characteristics of clients using CTOs

There are numerous characteristics of clients that have been profiled based on the CTO-IR. Moreover, OHIP data, which remained a consistent source of information for both the last review and this review, have also been employed to provide insight into some changes in characteristics of CTO clients.[24] Overall, the review found that CTO clients can be generalized as:

- Being predominantly male (64%);
- Having a wide age range, but many tend to be in their 30's;
- Being frequently diagnosed with schizophrenia (65%) or schizoaffective disorders (25%); and
- Living on their own (42%) or with their parents (24%).

[23] Even among respondents who mentioned any alternative, some suggested alternatives that were not applicable.
[24] Go to Section 2.2.2 to review uses and limitations of administrative data.

Gender: CTOs are increasingly being issued to males. In 2018, 64% of CTO clients were male, up from 53% in 2002-05 and 60% in 2006-09. The largest increase for males occurred in the younger group, where the proportion of younger males receiving CTOs has increased to 80% of the total for the youngest cohort (see Figure 4).[25] Insights from experts suggest that the course of illness is typically more challenging for men, as they face mental health challenges earlier than women and are more prone to risk-taking behaviour, which might explain the gender gap.

Figure 4.Gender by Age Group

2002-05				2006-09				2010 – 18			
	% Female	%Male	Total		% Female	% Male	Total		% Female	% Male	Total
15-19	37%	63%	83	15-19	45%	55%	40	0-24	20%	80%	603
20-44	30%	70%	1439	20-44	26%	74%	1594	25-44	31%	69%	2,161
45-64	66%	34%	936	45-64	57%	43%	947	45-64	45%	54%	1,630
65 +	68%	32%	277	65 +	59%	41%	304	65 +	57%	43%	591
	47%	**53%**	**2,735**		**40%**	**60%**	**2,885**		**37%**	**63%**	**4,985**

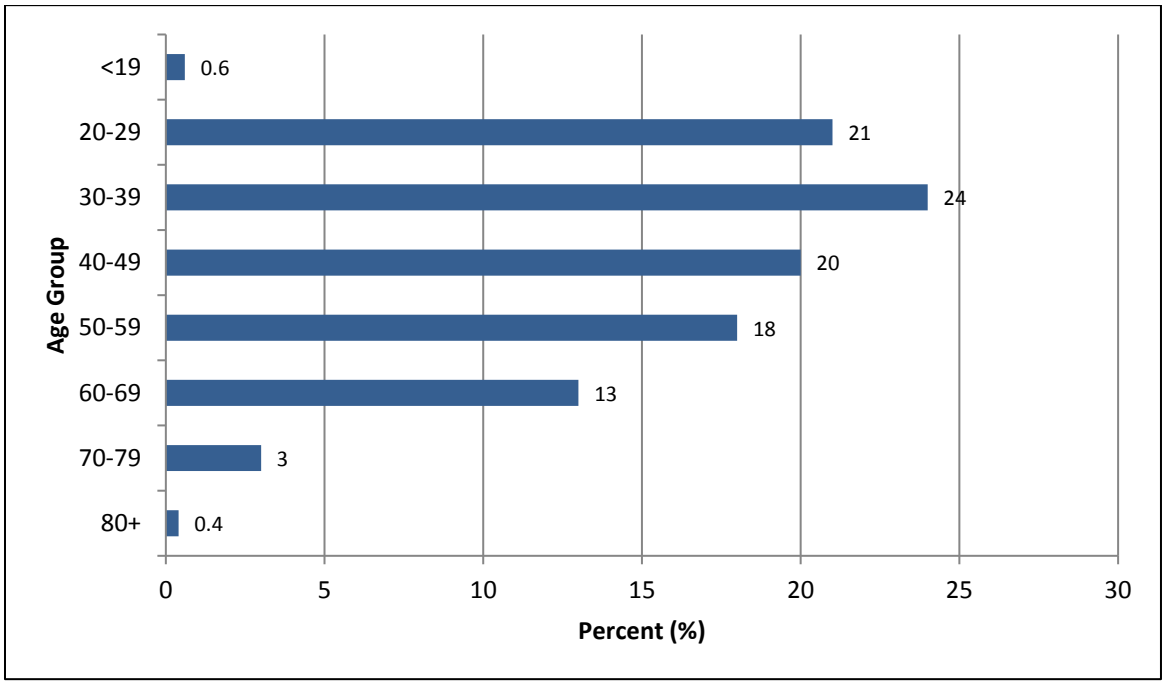
Source: 2002-2005: 2007 review; 2006-2009 2012 Review using OHIP data; 2010-2018 OHIP data provided for this review. Data is by fiscal year.

Age: Clients represented a wide age range, with the youngest aged 16 years and the oldest aged 89 years,[26]with the mean age being 43 and the median being 41. Almost one-in-four (24%) clients was in their 30s. There were few CTO clients who are teenagers or over 80 years of age (see Figure 5).

[25] The youngest cohort varies slightly between the comparison periods. For 2002-05 and 2006-09, the youngest cohort measured 15 to 19 year olds. The 2010-18 data measured those under 25.

[26] This data is derived from the CTO-IR, and there may be data entry errors in the birthdates used to describe ages. However, at least two entries have both the youngest and highest ages in them.

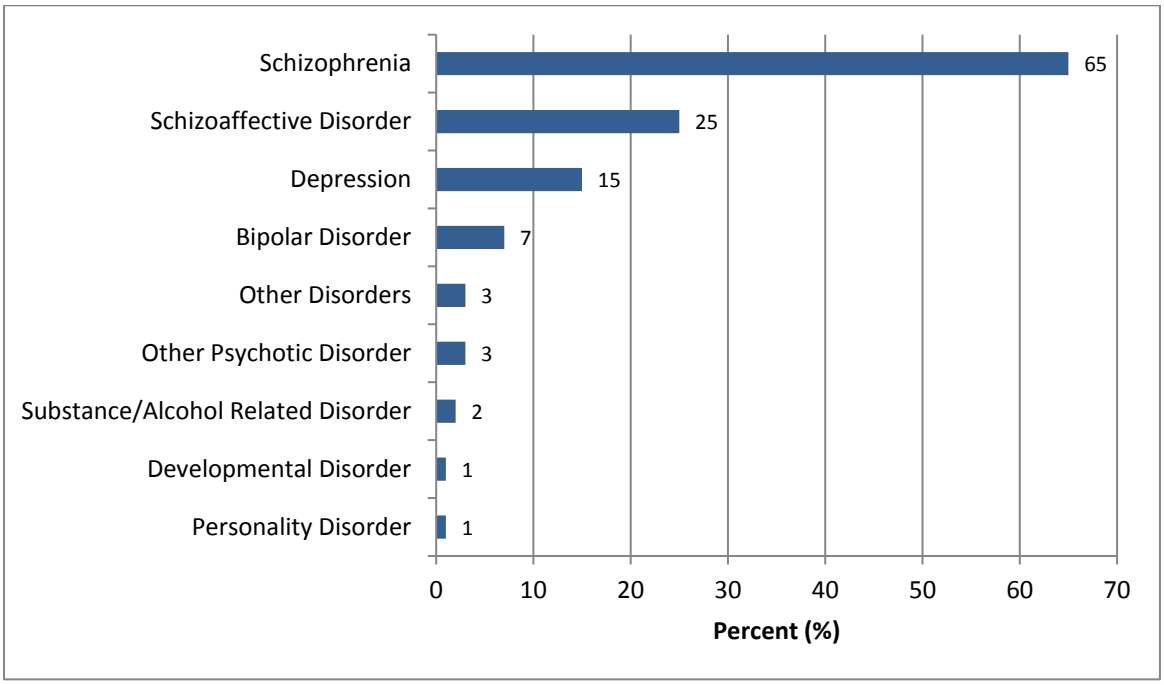
Figure 5. Percentage of CTO Clients by Age Group



Source: CTO-IR based on Q1 date of birth. Reference year: 2018.

Diagnosis: CTO-IR data indicates that CTO clients are most commonly diagnosed with schizophrenia (65%) or schizoaffective disorder (25%). Other significant mental health conditions together account for less than two in ten CTO clients (see Figure 6). These proportions are consistent with the data from the 2007 and 2012 reviews, both of which used different sources than the CTO-IR. The data in the chart below sums to more than 100%, and clients can be diagnosed with multiple conditions.

Figure 6. Percentage of Clients by Psychiatric Diagnosis



Source: CTO-IR, Q11, Base=2,608. Reference year: 2018. Responses may sum to >100% due to multiple responses

According to many experts and mental health professionals, many CTO clients do not agree with their diagnosis (according to the academic researcher interviewed, it is estimated that only 20% of those with a psychotic illness agree with their diagnosis), or have a lack of insight regarding their need for treatment. Some experts and mental health professionals also noted that a portion of CTO clients also had substance use challenges, and in some regions, higher numbers of clients have been placed in custody or have a high number of interactions with police.

Housing Status: Many experts and mental health professionals indicated that CTO clients often lack adequate housing, benefit from social assistance programs (e.g. Ontario Works, Ontario Disability Support Program) and qualify for legal assistance from Legal Aid Ontario. Although a majority of CTO clients live in a private house/condo or in a market-rental unit, the CTO-IR data indicates that a considerable proportion lived in subsidized housing (17%), in a room-and-board setting (8%), in Homes for Special Care/ Approved Homes[27] (2%) or were homeless/ used hostel (3%) (see Table 11).

[27] The finding that some clients are living in Approved Homes is hard to reconcile given that that program has not existed for many years.

Table 11. Percentage of CTO Clients by Type of Housing

Percent (%)		Issuance		
Type of Housing	**TOTAL**	**Issue**	**Renewal**	**Reissue**
Private house/Condo	29	38	28	23
Market rental unit	26	23	27	24
Subsidized rental unit	17	11	19	15
Room and board	8	3	11	5
Retirement Home	3	2	3	4
Hostel/Shelter /Homeless/On Street	3	5	3	7
Homes for Special Care/Approved Homes	2	2	2	3
Other/Don't know	12	18	10	25
n	*2,601*	*474*	*1,759*	*368*

Source: CTO-IR, Q12b. Reference year: 2018.

In terms of who they live with, a plurality (42%) live on their own, while 24% live with their parents and 15% live with their spouse, their children or other family (see Table 12). These findings have not changed from the 2007 review.

Table 12. Percentage of CTO Client by Living Arrangement

Percent (%)		Issuance		
	TOTAL	**Issue**	**Renewal**	**Reissue**
Lives with self	42	35	45	35
Parent(s)	24	31	23	19
Non-family	18	12	19	16
Other family	7	8	8	6
Spouse/Partner	5	6	5	7
Child(ren)	3	4	3	3
Don't know	10	14	7	21
n	*2,601*	*474*	*1,759*	*368*

Source: CTO-IR, Q12a. Reference year: 2018. Responses may sum to >100% due to multiple responses

Although a clear trend may not be easy to see, the data suggest that housing status is a complex issue, as it relates to the issue, renewal and reissue of CTOs. On the one hand, those who have been issued a CTO for the first time are more likely to live in a private house/condo (38%) than those who have a renewal (28%) or a reissue (23%). On the other hand, those who have been issued a renewal are more likely to live on their own (45%) when compared to those who have been given a first issue or a reissue (35%).

