COMMUNITY TREATMENT ORDERS: ETHICAL PRACTICE IN AN ERA OF MAGICAL THINKING

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ABSTRACT

With the passage of legislation in June 2000, coercive measures in the form of community treatment orders (CTOs) have become part of the community mental health landscape in Ontario. Given that community practitioners place a high value upon their ability to create voluntary and egalitarian partnerships with clients, the question of whether ethical practice is possible under conditions of legislated coercion is relevant. Based upon a review of the pro and con arguments that preceded CTO legislation, followed by an examination of available research on effectiveness, this paper suggests that forms of magical thinking have been at work on both sides of the CTO debate. A broader definition of coercion is proposed—one that envelops both overt and covert forms. Finally, the author offers an approach to ethical practice which is based on the use of transformative power rather than coercive power, and which includes a 3-step strategy (using liberation tactics, proactive contracting, and procedural justice).

INTRODUCTION

In Ontario, community mental health practitioners have a long history of working with clients who have sought treatment on a voluntary basis. In this form of relationship, there are many opportunities for practitioners to develop egalitarian partnerships with clients. Our community ethos is skeptical about the forms of legislated coercion which are associated with hospital-based psychiatry. Involuntary commitment, forced medication, and mechanical restraint are most often seen by community practitioners as disempowering, humiliating, or even hurtful (Everett, 1994).

In June 2000 the Conservative government of Ontario passed legislation which broadened the powers of the Mental Health Act and provided for community treatment orders (CTOs) (Ontario, 1990). CTOs outline a legal process through which certain people who have been designated as mentally ill are forced to comply with physician-ordered treatment plans while living outside hospital. Those people who do not comply with their treatment plans may be returned to hospital for

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* Note dthat the opinions expressed in this paper are those of the author and do not represent official policy of the CMHA-ON.

psychiatric assessment and possible re-admission (Boudreau & Lambert, 1993a). Even though CTO laws are consent-based—meaning that consumers must agree before being placed under orders—their coercive nature is seen as a threat to the community mental health sector's firmly held values of egalitarianism and partnership. The effect of CTOs in Ontario will not be known for some time; however, community mental health practitioners are already questioning whether ethical practice is possible under conditions of legislated coercion.

In this paper, I briefly review the arguments for and against CTOs. Even though the swift passage of legislation has stilled debate, the opposing value-laden perspectives are critical to a consideration of ethical practice. I then examine research evidence from jurisdictions in which CTOs already have been imple-mented to explore their efficacy. Based on the debate surrounding CTOs and the results of this review, I then: (a) suggest that certain forms of "magical thinking" have been at work on both sides of the issue; (b) propose a broader definition of coercion (one that takes into account the deeper dynamics of power and encom-passes both legally sanctioned and more-invisible, covert forms of coercion); and, (c) offer an alternative approach to ethical community mental health practice (which openly acknowledges the power differential between professionals and clients, emphasizes transformative power as opposed to coercive power, and intro-duces a three-step practice strategy).

THE DEBATES

Not surprisingly, debate about the increase of coercive measures in CTOs is intense. Opinions are polarized, and arguments have the kind of emotionality which surrounds other highly controversial issues such as abortion or the death penalty. People are either for or against CTOs; no middle ground seems possible.

Boudreau and Lambert (1993b) were among the first to identify the curious reality that both the pro and the con sides of the CTO debate employ the same, or similar, words to which are ascribed different, unshared meanings. They suggest that each side has blind spots and, as a result, are "talking past each other" (p. 84). Figure 1 expands on their work and illustrates the point further.

In substance, the arguments for and against CTOs are wide-ranging and complex; in thematic underpinnings, however, they are consistent.

The pro side of the debate adheres to what is called a *parens patriae* philosophy (Boudreau & Lambert, 1993b), which holds that society has a duty to care for those who won't or can't care for themselves—even if help must be forced upon them. From this vantage point, the essence of mental illness is the suspension of rational judgment: for certain seriously mentally ill persons who have lost the capacity to decide what is best for themselves, society must intervene and impose its will upon them "for their own good."

