The Role of Community Treatment Plans in Community Treatment Orders

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Community Treatment Orders (CTO) were introduced in Ontario in December 2000 as a means of providing a comprehensive plan of community supervision and treatment to a person suffering from a serious mental disorder. The CTO was meant to combat the "revolving door" pattern of admissions to hospital for patients who deteriorate in the community following discharge and can provide an alternative to ongoing detention in a psychiatric facility, provided certain legislated criteria are met.

Relationship between a CTO and a Community Treatment Plan

A CTO compels a person to attend appointments with their physician or other health-care practitioners and requires the person's compliance with obligations set out in a Community Treatment Plan (CTP). To be validly issued or renewed, a CTO must satisfy all of the substantive and procedural requirements in section 33.1 of the *Mental Health Act*. The substantive criteria for a CTO include, among others:

- the development of a CTP; and
- the requirement that a physician conduct an examination of the person within 72 hours before entering into the CTP.

Procedural safeguards to protect the patient's rights include:

- a physician giving a copy of the CTO to the person and to the Officer in Charge;
- rights advice being provided to the person or their substitute decision maker; and
- obtaining consent to the CTP from the person or their substitute decision maker, if the person is incapable with respect to treatment.

A CTP is a separate and distinct instrument from a CTO in that revocation of a CTO by the Consent and Capacity Board (Board) does not automatically extinguish the CTP. A CTP, however, must be completed in compliance with the *MHA* provisions in order for a CTO to be confirmed by the Board. According to section 33.7 of the *MHA*, a CTP must contain at least the following:

1. a plan of treatment for the person subject to the CTO;
2. any conditions relating to the treatment or care and supervision of the person;
3. the obligations of the person subject to the CTO;

4. the obligations of the substitute decision-maker, if any;
5. the name of the physician, if any, who has agreed to accept responsibility for the general supervision and management of the community treatment order, if different from the issuing physician; and
6. the names of all persons or organizations who have agreed to provide treatment or care and supervision under the community treatment plan and their obligations under the plan.

In other words, a CTP outlines the obligations of a person while living in the community during the period that a CTO compels the person to engage in community treatment and supervision.

Oversight and Review

Similar to patients whose liberty interests are affected by other *MHA* forms (*i.e*., a Form 3 detaining someone involuntarily in hospital), patients who are the subject of a CTO, or Form 45, have the right to apply to the Board to review the validity of the CTO. The review provides an important safeguard to a patient's rights by ensuring that the criteria outlined in section 33.1(4) have been met when a physician issues or renews a CTO.

A person who does not adhere to the conditions in their CTP can be forcibly returned to hospital by the police for an examination by the issuing physician. In cases where the Board has reviewed CTOs, the Board has stated that

"[t]he legislation must be interpreted in terms of the consequences for the person *subject to the CTO: the greater the consequence, the greater the clarity required in the terms of the Community Treatment Plan*."

As being forcibly returned to hospital is a serious restriction on the person's liberty, the Board requires that for a CTO to be upheld, the terms of the CTP must not be vague, overbroad or confusing to the person. The person must be able to understand their obligations and the consequences for failing to comply with those obligations based on a "plain reading of the CTP and CTO".

Recently, where the Board has found that a CTP contains vague or overly broad terms, it has revoked the CTO. For example, in three recent decisions made by differently constituted panels, the Board found the CTP obligations with respect to medications unclear.

In *Re SS* (June 2018), the Board found that on a plain reading of the CTP, it was unclear what SS's responsibilities were. The CTP allowed the doctor to substitute, discontinue, add or change the dosage of "medication for which SS was incapable". The CTP also required the person to take medications as prescribed. As capacity is treatment and time specific, this condition could result in a situation in which SS refused a prescribed medication and even if he was capable of refusing that medication, he could be forcibly brought back into hospital. The Board revoked the CTO on the basis that the CTP was "vague, confusing and overly broad."

Similarly, in *Re JD* (May 2018), the Board considered a clause of the CTP requiring JD to "take his medications" as prescribed by his physician or delegate; a list of possible medications was included. The panel found this provision too vague and, in its decision,

stated very clearly, that CTPs “must be as specific as possible or they run the likely risk they will be found to be vague and overly broad.” In the result, the Board revoked the CTO.

In *Re TMP* (October 2017), the CTP required TM to take “psychotropic medications” and included the names of two antipsychotic medications. Although the two antipsychotic medications were listed and the physician clearly stated that he had no intention of adding other psychiatric treatment, the panel still found that the CTP was drafted in such a way that it left open the possibility that any other psychiatric treatment could be started. The Board emphasized that the CTP must be specifically tailored to the person so that the person can understand the associated obligations.

Although Ontario CTOs are almost 20 years old, the Board is still refining its interpretation of the provisions in the *MHA* with respect to CTOs and CTPs. In addition to the specificity required of conditions in a CTP, the Board has also highlighted that the procedural requirements of the *MHA* are not mere technicalities but are “important safeguards for the protection of vulnerable persons and must be applied rigorously.” Going forward, physicians, CTO coordinators and psychiatric facilities should bear this in mind when crafting CTPs and issuing CTOs.

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