3.2.4 Where are CTOs originating?

The review found that CTOs are originating from a number of access points throughout the mental health system. Similar proportions are issued at inpatient psychiatric facilities (25%), from outpatient psychiatry (31%) and through ACT teams (29%) (see Table 13). However, there are differences in the kind of CTO issued and the nature of consent given. Specifically, virtually all clients that have their first issuance of a CTO (90%) come from an inpatient psychiatric facility. This proportion falls for both those who have CTO renewals (7%) and reissues (31%). Renewals largely originate from ACT teams (37%) and outpatient psychiatry (36%).

Table 13. Percentage of CTOs by Point of Access

Point of Access	Percent (%) of CTO users			
	Total	Issuance		
		First Issue	Renewal	Reissue
Outpatient Psychiatry	31	6	36	40
Assertive Community Treatment	29	2	37	23
Inpatient Psychiatry	25	90	7	31
Community Mental Health Program	8	2	11	4
Other	7	-	9	2
n	*2,601*	*474*	*1,756*	*368*

Source: CTO-IR Q3. Reference year: 2018.

It should be noted, however, that 31% of reissues are done at an inpatient psychiatric facility, compared to only 7% of CTOs renewals. As reissued CTOs have lapsed after their six-month period, the data would suggest that letting a CTO lapse often occurs after a return to an inpatient psychiatric facility. Those who have had consent provided by an SDM are more likely to have accessed CTOs through an ACT team (31%) compared to 13% who provided their own consent.

Geographically speaking, CTO rights advice requests are originating throughout the province; however, they are not evenly dispersed. Some areas of Ontario have higher concentrations than other areas relative to their population.[28] Specific differences include:

- South West and Central seem to have a higher proportion of CTO rights advice requests compared to the Ontario population. For instance, South West is home to about 7% of Ontario's population, but sees about 13% of CTO rights advice requests; and

[28] Where area of Ontario is defined by Local Health Integration Network and CTO is measured by rights advice requested to CTO clients.

- Central East and Toronto appear to have lower proportions of CTO rights advice requests than the Ontario population (see Table 14).

Table 14. CTOs and Population by Area of the Province

	Percentage of CTO Rights Advice Requests by Area of the Province Compared to Ontario Population			
Area	**CTO Rights Advice Requests**	**% of CTO Rights Advice Requests**	**Population**	**% of Population**
Central	1,114	16.4	1,900,000	14.0
Central E	476	7.0	1,500,000	11.0
Central W	446	6.6	922,000	6.8
Champlain	658	9.7	1,300,000	9.6
Erie	459	6.8	640,000	4.7
Hamilton	817	12.0	1,400,000	10.3
Mississauga	426	6.3	1,200,000	8.8
North Simcoe	473	7.0	479,471	3.5
North East	216	3.2	565,000	4.2
North West	34	0.5	241,236	1.8
South East	127	1.9	500,210	3.7
South West	881	13.0	962,539	7.1
Toronto	346	5.1	1,200,000	8.8
Waterloo	323	4.8	778,678	5.7
TOTAL	**6,796**	**100.0**	**13,589,134**	**100.0**

Source: PPAO Data, Reference year: 2018. Population numbers are taken from Local Health Integration Network websites. Data may be rounded and may not be a consistent year for each area.

These regional differences may be the result of the norms among physicians and hospitals within each area of Ontario. According to two experts interviewed, some physicians appear to use CTOs whenever they discharge a client from a hospital, while others use them sparingly.

3.3. The Effectiveness of CTOs during the Review Period

3.3.1 What effects do CTOs have on client well-being and satisfaction?

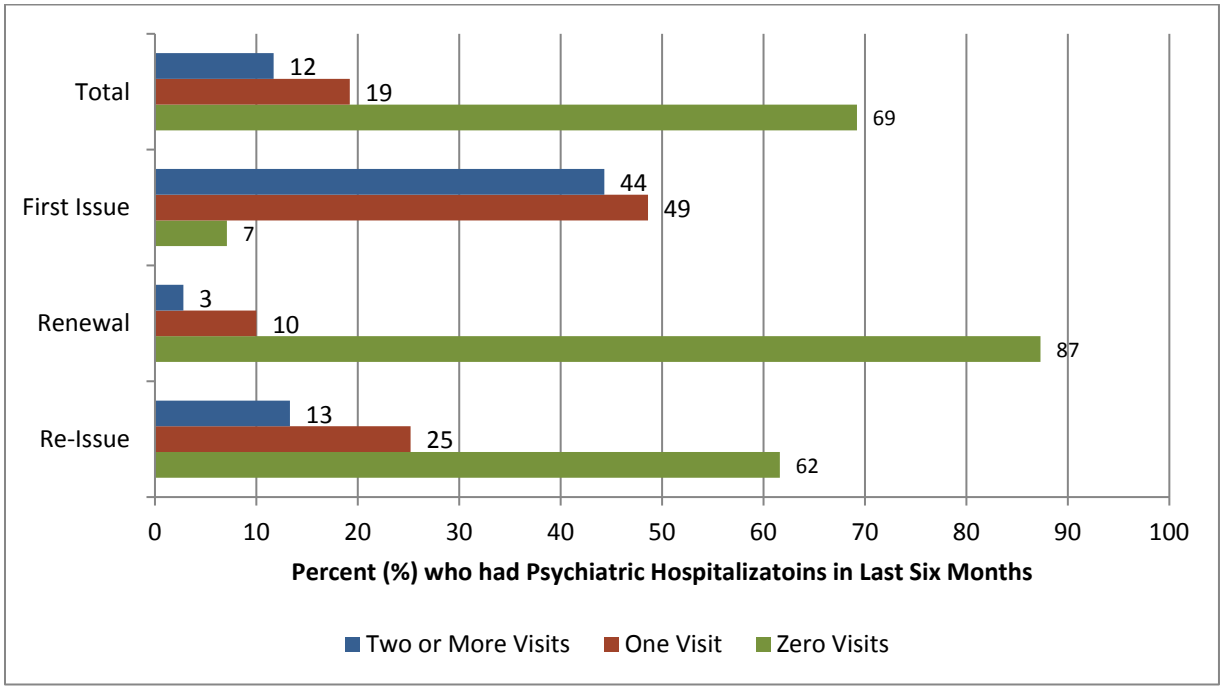
The review found that the effectiveness of CTOs may be mixed and largely case-dependent. Showing promise for both the client and society, CTOs may have positive outcomes with regards to hospitalization and interactions with the correctional system. As detailed below, evidence is mixed for clinical/medication outcomes, psychosocial outcomes, outcomes on quality of life and satisfaction with

care. However, when looking at the responses from clients and families, in the survey and interviews, it is clear that at least some see a positive impact on their mental health, well-being and functioning.

Hospitalization and service utilization outcomes: Although CTOs reduce hospitalization, according to the province's CTO-IR data, the literature paints a less clear picture when it comes to length of, and time to hospital readmissions; and service utilizations.

CTO-IR data show a drop in psychiatric hospitalization among CTO clients. Of those who had been issued their first CTO (i.e. not previously on a CTO), 93% had at least one psychiatric hospitalization over the previous six months (44% had two hospitalizations). However, among clients who have been on a CTO (i.e. those who had their CTO renewed), only 13% had a psychiatric hospitalization during the previous six months (see Figure 7).

Figure 7. Percentage of Clients with Psychiatric Hospitalizations in the Last Six Months by CTO Type



Source: CTO-IR, Q7, Base=2,608, Reference year: 2018

Although this is promising, one must consider that the data on which the findings are based are only estimates. Further, the findings in the literature are less clear. On one hand, there is some evidence of positive effects of CTOs on client hospital outcomes and service utilization. For instance, a systematic review of eight studies (four quantitative mirror image studies, three qualitative studies, and one survey of psychiatrists) summarized evidence on the effect of CTOs in Canada.[29] Four of the studies reviewed

[29] Kisely 2016, pages 3 to 5.

were from Ontario. Evidence from these Canadian quantitative studies showed that placement on a CTO was associated with reduced rates and length of hospitalization, as well as improved outpatient attendance, use of psychiatric services and housing. Another Canadian study found that the number of hospitalizations was reduced for CTO clients, and the median time to re-hospitalization was increased in the course of the CTO, as well as after the CTO had expired.[30] Additional studies found that CTO placement was associated with a number of positive outcomes, including reduced number, frequency, and length of hospital readmissions; increased time to readmission; as well as increased use of community services.[31] Furthermore, findings from the online survey indicated that, among respondents from the professional groups (see Table 15), there was a high level of agreement that CTOs had reduced hospital admission rates (80%).

On the other hand, findings from a systematic review of 18 quantitative studies from four international jurisdictions—including Canada—show no impact of CTOs on admission rates, of the number inpatient days and of community service utilization.[32] Other research that also found no link between CTOs and hospital and service utilization outcomes, including non-randomized quantitative studies,[33] randomized control trials,[34] as well as meta-analysis studies[35] of relevant randomized control studies of CTO outcomes.

Clinical and medication outcomes: The evidence on CTO effects on client's clinical and medication outcomes is mixed. One randomized control trial study in England and Wales found no significant effects on clinical outcomes, such as symptom severity, insight, or medication outcomes (such as type of medication, attitudes and adherence to medication).[36] And a meta-analysis of randomized control trials found no significant difference in psychiatric symptoms between study participants with CTOs and those without.[37]

However, findings from this review's primary research counter these findings. Mental health professionals participating in focus groups indicated that CTOs have had positive effects on client clinical and medication outcomes. Among professionals who responded to the survey (see Table 15), there was a high level of agreement that CTOs were effective in reducing the risk of serious harm to people in the community (73%). From the perspective of family, friends and SDMs who responded to the survey (see

[30] Nakhost, Perry, and Frank 2012, pages 5 to 6.
[31] These studies include Awara, Jaffar, & Roberts, 2013; Lera-Calatayud et al., 2014; Nakhost, Perry, & Frank, 2012; Nakhost, Simpson, & Sirotich, 2019; Rawala & Gupta, 2014; Segal et al., 2013; Taylor, Macpherson, Macleod, & Lyons, 2016.
[32] Maughan, Molodynski, Rugkåsa, & Burns, 2014.
[33]For instance, see Castells-Aulet et al., 2015.
[34] For instance, see one RCT from England and Wales (Dawson et al., 2013).
[35] For instance, see S. Kisely & Hall 2014.
[36] Yeeles et al. 2014.
[37] S. Kisely & Hall 2014.

Table 16), the majority (75%) agreed that their family members/friends were able to adhere to the treatment plan.