The con view is based on a civil libertarian ethic, wherein individual liberty is to be held sacrosanct unless the Rule of Law is violated (Boudreau & Lambert, 1993b). Thomas Szasz (1974), who argued that mental illness is a myth, is perhaps the best known civil libertarian in the field. However, in contemporary times,

FIGURE 1

Pro CTOs	Con CTOs
Autonomy Clients are autonomous when they are free of symptoms (CAMH Medical Advisory Committee as cited in CAMH, 2000).	**Autonomy** Clients are autonomous when they are free of coercion (Weitz, 2000).
Compassionate Clients who so obviously need help are being neglected and need CTOs to keep them safe and well (Connell, 1998).	**Compassionate** Forcing treatment only adds to the trauma clients have experienced (Queen Street Patient's Council as cited in CAMH, 2000).
Protection of rights Clients have the right to access psychiatric treatment (Schizophrenia Society of Ontario and the OMA Psychiatry Sub-section as Cited in CAMH, 2000).	**Protection of rights** Clients are free citizens and they have the right to refuse treatment even if it actually were good for them (Boudreau & Lambert, 1993a).
Least restrictive Clients, who would not otherwise, will be able to live in the community (Fielding, 2000).	**Least restrictive** The least restrictive answer is to allow clients to retain control over their own lives (Queen Street Patient's Council as cited in CAMH, 2000).
Humane Without CTOs, clients will continue to end up in the criminal justice system or be abandoned to homelessness and hunger by an uncaring community (Schizophrenia Society of Ontario as cited in CAMH, 2000).	**Humane** Forcing treatment is inherently inhumane and leads to all sorts of abuses (Weitz, 2000).
Best route to help Clients who are ill can't judge what is best for them and it is the state's job to see that they receive help—typically in the form of medication (Volpatti, 1998).	**Best route to help** Clients will actually avoid going for help if they know there is the possibility that they could be placed under a CTO (Higgins as quoted in Mallan, 2000). Medications don't solve people's problems—in fact, they can add to them (Weitz, 1999).
We need more options The present Mental Health Act does not allow for the kind of options CTOs would provide (OMA Psychiatry Sub-section as cited in CAMH, 2000).	**We need more options** What clients really need are housing, jobs and adequate levels of income (MDAMT, 2000; CMHA, 1998; Chambers, 1998).
Keeps the public safe Clients under CTOs will get the help they need which will diminish the possibility of dangerousness (Lamb, 1999, Mallan & Boyle, 2000).	**Keeps the public safe** It is a myth that people with mental illness are dangerous and that psychiatrists can predict dangerousness. Safety for everyone depends on treating clients with respect and dignity (Chambers, 1998).

disability groups cast their advocacy in the less extreme terms of citizen rights and civil liberties (Gadacz, 1994) and, in the specific case of consumers and psychiatric survivors, argue forcefully against psychiatry's legally sanctioned powers as an infringement upon individual rights and freedoms (for example, see Everett, 2000; Supeene, 1990; Chamberlin, 1978) .

The debates that surround CTOs frequently invoke the question, "Does society have the right to use force to obtain its ends?" The answer has traditionally been, "Yes, but only under conditions of threat." Therefore, a critical factor in Ontario's coercive response to the mentally ill is the perceived threat of danger. It is a well-established fact that the mentally ill, as a group, are less dangerous than the gen-eral population (Arboleda-Florez, Holley, & Crisanti, 1996; Monahan & Arnold, 1996). Further, it has been established that the mentally-ill are far more likely to be victims than aggressors (Roeher Institute, 1995). Nonetheless, public fears, fuelled by misunderstanding and stigma, run deep and require little incentive for ignition.

CTOs received a substantial boost in public support as a result of a series of widely publicized acts of aggression committed by mentally ill persons. In 1995, Brian Smith, a well-known Ottawa sportscaster, was shot and killed by a person deemed mentally ill (Mallan & Boyle, 2000). In March 1997, Zachary Antidormi, a two-year-old Hamilton boy was stabbed to death by his mentally ill neighbour for whom family members had tried unsuccessfully to get help. And, in September 1997, a man with an extensive history of mental illness pushed Charlene Minkow-skie, a young woman picked at random, in front of a Toronto subway train (Mal-lan, 2000).

A much less clear case was the1997 death of Edmund Yu, who was shot by police on a Toronto city bus after assaulting a woman and brandishing a small hammer. In similar situations in the past (such as the 1988 shooting of Lester Donaldson which resulted in charges of manslaughter against police officer, David Deviney), police have been severely criticized for the use of deadly force when confronting a mentally ill person. However, heightened conditions of public fear coupled with a neoconservative, law-and-order political climate caused the media to interpret the death of Edmund Yu (and others like it) as largely the victim's own fault (Cordileone, 2000). According to public/media opinion, if Edmund Yu had taken his medication, attended his appointments, and kept his housing, he would be alive today.

These sorts of cases became the basis for a strong political push for CTOs. Elizabeth Witmer, the Ontario Minister of Health and Long-term Care, stated: "We are now following through on our Blueprint election commitment to make sure that people with serious mental illness who pose a danger to themselves or to others are getting the treatment they need" (Ontario, 2000).

THE RESEARCH

Present government policy in Ontario calls for evidence-based best practices, meaning that models of treatment and service approaches must have a body of research attached to them which demonstrates efficacy (Ontario, 1999a & 1999b). Therefore, it is important to determine whether CTOs prevent dangerousness and get people the treatment they need.

The following brief review of available research offers ambiguous answers. Thirty-eight states plus the District of Columbia in the US have CTO legislation (Swanson et al., 2000). In Canada, only Saskatchewan has fully implemented CTOs and, to date, they have been used in a limited fashion (O'Reilly, Keegan, & Ellias, 2000). CTOs in North Carolina were instituted in 1973 (Fernandez & Nygard, 1990) and, therefore, are the most studied.

In describing a proposed model for assessing efficacy, Swanson et al. (1997) suggest that there is some speculative evidence that CTOs may improve long-term outcomes for clients. These authors argue that compliance with treatment is only one of the expected benefits. Other effects may be a stimulation of efforts on the part of case managers and the indirect mobilization of other supports (such as housing, family supports, and attention from psychiatrists and other clinicians) which can be critical to positive outcomes. While the many debates for and against CTOs base their cases exclusively on the supposed effects on clients, this research indicates that service providers and family members, too, will be impacted by CTOs.

In more recent research from North Carolina, Swartz et al. (1999) and Swanson et al. (2000) instituted randomized studies that examined measures of recidivism and dangerousness between control groups and patients placed under outpatient commitment orders. Both studies found no difference in either measure between those who were not under orders and those who were. However, when randomization was abandoned and CTOs were studied from the perspective of duration (clients under orders for less than versus more than 180 days), Swanson et al. (2000) found that clients under CTOs for longer than 180 days showed a reduction in violent behaviour. Similarly, when Swartz et al. (1999) abandoned randomization and looked at duration, they found that patients under orders for more than 180 days returned to hospital less frequently.

Researchers have also studied patients in Massachusetts, a state which does not have CTO legislation but which allows for involuntary outpatient treatment under an extension of its incompetence and guardianship laws. In this context, those judged incompetent to make treatment decisions can be detained by police and transported to a psychiatric facility where medication can be administered forcibly. During the two years following the implementation of this process, 20 pa-tients were found to have reduced their in-patient use markedly. However, matched control subjects showed a similar decline in use of in-patient resources, leading to non-significant results (Geller, McDermeit, Grudzinskas, Lawlor, & Fisher, 1997; Geller, Grudzinkas, McDermeit, Fisher, & Lawlor, 1998).