Table 15. Percentage of Mental Health Professionals Agreeing with Statements about the Effectiveness of CTOs

Statements Agreed With	2019	2012
CTOs have reduced hospital readmission rates	80%	64%
CTOs have a positive impact on the quality of life of the client	75%	65%
CTOs are effective in reducing the risk of serious harm to people in the community	73%	57%
CTOs have better outcomes than other community treatment options	60%	41%
CTO clients maintain their gains after the CTO expires	31%	26%

Source: Review of Community Treatment Order Survey (2019), Question D6 (2019 n = 242, 2012 n=344)

Table 16. Percentage of Clients and Family, Friends and SDMs Agreeing with Statements about the Effectiveness of CTOs

Statements Agreed With	Clients	Family, Friends, SDM
CTOs were the best option for me/my family member/ friend's situation	71%	85%
They were able to adhere to the treatment plan	96%	75%
I am/was satisfied with the treatment plan being delivered through their CTO	82%	69%
Their health improved as a result of the CTO	68%	69%
Their quality of life improved	71%	67%
I am/was satisfied with the services being provided to them as part of their treatment plan	89%	66%
I am/was more satisfied with the CTO than with other treatment options my family member/friend has experienced	71%	63%
Their treatment plan included medication that had bad side effects	46%	33%

Source: Review of Community Treatment Order Survey (2019), Question C1 (n = 28 Clients, n = 34 Family, Friends, SDM)

Mental health professionals, clients, SDMs and advocates agreed that the effects of CTOs on client well-being and satisfaction are not positive for every client. While many mental health professionals from focus groups recognized that there are a number of components to a community treatment plan, they separated medications from all other portions of the plan when it comes to client satisfaction and well-being. Specifically, mental health professionals considered medications to have the following main characteristics:

- The core of the treatment plan;
- The factor that is most likely to improve client well-being; and,
- The factor most likely to be resisted by clients.

Clients, family, friends and SDMs agreed that medication is at the heart of the matter. While medication may offer clients an improvement in their mental condition, some clients suffer from and complain about medication side effects, including feeling sluggish, not sleeping, feeling anxious, having poor motor control, feeling clumsy or gaining weight. Survey findings pointed to approximately one-third (33%) of family, friends and SDMs agreeing that their loved ones' treatment plan included medication that had adverse side effects (see Table 16).

Strictly speaking, these negative side effects are not specific to CTOs, but to the type of anti-psychotic medication prescribed under a CTO. Yet, two clients viewed them as negative impacts of CTOs on their well-being and satisfaction, perhaps because treatment adherence is part of a CTO. Further, both advocates interviewed indicated that the side effects of medication included reduced movement. These movement restrictions limit client mobility and thus how they can interact in society.

Social and psychosocial outcomes: The evidence of the effects of CTOs on client social and psychosocial outcomes is mixed. Evidence from the literature suggests that CTOs have no significant effect on client social and psychosocial outcomes. A number of quantitative studies found no significant effect of CTOs on outcomes such as global social functioning, occurrence of at least one arrest, housing/homelessness, employment, living status and social contacts.[38] Qualitative literature shows that, because of their focus on medication, CTOs are good at addressing physiological symptoms (such as hearing voices and hallucinations), but poor at addressing psychosocial symptoms (such as blunted affect, lack of motivation or social engagement).[39]

Evidence from this review's primary research indicates that CTOs have positive effects on social outcomes, at least in some cases. For instance, two clients interviewed stated that the CTO made their family take their mental health more seriously, and that since entering a CTO, they have developed a strong relationship with their family. Several clients interviewed noted that they have had successes in

[38]S. Kisely & Hall 2014; S. R. Kisely & Campbell 2014; Yeeles et al. 2014.

[39] For instance, see Canvin et al. 2014, page 8.

their lives since beginning the CTO, such as being able to drive again, starting or finishing university, and gaining part-time employment.

Outcomes with respect to being placed in custody or detained: The CTO-IR data show that clients on a CTO are less likely to be placed in custody or detained for criminal reasons or under the MHA. Of those who have been issued their first CTO, 41% were apprehended under the MHA, compared to 7% who have had a renewal or 16% who have had a reissue (see Table 17).

Table 17. Percentage of CTOs Being Placed in Custody and Involvement with Correctional System in Last Six Months

Percent (%), Past Six Months		Issuance		
	TOTAL	Issue	Renewal	Reissue
Apprehended under MHA	15	41	7	16
Criminal Arrest and Incarcerated	3	5	2	6
Probation and/or Parole	3	4	2	3
None of the above	66	35	75	64
n	*2,601*	*474*	*1,759*	*368*

Source: CTO-IR, Q10. Responses may sum to >100% due to multiple responses

Note: the CTO-IR also includes data on victims of crime and court diversion, which were both negligible.

Reducing the likelihood of being placed in custody or detained may be an important step. Involvement of law enforcement was brought up as a factor that influences the effects of a CTO on client well-being and satisfaction. Many mental health professionals and one advocate stated that involvement of law enforcement in CTOs has the potential to damage the relationship between the client and the rest of the healthcare team. As a result, one physician indicated that use of Form 47s was limited to situations without alternative.

Quality of life, satisfaction with care provision: Evidence of the effects of CTOs on client quality of life and satisfaction with care is mixed. Findings from one recent study of knowledge and views of CTO clients in Toronto show that they were significantly more likely to view CTOs as beneficial to someone else's quality of life and mental health, than to their own quality of life and mental health.[40] Findings from another study from Toronto indicated that most CTO clients reported having improved rapport with case management and clinical teams.[41]

Findings from this review's primary research pointed to a number of positive effects of CTOs on client quality of life and satisfaction with services. Two experts interviewed acknowledged that there are cases where CTOs positively impact client quality of life and "help them get back to their best baseline."

[40] See Nakhost, Simpson, and Sirotich 2019, page 6.

[41] See Mfoafo-M'Carthy 2014, page 5.

Several SDMs interviewed reported that their loved one's well-being and mental health had improved since beginning their CTO. Clients all reported that their conditions, symptoms, daily functioning or overall health had improved as a result of the CTO. Some interviewees noted that positive consequences of the CTO extended to other members of the household, who experienced less stress and better sleep.

Moreover, survey findings show that many clients were satisfied with the treatment plan delivered through the CTO (71%); agreed that their health improved as a result of the CTO (68%); and agreed that their quality of life improved (71%). Almost all clients were satisfied with the services provided to them as part of the treatment plan (89%), and most were more satisfied with the CTO than with other treatment options they experienced (71%).

Similarly, many family, friends and SDMs surveyed were satisfied with the treatment plan delivered through the CTO (69%); agreed that the health of their family member/friend improved as a result of the CTO (69%); and agreed that the quality of life of their family member/friend improved (67%). They were satisfied with the services provided to the clients as part of the treatment plan (66%), and were more satisfied with the CTO than with other treatment options their family member or friend had experienced (63%). Among professional survey respondents (see Table 15), there was a high level of agreement in 2019 that CTOs had a positive effect on the quality of life of clients (75%).

Personal agency: Some clients with CTOs may feel a loss of personal agency, especially if they are involved with law enforcement. Although the study mentioned above found that CTO clients became more empowered,[42] the primary research conducted for this review found the opposite. Four out of five CTO clients interviewed expressed feeling coerced and lacking personal agency. While some studies found that CTOs had no significant effect on experienced or perceived coercion,[43] many studies found that clients object to their CTOs because they are restrictive and coercive.[44]

Findings from the review's primary research concur with the literature with regard to feelings of coercion and lack of personal agency among CTO clients. While clients interviewed often viewed CTOs as a less restrictive alternative, in the course of a CTO they may feel coerced, emotionally burdened and lacking personal agency. One or two mental health professionals indicated that a psychiatrist may use a CTO in a punitive way or make the process seem punitive by reviewing a client's past records in order to cherry-pick factors that would indicate a client has no insight. They related that such practices do not make clients feel good about themselves, let alone about the CTO process.

CTO clients are not the only ones to indicate a lack of personal agency. Some SDMs interviewed for this review brought forward a number of concerns about their lack of personal agency in the CTO process.

[42] Ibid.

[43] For instance, see Kisely & Campbell 2014; Yeeles et al. 2014.

[44] See for instance Corring, O'Reilly, & Sommerdyck 2017; Rawala & Gupta 2014; Riley, Høyer, & Lorem 2014.

One SDM stated that they had no say into their loved one's treatment. Another SDM interviewed was frustrated that the psychiatrist followed the wishes of the client over the SDM's wishes, even though the client had been found not capable of consenting. Others felt very sufficiently involved in the CTO process and discussions around treatment, which indicates the large variability in how CTOs are being managed across the province.

3.3.2 What services and supports are CTO clients using?

The availability of the services clients require remains a key concern to stakeholders. Survey findings indicated that family members, friends and SDMs were mainly concerned about the availability of needed services for their family member in the community, with 43% mentioning they were very concerned. The availability of needed services in the community was also the first and primary concern of family, friends and SDMs in the 2012 review of CTOs. However, it is important to note that this finding appears to vary by geography, as most respondents in the Greater Toronto Area said they were not concerned with the availability of services in the community.

The CTO-IR tracks psychiatric and other health services used by clients over the six-month period before the CTO was issued. If an individual has been issued a first CTO, then the prior six-month period represents a time when that individual was not on a CTO. As such, comparing those on their first CTO to those on a renewal CTO gives a sense of how the services being accessed had changed.

There are substantial changes in clients' use of services while they are on a CTO compared to the six months before they are on a CTO. For example, they access more outpatient psychiatric services, community mental health services, ACT teams, medication management, supportive housing services, and crisis intervention. Meanwhile, those on CTOs are less likely to receive crisis intervention. Clients' use of inpatient psychiatric services was not available (see Table 18).

Table 18. Percentage of Clients Using Service in Previous Six Months

Percent (%) Using Service	Prior to CTO*	On CTO
Hospital inpatient psychiatry	90	NA
Crisis intervention	40	19
Hospital outpatient psychiatry/mental health	27	51
Community mental health	15	25
ACT treatment	11	36
Medication management/addiction services/clinic	12	34
Supportive housing	4	11
Non-psychiatric medical care	4	2
Private psychiatrist	2	8
Case management	NA	23
n	***474***	***2,602***

Source: CTO-IR, Q8 and Q9. Reference year: 2018. Responses may sum to >100% due to multiple responses.
*Prior to CTO calculated by looking at the services provided over the six months prior to a first issue of a CTO. Those that are receiving a renewal or reissue have been filtered out.

Experts interviewed felt that some services were provided adequately, while others were not. Five experts interviewed considered support from ACT teams and intensive case management to be adequate. Supportive housing services were seen as inadequate owing to long waitlists and precarious living conditions (e.g. when housing is only offered temporarily, resulting in CTO clients having to constantly move or be homeless). All experts advocated for increased access to housing; one expert also noted that supportive housing would reduce the burden on ACT teams since similar services are provided as part of supportive housing.

3.3.3 What are the factors which influence the effectiveness of CTOs?

Several lines of evidence—including the literature review, interviews with experts, interviews with clients and SDMs, focus groups and survey—point to a number of factors that can influence the effectiveness of CTOs. These factors fall under two categories: client characteristics and features of the CTO.

Client characteristics: Client characteristics that influence the effectiveness of CTOs include client insight into their mental health and compliance with their community treatment plan, as well as socioeconomic, psychosocial and health factors. Findings from most primary research lines of evidence (interviews with experts, focus groups, interviews with clients, family/friends/SDMs and advocates, and survey) suggest that not only does client insight and likelihood of compliance affect physicians' decisions to recommend a CTO, but these factors also influence the effectiveness of CTOs.