In an international review of CTO outcomes, McIvor (1998) found: (a) little evidence that CTOs achieve their clinical goals, (b) no guidelines describing which patients might do well under CTOs, and (c) no standardization in either legislation or application. An Israeli study (Durst, Teitelbaum, Bar-El, Shlafman, & Ginath, 1999) produced somewhat more positive results. These authors found that, out of 326 orders served, 43.3% were seen to have prevented hospitalization, 32.5% resulted in admissions despite the order, and 22.1% of cases achieved only partial success.

In general, the research on CTOs suffers from a number of problems:

1. CTOs have been instituted in a limited fashion in the United States and hardly at all in Canada. Where they exist, they are reported to be poorly understood and under-utilized (Torrey & Kaplan, 1995; Miller, 1992).

2. Available research often suffers from a number of methodological limitations which render findings suspect (Swartz et al., 1997).

3. CTOs constitute only one out of many variables that can affect outcomes (Fernandez & Nygard, 1990).

4. CTOs are expressed in a variety of legal iterations so there is no homogeneity of application and, thus, the expectation for uniform results is reduced (Swartz et al., 1995).

5. What little we know of CTOs indicates that they are difficult to enforce (Torrey & Kaplan, 1995). While both sides of the debate assume force as a central component, there is little evidence that force is actually being used. In fact, in North Carolina, the legislation expressly prohibits the use of physical force for detention or to obtain medication compliance (Borum et al., 1999).

6. The potential effectiveness of this sort of coercive measure is almost impossible to assess when it is instituted in areas where there are inadequate services, a circumstance which leaves clients unable to comply, even if they want to (Diamond, 1995).

In summary, research regarding the efficacy of CTOs is limited and tends to raise more questions than it answers. Nevertheless, among those who favour CTOs, the belief that positive outcomes eventually will be forthcoming remains strong.

MAGICAL THINKING

Rosen (as cited in Diamond, 1995) argues that certainty exists only upon the high plain of intellectual debate. Down in the "swamp," where real life is lived and where community mental health practitioners and clients interact, conditions are murkier. Here, questions do not have clear answers, interests compete, and decisions are difficult.

"Magical thinking" is a leap-of-faith process which does not acknowledge nuances and complexities and, instead, leads to unshakable conclusions based on belief rather than fact. While there is substance on each side of the CTO debate, both factions appear to have engaged in forms of magical thinking.

Fuelled by fears for public safety and rationalized by an ethic of "doing good," the belief among those who support CTOs is that they will protect society from dangerous mental patients, get treatment for those who routinely refuse help, and reduce the need for hospitalization. However, no one knows for sure whether CTOs are capable of satisfying this list of objectives. Magical thinking is also at work when proponents of CTOs ignore the reality of Ontario geography and services patterns. Most regions of the province lack adequate mental health services and community supports, meaning that clients in these under-serviced regions literally cannot comply with CTOs.

Magical thinking is also part of the landscape for those who oppose CTOs. The reality is that some clients *do* discontinue their medications and experience damaging relapses. Some may make decisions which place themselves or others in

harm's way, yet do not meet the criteria for involuntary admission. Clients may reject treatment plans, even when they are offered repeatedly and take preferences into account. And, finally, family demands for increased supervision and monitoring may seem entirely sensible when clients are assaultive in the home or when their risk behaviours are extensive (i.e., serious self-harm, eviction from housing, uncontrolled substance use, unsafe sexual practices, and repeated exposure to sexual or physical assault) (Diamond, 1995).