Experts, mental health professionals, family/friends/SDMs all agree that CTOs are more likely to be effective for clients who are insightful enough to comply with their community treatment plan. These factors impact the effectiveness of CTOs because clients who do not follow their community treatment plan run the risk of being issued Form 47, which allows police to apprehend them and bring them to the hospital involuntarily.

Experts, mental health professionals and SDM/friends/family pointed to a number of socioeconomic, psycho-social and health factors that can influence the effectiveness of CTOs. Factors such as availability and stability of income, communication skills, and social capital in the form of support from friends and family increase the effectiveness of CTOs.

Virtually all clients, SDMs, health professionals and advocates emphasized the support and advocacy of clients' family members and friends. Some SDMs interviewed stated that if their loved one was not supported by family, their health and situation would be worse. Based on this evidence, it seems that CTOs are more likely to be effective for clients with substantial support from family and friends.

SDMs who are family members of the client would go to significant lengths to find the proper support and treatment for their loved ones such as:

- Attending conferences and support groups;
- Finding complementary treatments such as client support groups, day programs and outpatient psychiatry from hospitals; and,
- Advocating for their rights to healthcare providers and hospital staff.

History with the correctional system and substance use can also negatively impact the effectiveness of the CTO. One expert noted that it is not uncommon for clients to be rejected by an ACT team on the grounds of their history with the correctional system, which destabilizes the recovery process. Being placed in custody also jeopardizes the effectiveness of the CTO as the treatment, care and supervision are discontinued for the duration. As one SDM noted, when their loved one was in custody, their CTO was ignored and it took considerable efforts to re-stabilize them after their release.

Although housing can be considered a systemic issue, especially when considering its impact on those with serious mental health conditions (See Section 3.2.1 for characteristics of client housing and Section 3.3.2 for housing support services being accessed), those consulted for this review considered housing also as a client characteristic that impacts the effectiveness of CTOs. Corroborating the findings from the literature, experts and mental health professionals commonly referred to housing as one of the most pivotal factors that can influence the effectiveness of CTOs in two ways:

- Access to supportive housing often comes with a package of services that are similar to those provided by ACT teams. This housing prevents some clients from being hospitalized or being

homeless in the community without services, particularly in cases where the demand for ACT services is greater than the supply.

- Regardless of whether or not housing is supportive (i.e. offers support similar to that provided by ACT team), it provides a fixed address, which helps ACT teams locate CTO clients more easily and ensures timely follow-up visits and support that help the client adhere to the community treatment plan.

The waiting time for subsidized public housing and supportive housing varies between and within regions in Ontario. According to those interviewed, in some areas the waiting time is too long to accommodate CTO clients in a timely manner (e.g. average of 10 years in Toronto), which is likely to adversely affect the effectiveness of CTOs. Fortunately, wait times can be reduced by some advocacy organizations and some organizations granting high priority housing to CTO clients who also have other medical conditions, such as HIV.

The literature review corroborated these findings. For instance, studies showed that client background characteristics (such as history of involuntary hospitalization, history with the correctional system, access to finances and access to housing) shape their experiences with CTOs, including their sense of coercion.[45] Some clients (for instance those with longer psychiatric history) may benefit more from a CTO,[46] whereas some positive outcomes (for instance reduction in the number of visits to the emergency department) may be more likely for clients diagnosed with schizophrenia only.[47]

As a result of all of these factors, a common view among experts and mental health professionals in the focus groups was that CTOs are only one piece of the puzzle, and that there is a greater need to approach overall treatment of clients more holistically through treatment more centred around the individual needs of the client and through a wider breadth of community services.

CTO features: From interviews with experts, focus groups, interviews with clients and SDMs, and the survey, CTO effectiveness can be influenced by factors within the CTO itself, such as its community treatment plan and the support provided by the physician. Most experts discussed how the length of time between CTO renewals can negatively impact their effectiveness. As per the Ontario MHA, CTOs are issued for a period of six months, and can subsequently be renewed every six months, as many times as needed. Overall, experts argued that it is better for clients to plan on receiving services for a longer period of time than six months at a time. Some clients and SDMs interviewed agreed that lengthening the CTO from a six month time-period would be helpful.

[45] See Nakhost, Sirotich, Pridham, Stergiopoulos, & Simpson, 2018; Pridham et al., 2016.
[46] See Taylor et al., 2016, page 2.
[47] See Lera-Calatayud et al., 2014, page 3.

The content of the community treatment plan is another factor that can influence the effectiveness of a CTO. CTO coordinators participating in focus groups emphasized that they do not want to create community treatment plans that are burdensome on clients or that might lead to clients failing to adhere to treatment. According to some mental health professionals, increasing client involvement in designing their community treatment plan helps mitigate the risk of client dissatisfaction and treatment discontinuation. Client input could include medication plans and other services, as well as the client's spiritual perspective. Indeed, as one advocate strongly emphasized it, spiritual, religious and faith-based care is a very important part of recovery if the client has strongly held beliefs in these areas.

A CTO can only be as effective as the community treatment plan on which it is based, which is in turn contingent upon the availability of resources and services in the community. The more resources and services available, the more comprehensive the community treatment plan can be in practice, thereby impacting the effectiveness of the CTO. There was a common view among experts and mental health professionals that CTOs should be seen as a rehabilitation tool that provides clients with comprehensive services and opportunities, including treatment, ACT team and intensive case management services, employment services, housing accommodation, services to mitigate side effects and the like. In theory, a service is not supposed to be in a plan unless it is available in the community. Yet, the review heard of community treatment plans that list community services that are not accessible to the client (particularly in rural regions of Ontario).

Interviews with clients and families also demonstrated the variation in service access across the province. While some clients had several services outlined in their CTO, such as case management and access to ACT teams, others were not connected to any services other than check-ins with their doctor every few months.

As mentioned earlier, CTO clients taking anti-psychotic medication often suffer from their side effects. It is often the case that side effects negatively impact the effectiveness of a CTO as clients stop complying with the community treatment plan or withdraw consent to the CTO altogether. Thus, effective community treatment plans often include side effect mitigation strategies. One interviewed client related that their community treatment plan included a free YMCA membership, with the services of a personal trainer, to manage the side effect of weight gain. However, the review heard that side effect mitigation strategies are not always included in community treatment plans or at least not thoroughly communicated to the client and their SDM.

Another factor that impacts the effectiveness of CTOs is the degree to which service providers (physicians, CTO coordinators and members of ACT/intensive case management teams) build rapport and develop supportive relationships with clients (and, in some cases, their SDMs and family members). Experts, clients and SDMs all agreed on the importance of strong and positive relationships. Clients and families also discussed the importance of having consistent and regular contact with their doctor and treatment team to help build this rapport. Clients who feel that their service providers have their best interests at heart and feel that their sense of personal agency is respected are more likely to trust their service providers and comply with their community treatment plan. To the contrary, weak relationships jeopardize the effectiveness of the CTO. One client and one SDM who had weak relationships with their psychiatrist – because they had a feeling of poor personal agency - were the most dissatisfied among all interviewed clients and SDMs. This is likely to adversely impact adherence to treatment, which would ultimately impede the effectiveness of the CTO. Two SDMs noted that mental health professionals do not always follow through with their obligations to the client on the CTO, which has caused their loved ones to deteriorate since being on a CTO. On the other hand, those with good relationships to their treatment team, cited those relationships as a key factor in helping them adhere to their CTO.

> *"When asked what helps her remain on her CTO, one client said: My psychiatric nurse listens to me and doesn't treat me like I'm sick… my psychiatrist is outstanding. He's very patient and he listens to me and modifies my dose if it isn't working for me"*
>
> *(Client)*

Another factor that may impact the effectiveness of the CTO is how it is described to the client and SDM. Framing the CTO in a positive way, describing it as a safety net or insurance policy, seems to help clients and families view the CTO as a protective mechanism. Several people discussed the value in presenting the CTO in this light, and said this approach helped them adhere to their medication regime and stay out of hospital.

Findings from the literature review corroborate the importance of positive support from service providers to CTO effectiveness. For instance, a study found that positive, collaborative and recovery-focused relationships with clinicians help CTO clients accept the conditions of a CTO, and are subsequently conducive to the CTO's success, whereas difficult relationships with clinicians impede successful engagement of CTO clients.[48]

3.3.4 Is there a standard discharge planning process for a CTO client?

The review found that there is no standard discharge planning process for CTO clients, although there do appear to be norms. Physicians appear to have discretion when it comes to the discharge process,

[48] See Corring et al., 2017, page 4.

but experts and mental health professionals commonly stated that engaging the client in the process is paramount to a successful CTO discharge.

In general, towards the end of a CTO, the physician will discuss the CTO with the client and assess their degree of insight into their mental health and need for treatment, their perceptions of and experiences living with a CTO, and the consequences of stopping the community treatment plan. This discussion provides the physician with an understanding of whether or not a renewal is needed. The ultimate goal is to help clients reach a point where they will follow their physician's recommendation for treatment without the need of a CTO, leading to a full discharge from the CTO process. Mental health professionals in the focus groups suggested that they do what they can to keep services in place for the client after the CTO has been removed.

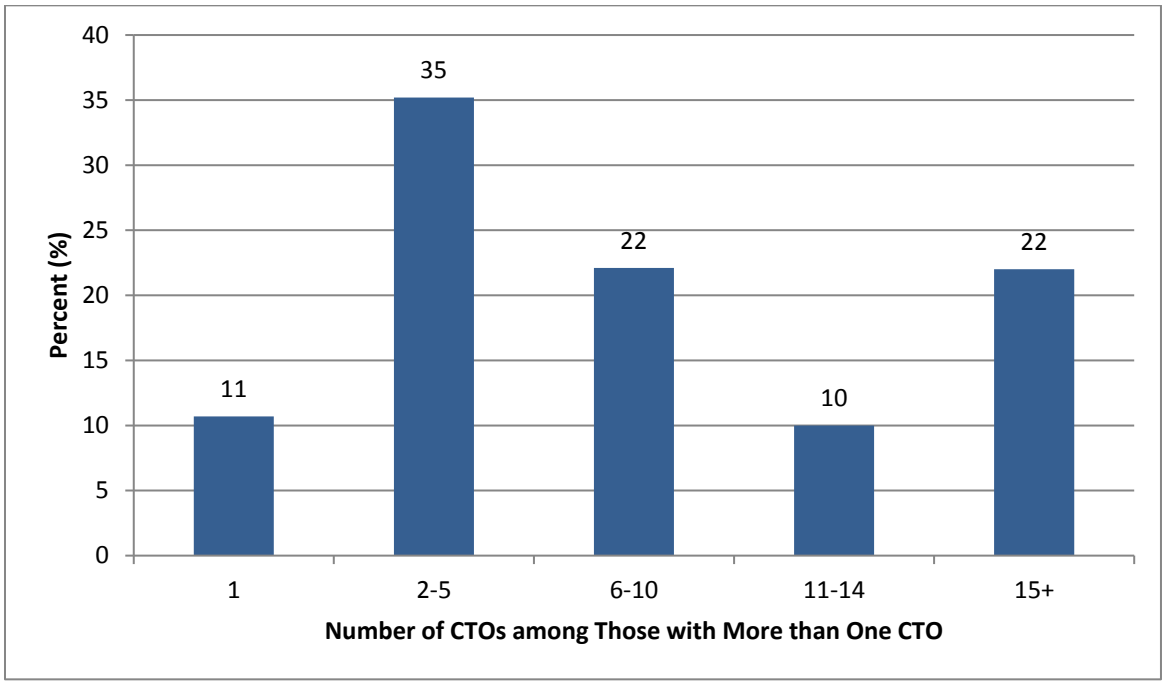
> *"Discharge can be a shotgun effect; there's no consistency. What works for some may not work for others. Discharge is more of a revolving door since people are spit back out into society, or worse, they end up on the streets or in custody."*
>
> *(SDM, parent)*

Two SDMs interviewed expressed their concerns about the lack of planning for their loved one's discharge from a CTO. One SDM noted that when their loved one was previously discharged, the support provided by the CTO coordinator and other mental health service providers was discontinued. As a consequence, their loved one was involuntarily hospitalized before being issued another CTO.

3.3.5 How many times, on average, are CTOs renewed for the same client?

Virtually all experts and mental health professionals indicated that clients need more than one CTO. Clients are seldom discharged from the CTO, and many need their CTOs to be renewed numerous times over a long period of time. In some cases, clients are told that they will be on a CTO for the rest of their lives. Figure 8 shows the frequency distribution of CTOs for clients who have been issued more than one CTO (i.e. those who have had CTOs renewed or reissued). Almost one in four CTO clients (22%) has been issued 15 or more CTOs.

Figure 8. Percentage of Clients by Number of CTOs Issued



Source: CTO-IR Q5, Base=2,394, Reference year: 2018.

3.3.6 Does the effectiveness of CTOs differ by client sociodemographic, geographic, or ethno-cultural factor?

Differences by socio-demographic factors: The effectiveness of a CTO does not clearly differ by socio-demographic factors. Rather, findings from different lines of evidence show that in some cases, the effectiveness of CTOs differ according to some client socio-demographics. One study from the United Kingdom explored differences in CTO effectiveness among sociodemographic factors (e.g. gender, age, education, marital status, accommodation status). Findings showed no statistically significant interactions between the subgroups and the study's numerous primary and secondary outcomes. Although the findings did show some relations between outcomes and age and education, no consistent pattern emerged.[49] Another study, using multivariate analyses, evaluated the effect of CTOs on changes in mental health service use in Western Australia.[50] Findings showed some differential effects by socio-demographics. For instance, seniors, and people without responsibilities for work, study or home had significant decreases in length of hospitalization following CTO placement; and female CTO clients used significantly more outpatient services than male CTO clients.

[49] See Yeeles et al., 2014, pages 5 to 7.

[50] Segal et al., 2013.

Differences by geographic factors: Findings from many lines of evidence (interviews, focus groups, survey, and literature review) show that the effectiveness of CTOs is likely different depending on geographic factors—primary a rural/urban divide. Experts and mental health professionals pointed to shortages of CTO resources (e.g. physicians/psychiatrists, ACT team services and CTO coordinators) in rural and remote communities. Thus, CTOs are more effective in urban areas than in rural areas owing to better access to services. Other experts noted that there are few CTOs issued in Northern Ontario, which raises the question of whether communities in Northern Ontario are well-served.

The differences in the effectiveness of CTOs by rural locations have also been documented in the literature. For instance, the Australian study mentioned above evaluated the effect of CTOs on changes in mental health service use in Western Australia found that rural residence was associated with a significant increase in length of hospitalization.[51]

Differences by ethno-cultural factors: Experts and focus group participants found it difficult to speak to gaps in the effectiveness of CTOs by ethno-cultural factors, including racialized or Indigenous communities. However, they acknowledged that client ethno-cultural background may influence the outcome of CTO treatment primarily because of two factors: language; and cultural beliefs about mental illness. Interviews with clients and families reinforced the importance of considering culture and language when working with people from diverse backgrounds. For instance, clients with limited skills in English, such as unilingual French speakers, immigrants or refugees, might be disadvantaged where CTO services are provided (mainly) in English. SDMs who are not proficient in English also have a difficult time communicating with the treatment team about the CTO, and often times require additional family members to be involved.

This reinforces the idea that some family members raised about formally involving the family in the treatment plan and the CTO process overall. Some people discussed how valuable family meetings were in helping their family member adhere to their CTO.

Furthermore, culture shapes client insights into their illness and the type of treatment they need. In some cultures, mental illness is associated with spiritual issues, which may influence client compliance with CTOs and subsequently the effectiveness of CTOs. For example, one advocate who works largely with African Canadians indicated that this community's view of mental illness requires clients to gain support from the community as part of the treatment. While hospitals will still be necessary to provide care, those in the community that understand the cultural background of the client can help the individual in a more holistic way.

[51] See Segal et al., 2013, page 3.

Survey findings indicate that most respondents did not see differences in the effectiveness of CTOs in serving diverse populations, such as racialized groups, ethno-cultural communities, Francophone communities, and Indigenous communities (see Table 19). For all communities tested in the survey, respondents most commonly selected a neutral response to the question. For instance, while only 37% of respondents agreed that CTOs are effectively serving ethno-cultural communities, only 17% disagreed. Nearly half (47%) reported a neutral response. When combined, these findings suggest that these specific communities are not adequately served, but it is possible that there is not much difference when compared to the rest of the population. That being said, it is worth noting that for Indigenous communities, more people disagreed than agreed (25% versus 19%), which suggests that Indigenous communities are the least well-served.

It is important to note, however, that there was limited feedback from the members of diverse communities, including racialized groups, ethno-cultural communities, Francophone communities, and Indigenous communities. Given this limitation, conclusions around diverse groups should be viewed with a degree of caution.

Table 19. Percentage of Agreement with Statements about the Effectiveness of CTOs for Specific Communities

Communities	Agree	Neutral	Disagree
Racialized communities (i.e. visible minorities)	37%	47%	16%
Ethno-cultural communities	37%	47%	17%
Francophone communities	23%	65%	12%
Aboriginal communities	19%	56%	25%

Source: Review of Community Treatment Order Survey (2019), Question D6 (n = 242)

These unclear findings are echoed in the literature. For instance, the British study mentioned above also explored differential effects among ethno-cultural groups (including ethnicity, and country of birth) but found no statistically significant differences[52]. One study did cover some ethno-cultural differences; the Australian study mentioned above found that Australian Indigenous clients accessed significantly fewer outpatient services, potentially due to decreased access to them.

[52] See Yeeles et al., 2014, page 4.

3.4. Methods used to evaluate the outcome of any treatment used under CTOs

3.4.1. What client outcomes are being measured?

The review found that there are standard performance metrics for measuring the effectiveness of CTOs, but more may need to be used to fully measure client outcomes. Client outcomes that are the most frequently measured in the literature relate to hospital and service utilization, and include:[53]

- Number of psychiatric (emergency) visits;
- Number and length of re-admissions;
- Time to readmission; and,
- Type of health and community services utilized.

The following outcomes are also used in the literature, though less frequently perhaps because they more difficult to measure:

- Clinical outcomes, such as symptom severity and insight into mental health;
- Social functioning outcome, such as accommodation status, substance use and interaction with the correctional system;
- Economic outcomes, such as employment status;
- Quality of life, such as self-esteem and quality of life;
- Experience of and satisfaction with services, such as relationships with service providers and perceived coercion; and,
- Adverse events, such as mortality.

Experts and mental health professionals consulted for this review have confirmed the finding that hospital and service utilization rates are the most frequently measured outcomes, perhaps because they are relatively easier to measure. When physicians issue, renew or reissue CTOs, the CTO-IR is used to collect information on client outcomes over the past six months, such as:

- Number of psychiatric hospitalizations;
- Client services accessed;
- Services listed in the community treatment plan; and,
- Client involvement with legal system.

[53] Castells-Aulet et al., 2015; S. R. Kisely et al., 2017; Nakhost et al., 2012; Nakhost, Sirotich, Pridham, Stergiopoulos, & Simpson, 2018; O'Reilly & Vingilis, 2018; Rugkasa, 2016; Segal et al., 2013; Yeeles et al., 2014.

Mental health professionals noted that some additional indicators are sometimes collected, even if to a lesser degree, including:

- How often Orders for Examination (Form 47) are issued;
- How many community referrals were being made for those on CTOs; and,
- How many days a CTO client has been in hospital prior to a CTO, while on a CTO and after a CTO.

Some case managers indicated that housing, quality of life, employment and how well a person can manage barriers were considered in the case management plan and monitored among clients.

Despite the use of these performance indicators, there may be outstanding gaps in the outcomes being measured. Overall, one expert and many mental health professionals noted that, despite CTOs being in force in Ontario for almost 19 years, little is being done to measure client outcomes in a consistent way, both within health facilities and at large by the MoH. These participants stated that some of the most common outcome measures (such as hospitalization and service utilization rates) are poor measures, as they lack the ability to portray the full picture. For example, a CTO client may utilize hospital services at the same rate as before the CTO, yet may have better quality of life or have secured better housing following placement on a CTO. By focusing exclusively on hospital and service utilization rates, these positive outcomes go unmeasured.

Furthermore, CTOs may result in a high initial cost associated with increased use of general health services, but subsequently result in lower longer-term costs, through benefits such as increased life expectancy. A few experts suggested that better outcome measures are needed, such as return to work or school, use of general health services, housing stability, social capital, financial stability, correctional recidivism and degree of substance use.

3.4.2. How are client outcomes being measured?

The review found that there are gaps in how client outcomes are being measured. Experts and mental health professionals in the focus groups emphasized that not only is the scope of client outcome measures narrow, but there is also no standardized and coordinated information system to collect data on client outcomes. This opinion exists, despite the fact that there is a CTO-IR entry that was designed to be made for every CTO issued, renewed or reissued. Indeed, some of the existing client outcome measures are collected by physicians themselves or through CTO coordinators.

Two issues arise when collecting outcomes through CTO coordinators, as noted by the academic researcher: first, not every physician has a CTO coordinator; and second, not every CTO coordinator uses the same tools and standards. In a focus group, the review heard from one psychiatrist completed a file review of 50 clients to determine the change in the days in hospital for clients prior to a CTO and after a CTO. CTO coordinators often indicated that they had to implement their own spreadsheets, which

included both outcome data and administrative data that kept track of important dates (such as renewal dates) for the clients and their CTOs.

One physician argued that it would be ideal to collapse fractured databases into an integrated, standardized database, with the capacity to measure outcomes longitudinally to better predict what factors lead to more successful long-term outcomes. He further suggested that the Ontario Common Assessment of Need would be a good starting point as a model. The common feeling among mental health professionals was that the MoH does not express an interest in collecting, analyzing or disseminating data on an aggregate level, so that more information about CTOs on a province-wide basis could be shared.[54]

The review's experience with the databases supporting CTOs corroborates the mental health professionals' concerns. Despite the best efforts of MoH staff, two months were required to prepare CTO-IR data for analysis. Moreover, CTO-IR data were incomplete, with only about 38% of the CTO records present in PPAO appearing in CTO-IR. Hence, although the CTO-IR was designed to inform the mandated reviews of CTOs, there is clear evidence that client information has either not been collected for every CTO issued, renewed or reissued or that collected data have not been compiled into a centralized database. In either case, the CTO-IR data were not ready to fully support a systemic analysis of CTOs at the provincial level.

It is important to note that since the last review, the MoH began providing CTO coordinators with more training about collecting data on CTOs. In early 2019, the Provincial System Support Program at the Centre for Addiction and Mental Health developed an online curriculum for CTO coordinators and physicians to enhance their knowledge of CTOs on five key topics. One of these topics was tracking CTOs through CTO-IR and OHIP. This module directed CTO coordinators to consistently use the CTO-IR database and physicians to use OHIP to bill for CTOs. The review notes that that the course will be an important tool in addressing these data collection shortfalls.

3.4.3. Are differences in client outcomes being measured by client socio-demographic, geographic, or ethno-cultural factors?

Ability to measure differences in client outcomes by client specific factors depends on the scope of outcomes and background information collected for every client. In the literature, a number of studies of CTO outcomes conducted sub-group analyses of CTO outcomes by socio-demographic, geographic and ethno-cultural sub-groups.[55] Findings from a Toronto study, which delved into the lived experiences

[54] It should be noted that the MoH hosts an online course for CTO coordinators and physicians that teaches tracking CTOs through data collection and billing.

[55] For instance, see Segal et al., 2013 for Australia and Yeeles et al., 2014 for UK.

and perceptions of CTO clients from ethnic minority backgrounds, show that client outcomes were measured for specific ethno-cultural groups.[56]

The review found that, in Ontario, differences in client outcomes can be measured by some socio-demographic and geographic factors, using the CTO-IR data. As has been demonstrated throughout this review, the CTO-IR form collects client socio-demographic information, such as:

- Age;
- Gender;
- Family background (i.e. who does the client live with); and
- Housing type (e.g. private house, shelter, homeless).

Geographic location is not collected, but could be imputed with the information provided. The name and address of the organization/agency with whom the physician is affiliated are collected, which could be coded to determine the client's approximate geographic location. Although not the most efficient means of analysis, differences in client outcomes could be analyzed by socio-demographic and geographic factors.

The CTO-IR does not collect information pertaining to the ethno-cultural background of the client, such as whether the client is from a minority population (e.g. racialized communities, Indigenous communities, or Francophone community). As a result of this data gap, client outcomes cannot be measured against ethno-cultural factors.

[56] Mfoafo-M'Carthy, 2014.

4 CONCLUSIONS AND RECOMMENDATIONS

In answering the review questions, the 2019 review has come to a number of conclusions and has distilled a number of recommendations to better serve CTO clients. These conclusions and recommendations should be considered in light of the difficulties with data quality and with regard to the limited input from mental health advocates and groups representing diverse populations.

The number of CTOs issued, renewed and reissued in Ontario continues to grow. Although this growth may in part be due to increased awareness and acceptance of CTOs, it may also be due to factors that are concerning, such as issuing CTOs to free up hospital beds or to help clients gain priority access to stretched services. Further, it is unclear whether this growth is sustainable as the work load of CTO coordinators, the PPAO and the CCB continues to get heavier. The system that supports CTOs is struggling to meet demand with physicians and CTO coordinators perceiving CTOs to be an administrative burden.

Despite these concerns, the data from the CTO-IR found that, at least in the short term, clients on CTOs have reduced rates of hospitalization and interaction with the correctional system relative to the six-month period prior to the CTO. Longer-term outcomes are less clear such as impacts on clinical/medication situation, psychosocial outcomes, quality of life and satisfaction with care.

Although CTOs may be more accepted now then previously, especially among the mental health community, concerns around informed consent persist. Some clients and SDMs interviewed were concerned about a lack of personal agency, and some were aware of alternatives to CTOs. Mental health advocates continue to raise concerns about CTOs as a coercive practice. Further, many clients and their SDMs voiced concern about the side effects of their medication, with a few indicating that the side effects were not disclosed before they accepted a CTO. Concerns around consent must be viewed in light of the finding that the majority of CTOs are now issued through an SDM. Despite these findings, some clients and SDMs interviewed did not express feelings of coercion. These discrepancies may highlight the variation in how CTOs are communicated and managed across the province.

CTOs are an ongoing treatment mechanism. Rather than acting as a bridge to living in the community, clients that enter a CTO generally remain through multiple renewals. CTOs currently lack a discharge planning process. Although there are strict criteria to enter a CTO, there is no guidance to help physicians, clients and their SDMs understand when and how to discharge the client from one.

The effectiveness of a CTO depends on the community treatment plan on which it is based. That is, success is contingent on clients having access to mental health services and supports in the community. Clients in communities that lack service capacity or that do not offer required services may be ill served by a CTO. Clients and families who have regular and consistent connection with their treatment team, including having a number to call if they need support, stand a better chance of benefiting from a CTO.

However, those who have limited access to services, in particular, clients in rural communities, may be at a disadvantage.

The MoH aims to support CTOs through the CTO-IR, a record and data system intended to allow for province-wide analysis of CTOs. However, the data collected through the CTO-IR is incomplete. Further, the means by which data are stored does not allow for timely access for analysis. As a result, some of the core findings of this review were analyzed using data from other sources.

Given the growing number of CTOs and the perception that each is an administrative burden, the recommendations to improve CTOs often revolve around balancing efficiency with protecting the interests of clients. Other recommendations aim to address other issues that were identified by the review, such as mitigating the side effects of medication and improving the data being collected.

4.1. Recommendations to Improve CTOs

Given these findings, the review recommends the following:

1. Lengthen the CTO validity period for CTO renewals to a maximum of two years

It is clear from this review that the six-month duration of a CTO may be too short to be effective or efficient. In this regard, the review recommends that the MoH support a change to the legislation to extend the maximum duration of renewals to up to two years. Should it be desired by the physician, the client and their SDM, the duration could be set at any duration less than this, but the two-year maximum may be an appropriate way to promote effectiveness and efficiency, while still protecting the rights of clients. It should be noted that CTO duration is already set at longer periods in New Brunswick (one year) and Quebec (one to three years). The duration for the first issue and reissue would remain at six months.

2. Engage stakeholders in discussions about how the CTO process could be streamlined

The process of issuing, renewing or re-issuing a CTO involves a considerable number of administrative hurdles. Some stakeholders questioned specific requirements, such as the mandatory CCB hearing at every second renewal. From an administrative perspective, mental health professionals described those mandatory hearings as a considerable burden. From a clinical perspective, some physicians warned that the administrative burden may result in gaps in treatment at the expense of the clients. Hence, they spoke about the need to streamline the CTO process. From a rights perspective, the fact remains that those mandatory hearings are safeguards to ensure that clients' rights are respected. In light of all the above, the review recommends that the MoH engage stakeholders in discussions about how to streamline the CTO process while maintaining the best interests and rights of clients.

3. **Consider further defining the position of CTO coordinator**

CTO coordinators have an important role in the initiation and planning process of CTOs, particularly in assisting physicians to obtain consent from clients (and SDMs if any) and in developing community treatment plans. Although this review has no evidence to suggest that CTO coordinators lack the skills to complete these tasks effectively, little is in place to ensure that they do. Given that clients and SDMs must be considered particularly vulnerable groups in the mental health system, more could be done to close this gap. To potentially guide the hiring and development of CTO coordinators, the review recommends that the MoH consider whether the position of CTO coordinator could be further defined with respect to appropriate educational backgrounds (including areas of study and levels of attainment), ongoing training needs and desired competencies.

4. **Communicate more effectively with clients and SDMs, especially about medication side effects, and include side effect mitigation strategies in community treatment plans;**

Clear, frequent communication with a treatment team member, and mechanisms to ask questions are important for clients and families. Discussing CTOs in a way that clients and families understand, including framing the CTO as a safety net, may also help improve their experience with CTOs.

Clear communication is especially important when it comes to medication side effects, which are often a reason that client are unwilling to enter a CTO or do not adhere to their treatment plans. Some clients were not aware of potential medication side effects or potential strategies to mitigate those side effects. And in some cases, neither was their SDM.

The review recommends that the MoH work with the College of Physicians and Surgeons of Ontario, the Local Health Integration Networks and Ontario Health Teams to encourage:

- Additional support structures to help improve the communication between clients and families and their CTO treatment team. These structures could include more frequent meetings, a dedicated person to answer questions, or a hotline to call for information;
- Communicating possible side effects to clients and SDMs during the CTO issuance process; and,
- Including side effect mitigation strategies in community treatment plans.

5. **Consider the role of CTOs in the correctional context**

Interactions with the correctional system have a negative impact on CTO effectiveness. Stakeholders have indicated that history involvement with the correctional system affects whether a client is considered for a CTO. In addition, community treatment plans are discontinued while a client is in custody, which generally causes their mental health to deteriorate. These findings highlight a lack of collaboration between the mental health and correctional systems. The review recommends that the MoH further study the role of CTOs in the correctional context. More specifically, mechanisms need to

be identified to improve collaboration between the mental health and correctional systems, including the two provincial ministries that oversee them—in particular, so that CTO clients who are in custody can continue to receive the care they need.

6. Establish a standardized discharge process

No standardized discharge process exists. Physicians lack guidance when it comes to discharging a CTO client. Furthermore, some SDMs interviewed expressed concerns about clients' health condition in the aftermath of a discharge, owing to the lack of a standardized process. By comparison, the process of issuing, renewing or re-issuing a CTO is standardized. Therefore, the review recommends that the MoH support the discharge process by introducing client-centered guidelines for discharge and renewal.

7. Ensure the data system analyzes CTOs from a systemic perspective

All physicians and CTO coordinators issuing, renewing or re-issuing a CTO are required to complete the CTO-IR, which was designed to gather relevant information about all CTOs in Ontario, with the ultimate and sole purpose of informing the legislated review of CTOs. Yet, the CTO-IR could be improved to better serve this purpose. The review could not disentangle whether the lack of data is at the collection end (whether physicians and CTO coordinators are not collecting the data) or at the synthesis end (whether the records are not being entered into a province-wide database). In either case, the review recommends that the MoH take steps as soon as possible to ensure that the CTO-IR data are collected and processed in full, so that CTO data can be analyzed from a systemic and longitudinal perspective to inform future legislated reviews. As mentioned above, the new course may be a starting point in addressing this concern.

8. Collect ethno-cultural background information through the CTO Information Record

Few data are being collected to understand differences in the effectiveness of CTOs and client outcomes by ethno-cultural factors. While the CTO-IR form gathers some client socio-demographic information, it does not gather ethno-cultural information. As studying the effectiveness of CTOs by ethno-cultural factors is important to comprehend, the review recommends that the MoH add a question to the CTO-IR to collect ethno-cultural information.

9. Consider culture and language needs when working with clients on CTOs and their families.

Clients and families from immigrant, refugee and ethno-cultural communities require additional considerations to ensure they can be successful on a CTO. For example, involving the family in discussions related to the CTO, especially the treatment plan, may be culturally appropriate for some clients. In other situations, when the client or SDM are not fluent in English, it is important to consider the supports that can be provided (e.g. qualified interpreters). Considering the impact of culture and language will help ensure that the CTO process is equitable for all of those involved.

4.2. Recommendations for Future Reviews

As CTOs are to be reviewed every five years, the following recommendations are submitted to better focus the efforts of future reviews to understand the performance of CTOs in delivering positive outcomes for clients.

10. Pursue new review questions

The review has uncovered several areas that warrant further study, even if they do not neatly align with the existing review questions. Finding answers to these questions will enable the MoH to understand the role and trends of CTOs in Ontario more fulsomely. Therefore, the review recommends that further reviews also examine the following issues:

- Given the likelihood that most CTOs will be renewed, more research should be done on the factors that impact clients', SDMs' and physicians' decisions to renew a CTO.
- Given the increasing involvement of SDMs in CTOs, more research is necessary to determine whether SDMs are being increasingly involved to expedite implementation and whether clients that required an SDM for the initial issuance could consent on their own for renewals.

11. Allow more time for advocacy groups to formulate their inputs to CTO reviews

The review has attempted to engage as many stakeholders as possible, under the constraint of timelines and budget. Some advocacy groups indicated that the process was precipitous and would have needed for more time to prepare and give their input for the review. Given the importance of listening to these stakeholders, the review recommends that MoH allow future reviews more time to gather feedback, so that all stakeholders can be and feel part of the review process.

12. Send evaluation team members to interview clients in their environment

Attempts to recruit CTO clients to participate in the review were only somewhat successful. It has to be recognized that CTO clients are not a group that would be readily available and willing to engage in interviews, focus groups or surveys. Clients often lack the transportation or the tools required to participate in the review. For future reviews, it is recommended that MoH provide the means for future project researchers to go into the field to recruit and interview CTO clients, with the help of CTO coordinators. Perhaps researchers could work with ACT teams to meet CTO clients in their environment.

13. Hear from Indigenous groups and Francophone communities

The review attempted to engage service providers that work with Francophone and Indigenous communities. However, those efforts were not productive. To the extent that CTO experiences of clients from these diverse populations matter, the review recommends that the MoH provide the time and resources for these voices to be better heard.

APPENDICES

APPENDIX A. EXPERT INTERVIEW GUIDE (STANDARD VERSION)

Community Treatment Order Review
Stakeholder Interview Guide

Thank you for agreeing to participate in the review of the community treatment order (CTO). This is the third review of CTOs in Ontario and as such will cover the period from 2012-2019.

The Provincial System Support Program at CAMH, at the request of the Ministry of Health, issued a RFP for an independent review of community treatment orders (CTOs). R.A. Malatest and Associates was the successful proponent. R.A. Malatest & Associates Ltd., an independent research firm, will be conducting interviews, surveys and focus groups with CTO clients; family, friends, and substitute decision-makers; health care professionals; service/support agencies; law enforcement agencies; organizations representing stakeholder groups; and MoH decision-makers. The findings of the interviews will be combined with other feedback and presented in a report. The report will be made publicly available.

The purpose of our interview is to gather your unique insights on CTOs. We expect the interview to last approximately 60 to 90 minutes. Through this interview, we hope to learn from your experiences on:

- The reasons that CTOs were or were not used as a means of treating clients;
- The effectiveness of CTOs; and
- The method used to evaluate the outcomes of any treatments used under CTOs.

Confidentiality and Anonymity:	Please note that your participation in this interview is voluntary; you have the right to not answer any question, and you may withdraw from the interview at any time. Any information you provide will be kept confidential in accordance with the Privacy Act, will be used only for evaluation and research purposes, and will be reported in aggregate form. With your permission, the interview will be audio-recorded to ensure that your comments are captured in an accurate manner. The recordings will only be heard by evaluators at R.A Malatest & Associates Ltd.
Questions:	If you have any questions about the project, please do not hesitate to contact Derek Hughes, R.A. Malatest & Associates Ltd. at (toll-free) 1-888-689-1847 ext 105.

A. Involvement with Community Treatment Orders

1. What best describes your involvement with CTOs?

B. When to use a CTO

2. What factors affect psychiatrists' decisions to recommend a CTO?

3. What factors affect clients' decisions to accept one? What about SDMs?

4. What alternatives to CTOs are being used to support individuals with similar needs in the community? Should those alternatives be use more frequently? Less frequently?

5. Who is typically issued a CTO? What are their backgrounds, medical conditions and socio-economic characteristics?

6. Are you seeing more or fewer clients on CTOs? What would explain a change?

C. Balancing Treatment with Consent

7. Does the legislation appropriately balance the need for treatment with clients' interests?

8. Are clients able to consent to the CTO or do you think they lack real choice?

D. Treatment Plans and Services

9. What input do clients, as well as their family and friends, have in developing treatment plans?

10. Do clients get the services set out in the treatment plans?

11. Do clients frequently fail to adhere to their CTOs?
    - Do you feel that there are any factors that make it difficult for CTO clients to adhere to the CTO?
    - What helps CTO clients adhere with the CTO?
    - How should non-compliance be addressed?

E. Termination and Renewal

12. Is there a standard discharge planning process for CTO clients? To what extent is this process followed?

13. Are clients being renewed at appropriate times? Should more clients get renewed? Should fewer?

F. The effectiveness of CTOs during the review period

14. To what extent do CTOs support clients' day-to-day experiences and overall wellbeing?

15. What factors impact the effectiveness of CTOs?
    - How do clients' psychosocial and health characteristics impact effectiveness?
    - Is the CTO program effectively serving Ontario's Indigenous, rural, multicultural, and Francophone communities?

G. Methods used to evaluate the outcomes of CTOs

16. What outcomes of CTOs are currently being measured?

17. How are client outcomes being measured?
    - What effectiveness measures are in place?
    - Are the current methods of measuring outcomes valid and reliable?

H. Suggestions

18. Thinking back to our overall discussion, do you think any changes need to be made in how CTOs are being issued and administered? What do you think needs to change?

Thank you very much for your input.

APPENDIX B. FOCUS GROUP GUIDE (STANDARD VERSION)

Community Treatment Order Review

Focus Group with CTO Coordinators/Case Managers/Psychiatrists/Mental Health Care Workers – Moderator's Guide

Introduction	10 MINS

Welcome! I'd like to thank you all very much for being here. My name is [NAME] and I will be leading the group today. These groups are being held across the province as part of the third Community Treatment Order Review. I work for a research company called R.A. Malatest & Associates Ltd. The Provincial System Support Program at CAMH, at the request of the Ministry of Health and Long-Term Care, issued a RFP for an independent review of Community Treatment Orders or CTOs. R.A. Malatest and Associates was the successful proponent.

Our purpose today is to learn about your experience as a CTO coordinator or case manager/mental health professional and to find out how you feel CTOs are working or not working for clients. The findings of the focus group will be combined with other feedback and presented in a report. The report will be made publicly available.

The group will take about 2 hours in total but we will be taking a ten minute break.

Everyone here today is involved in the coordination or case management of CTOs/provision of mental health services. Some of you may know each other and some may not. Let's do a round table of introductions with first names only.

My main role today is to make sure the discussion stays on track and that everyone has a fair chance to contribute. Feel free to make any comments, negative or positive, about any of the things we will be discussing today. This is a free flowing discussion and there is no right or wrong answer.

Before we get started, I would like to take a few minutes to explain a few things about today's group discussion.

DISCLOSURES

Confidentiality. Everything that you say here will be kept strictly confidential. This means that nothing said in this group will ever be associated with anyone's name. Only the project team at Malatest will have access to this information and no-one will be identified in reporting the results of these discussions. I would also ask that you similarly maintain the confidentiality of what is said during the group discussion.

Voluntary participation. Your participation in this group is entirely voluntary. You may stop participating at any time. You do not have to answer any questions that you do not want to answer. You may step away from the group at any time with no consequences.

Recording. This session is being taped so that we can write an accurate summary of what was said—not of who said what. If there are any objections we will not tape the session.

[If observers: Briefly mention that colleagues are present to listen-in as they are very much interested in hearing their views.]

Is everyone comfortable with these points and with the discussion being recorded?

GROUND RULES

- Please talk one at a time in a voice as loud as mine.
- Avoid side conversations with your neighbours.
- We would like to hear from everyone in the course of the discussion, but you don't have to answer every question.
- Feel free to respond directly to someone who has made a point. You don't have to address your comments to me.
- Say what is true for you – we are not looking for any specific answer.

Does anyone have any questions before we continue?

Great! We have a lot to discuss so let's get started.

SERVICES AND CLIENTS — 5 MINUTES

I'd like to start the discussion by hearing about your experience as a CTO coordinator or case manager or psychiatrist.

1. What is your role in the CTO process?

2. What are some of the more common characteristics of the clients you serve (including gender, age, mental health issue, cultural background, urban/rural)? Do you offer services to equity groups like Indigenous, Franco-Ontarian or immigrant communities?

EXPERIENCE WITH CTOS	30 MINUTES

3. In what context are CTOs issued?

4. Are there any alternatives? Should those alternatives be followed more often? Less often?

5. Are you seeing more or fewer clients on CTOs? What would explain a change?

6. What input do CTO consumers, as well as their family/friends, have in developing treatment plans?

7. Do clients on CTOs get the services set out in the treatment plans?

8. Are clients able to consent to the CTO or do you think they lack real choice?

9. Do clients on CTOs frequently fail to adhere?
    a. Do you feel that there any factors that make it difficult for CTO consumers to adhere to the CTO? *[Prompts: access to services, lack of encouragement or support, location of services, duration of CTO too short, access to rights advice, etc.]*
    b. What helps CTO consumers adhere with the CTO?

10. Is there a standard discharge planning process for CTO consumers? To what extent is this process followed?

Great! Thanks everyone for sharing. Before we continue, let's take a 10 minute break.

OUTCOMES OF THE CTO — 30 MINUTES

Now let's talk a bit about if and how the CTOs worked or did not work for clients, based on what you have observed as part of your work.

11. During or after the completion of the CTO, what changes have you noticed? Were these positive or negative changes?
    - *Positive experiences may include: stability/stay out of hospital, support and attention, continued treatments, finding housing, completing education, reintegration, improved relationship with family/friends, less worry about loved one, etc.*
    - *Negative experiences may include: loss of personal autonomy, loss of control, created tension between family/friends and loved one, etc.*

12. What typically happens when the CTO ends? *[Prompts: is a new CTO in place, is the consumer rehabilitated / ready to move on, relapse, etc.]*

13. How do these outcomes differ by client characteristics such as sociodemographic, geographic, or ethno-cultural factors?
    a. Are their groups for whom CTOs are particularly effective?
    b. Are there groups for whom CTOs are particularly ineffective?

MEASURING SUCCESS — 10 MINUTES

14. How does your organization track progress of those on CTOs? How does it collect that data?

AREAS FOR IMPROVEMENTS TO THE CTO — 15 MINUTES

There may be some aspects of the CTO that you like and some that you do not like.

15. I would also like you to identify any priority actions/changes/modifications that you would like to see implemented that would make CTOs better (for physicians, for consumers, for substitute decision-makers, for coordinators and case managers, etc.).

WRAP-UP	5 MINUTES

That's all the questions that I had for you.

Great! Thanks everyone for sharing your experience with CTOs.

APPENDIX C. CLIENT INTERVIEW GUIDE (STANDARD VERSION)

INTRODUCTION

Thank you for agreeing to participate in this interview. My name is [NAME] and I will be conducting the interview today. I'm going to spend about 5-7 minutes explaining the interview before we begin the discussion. We are doing a number of these interviews with CTO clients across the province. The interviews are part of the third community treatment order review. Every so often, CTOs are reviewed to see how they are working for clients such as yourself. I work for a research company called R.A. Malatest & Associates Ltd and we are working with The Provincial System Support Program at CAMH, at the request of the Ministry of Health to conduct this review.

During this interview, I want to learn about your experience with the CTO and to find out how it's working or isn't working for you. The findings will be combined with other feedback and presented in a report. The report will be made publicly available.

The interview will take about 30-35 minutes and you will receive an incentive of $50.00 for participating. You will receive the incentive in the mail in about three weeks' time. If you have a pen and paper, I will give you an email and phone number that you can contact, if the incentive does not arrive by that time **[g.armitage@malatest.com, 1-888-688-1847 x 101]**

As I ask my questions, it is important to note that there are no right or wrong answers. Feel free to say anything, good or bad, about any of the things we will be talking about today.

DISCLOSURES

Prior to getting started with my first question, I want to say everything that you say will be kept **strictly confidential**. This means that nothing said to me will ever be associated with your name. No-one will be identified in reporting the results of these discussions.

Also, your participation in this interview is **entirely voluntary.** You may stop participating at any time. You do not have to answer any questions that you do not want to answer. You may end the interview at any time with no consequences.

Do you have any questions before we continue?

ACCEPTING A CTO

I'd like to start by hearing about your first experiences with the CTO.

1. What did you think when you first heard about the CTO? Did you think it was a good thing or a bad thing? Why?
   - *Positive aspects could include: support, access to services, desire to avoid hospitalization, satisfaction with previous CTO, etc.*
   - *Negative aspects could include: concerns with autonomy and dignity, dissatisfaction with decision-maker, not needed, pressure, etc.*

2. Who suggested a CTO as an option for you? [Prompts: psychiatric ward, family physician, assertive community treatment (ACT) team, friend or family member, etc.;]

3. Were there any other options? Which ones?

4. Did you agree to accept the CTO or do you think you had no choice?

5. Did your CTO involve a substitute decision-maker? Did you feel that the substitute decision-maker had your best interests in mind when it came to the CTO?

6. Were you involved in developing your treatment plan? Did you feel like you were part of the decisions?

LIFE WITH A CTO

7. Would you say that it was easy to follow the CTO or would you say that it was hard? Why? *[Prompts: access to services, lack of encouragement or support, location of services, duration of CTO too short, access to rights advice, etc.]*
   a. Was there anything that made it hard for you to follow your CTO?
   b. What has helped you remain or complete the CTO?

8. Now let's talk a bit about if and how the CTO worked for you or did not work for you. There may have been some good changes, no changes, or even bad changes to your life.
   - *Positive experiences may include: stability/stay out of hospital, support and attention, continued treatments, finding housing, completing education, reintegration, etc.*
   - *Negative experiences may include: loss of personal autonomy, loss of control, etc.*

9. There may be some things that you like about the CTO and some that you do not like. If you were in charge, what would you change to make the CTO better? What would you keep the same? Let's start with what you would change.

WRAP-UP

That's all the questions that I had for you.

For the incentive:

1) Is it OK if I send a cheque? **[EXPLAIN THAT WE PREFER TO SEND A CHEQUE BUT UNDERSTAND IF THEY DO NOT HAVE ACCESS TO A BANK ACCOUNT]**

   Yes

   No **[Send cash]**

2) Can you please provide me with a mailing address to send the incentive? Also, if you have an email or phone number, please provide that as well.

_____

_____

_____

_____

_____

_____

APPENDIX D. ONLINE SURVEY QUESTIONNAIRE

INTRODUCTION

The Provincial System Support Program at CAMH, at the request of the Ministry of Health, issued a RFP for an independent Review of Community Treatment Orders (CTOs). R.A. Malatest and Associates was the successful proponent. This is the third review of CTOs in Ontario and as such will cover the period from 2012-2019.

We hope that you can help by sharing your knowledge and experiences. Anyone with an interest in CTOs 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. The findings of this survey will be combined with other feedback and presented in a report. The report will be made publicly available.

No one outside of R.A. Malatest & Associates Ltd. will have access to individual responses. Responses will remain strictly confidential and will be reported in aggregate form only. For more information on privacy please read our policy by clicking here.

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 would like to complete it over the telephone please call 1-855-688-1137. If you have any questions, ask for Jesael Lisiecki. You can also email him at j.lisiecki@malatest.com.

• INVOLVEMENT WITH COMMUNITY TREATMENT ORDERS

- Which of the following <u>best</u> describes your involvement with CTOs:
  - ❍ Client->skip to Part B
  - ❍ Family/friend->skip to Part C
  - ❍ Substitute decision-maker >skip to Part C
  - ❍ Psychiatrist - [all remaining options skip to Part D]
  - ❍ Other physician
  - ❍ CTO coordinator
  - ❍ CTO case manager
  - ❍ ACT team member
  - ❍ Community mental health worker
  - ❍ Inpatient mental health worker
  - ❍ Lawyer
  - ❍ Client advocate
  - ❍ Consent and Capacity Board member
  - ❍ Mental health researcher
  - ❍ Government representative
  - ❍ Student
  - ❍ Police representative
  - ❍ Other (please specify)_____

• PART 1: QUESTIONS FOR CLIENTS

- How many CTOs have you been issued?
  - ❍ 1
  - ❍ 2-5
  - ❍ More than 5
  - ❍ Prefer not to answer

- 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
  - ❍ Prefer not to answer

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

(Select all that apply)

- ☐ Hospital inpatient
- ☐ Hospital outpatient
- ☐ Hospital leave of absence
- ☐ ACT Team (Assertive Community Treatment)
- ☐ 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)_____
- ❍ None of the above (x)
- ❍ Prefer not to answer (x)

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

	Agree	Neutral	Disagree	Prefer not to answer
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 was able to adhere to the treatment plan	❍	❍	❍	❍
My treatment plan included medication that had bad side effects	❍	❍	❍	❍
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]

- Do you know of any other treatment options other than hospitalization and CTOs available in your community?
  - _____
  - No comment
  - Prefer not to answer

- Do you have any comments to make about the effectiveness of your CTO?
  - _____
  - No comment
  - Prefer not to answer

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

	Not concerned	Somewhat Concerned	Very concerned	Prefer not to answer
The amount of choice I had when issued with a CTO	❍	❍	❍	❍
My rights under a CTO	❍	❍	❍	❍
The availability services I need in my community	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

GO TO PART E

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

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

	Agree	Neutral	Disagree	Prefer not to answer
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	❍	❍	❍	❍
They were able to adhere to the treatment plan	❍	❍	❍	❍
Their treatment plan included medication that had bad side effects	❍	❍	❍	❍
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]

- Do you know of any other treatment options other than hospitalization and CTOs available in your community?
  - _____
  - No comment
  - Prefer not to answer

- Do you have any comments to make about the effectiveness of CTOs?
  - _____
  - No comment
  - Prefer not to answer

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

	Not concerned	Somewhat concerned	Very concerned	Prefer not to answer
The amount of choice my family member/ friend had when issued with a CTO	❍	❍	❍	❍
My family member/ friend's rights under a CTO	❍	❍	❍	❍
The availability of needed services in my family member's community	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

GO TO PART E

• PART 3 – ALL OTHER GROUPS

- Have you signed a CTO or community treatment plan as a physician, community mental health worker or other health practitioner?
  - ❍ Yes
  - ❍ No
  - ❍ Prefer not to answer

Ask D2 if D1=Yes

- Please indicate how many CTOs you have signed?
  - ❍ 1
  - ❍ 2-5
  - ❍ More than 5
  - ❍ Prefer not to answer

- To what extent are the following limiting the use of CTOs in Ontario?

	Very important	Somewhat important	Not important	Prefer not to answer
Level of knowledge and 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 supervising a CTO client	❍	❍	❍	❍
Insufficient community resources available for clients on CTOs	❍	❍	❍	❍
Concerns regarding compensation and liability	❍	❍	❍	❍
Potential negative impact on the relationship between client and their service provider	❍	❍	❍	❍
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]

- To what extent are the following supporting or encouraging the use of CTOs in Ontario?

	Very important	Somewhat important	Not important	Prefer not to answer
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]

- What alternatives to CTOs are being used to support clients in your community?
  - _____
  - No comment
  - Prefer not to answer

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

	Agree	Neutral	Disagree	Prefer not to answer
The CTO program is effectively serving the following communities:				
• Aboriginal communities	❍	❍	❍	❍
• Rural communities	❍	❍	❍	❍
• Ethno-cultural communities	❍	❍	❍	❍
• Racialized communities (i.e. visible minorities)				
• 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 client	❍	❍	❍	❍

[PROGRAMMING NOTE: ROTATE STATEMENTS]

- Do you have any comments to make about the effectiveness of CTOs?
  - _____
  - No comment
  - Prefer not to answer

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

	Agree	Neutral	Disagree	Prefer not to answer
The rights of CTO clients are adequately protected	❍	❍	❍	❍
Clients are advised of their rights	❍	❍	❍	❍
The legal safeguards in the legislation are appropriate	❍	❍	❍	❍
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 noncompliance are satisfactory	❍	❍	❍	❍
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]

- Do you have any comments to make about CTO management and administration?
  - _____
  - No comment
  - Prefer not to answer

- **YOUR VIEWS**

- Please provide us with any thoughts about CTOs that have not already been covered
  - _____
  - No comment
  - Prefer not to answer

- **INFORMATION ABOUT YOU**

- I am
  - ❍ Male
  - ❍ Female
  - ❍ Trans/non-binary
  - ❍ Other (please specify)_____
  - ❍ Prefer not to answer

- My age is:
  - ❍ Under 30
  - ❍ 31-60
  - ❍ Over 60
  - ❍ Prefer not to answer

Based on the map above, what health region do you live in?

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

❍ Outside Ontario (specify)_____

❍ Prefer not to answer

• SURVEY CLOSING

[ASK IF QA1 = 1.Client or 2.Family/friend or 3.Substitute decision-maker]

G1. As part of this review of CTOs, we are holding discussions with people involved with or affected by CTOs. We would like to invite you to one of these discussions. The discussion will last for about two hours. We will cover your costs in attending the meeting up to a total of $50.00.

Would you agree to participate in this discussion group?

❍ Yes

❍ No

If yes

2. A member of our research team will contact you to confirm the time and date of the discussion. Could you provide us an e-mail address and a phone number where is it possible to reach you?

○ _____

○ Prefer not to answer

[SURVEY IS SUCCESSFULLY COMPLETED]

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

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