Second, the role of coercion in the mental health system is a more complex matter than opponents' arguments acknowledge. Magical thinking is at work when the con side of the CTO debate concentrates exclusively on legislated coercion and ignores other forms. There are, in fact, numerous ways that community mental health practitioners (and other service providers) place coercive pressures on clients seeking compliance and conformity (Monahan et al., 1995). Assertive Com-munity Treatment (ACT) teams are a case in point. True to their name, these teams have a mandate to pursue clients assertively into their homes and communities and to form relationships with their families and others in order to develop an encircling wall of covert coercion designed to ensure compliance with medication and treatment plans (Diamond, 1995). While it can be argued that these activities are less invasive than CTOs and they, too, are for clients' own good, they are nonetheless a form of coercion. Figure 2 below illustrates other covert coercive tactics which occur from time to time (for further discussion, see Roeher Institute, 1995). The reality is that community mental health services are not free of coercive

FIGURE 2

Overt Coercion	Covert Coercion
Involuntary commitment and treatment	Denial of service or opportunity
Mechanical or chemical restraint	Threats of withdrawal of service
Mandatory reporting of suspected child abuse	Withholding privileges, information or resources
Mandatory drug testing	Assertive persuasion
Mandatory substance abuse treatment	Taking over the management of money or medication
Eviction from housing	Restricting movement, access, visitations, guests
Denial of financial assistance	Ghettoizing
Court-ordered assessments	Ignoring clients' views
Apprehension of children through Child Welfare	Judgemental comments on suitability of partners or sexual practices
Judgements regarding competency	Not taking action
Community treatment orders	Encircling clients with web of pressure from friends, relatives, and other professionals

measures and there are additional forms of coercion other than overt legalized versions.

In addition, legal coercion is surrounded by: (a) checks and balances against excessive or inaccurate use, (b) mechanisms for monitoring it, and (c) usually the right of appeal. Covert tactics, on the other hand, are unmonitored, indirect actions that also seek compliance, but in ways which are less visible and, therefore, are much harder for clients to detect, avoid, or protest.

Another example of magical thinking is the assumption that clients inevitably will oppose the application of coercion. On the contrary, in a review of research on involuntary admission, Monahan et al. (1995) found that 69% of patients committed involuntarily reported that it was fortunate that they had been forced into hospital, 54% said they would likely seek hospitalization again if they were to find themselves in difficulty, and 80% reported being helped. In addition, in North Carolina research, Borum et al. (1999) studied 306 clients about to be placed under CTOs and found that 75% of subjects believed that CTOs made it more likely that they would be able to stay out of hospital.

Research also suggests that, for clients, it may be the *process* by which coercive measures are applied that is most disturbing. Monahan et al. (1995) found that 27% of patients felt that involuntary admission was embarrassing, 41% said it was unpleasant, 46% characterized it as depressing, and 29% felt degraded. In a qualitative study of consumers and psychiatric survivors, Everett (2000) found that humiliation during the process of involuntary commitment was a key ingredient in the formation of a political activist identity. Further research has shown that coercion can also result in negative feelings in patients, pessimism regarding treatment outcomes, and a breach in the trust between professional and client (Kaltiala-Heino, Laippala, & Salokangas, 1997).

The Dangers of Magical Thinking

The danger in adopting the magical thinking of CTO supporters is that CTOs could be implemented without sufficient evaluative scrutiny. Without outcome data, there would be no method by which to monitor regional differences, to mod-ify CTOs if they were only partially effective, or to abandon them if they did not work. In addition, advocacy efforts for other valuable supports such as housing or job programs could wane or become even less effective. Government could come to believe that it has responded adequately to the complex needs of the seriously mentally ill with a one-size-fits-all solution.

On the other hand, the danger of adopting the magical thinking of CTO opponents is that continued resistance to the existence of CTOs could impede the development of effective and ethical community mental health practices designed to help those clients who are at risk for, or who will be placed under, such orders. In addition, covert coercion could continue to constitute an unchecked, invisible, and unmonitored tactic. Without CTOs, covert coercion could be used in the face of clients' very real and sometimes intractable problems, and could be invoked without regard for its potential for harm.

ETHICAL PRACTICE

One of the most important foundations of ethical practice is an acknowledgement of power, and the power differentials which are inherent in helping relationships.

Coercive Power Versus Transformative Power

Aversion to CTOs stems, in part, from the myth that the exercise of power is almost always bad. This belief is based on a narrow understanding of only one form of power, power-as-dominance. We can be forgiven for this narrow view because many of our historical and present-day social and political structures are based on the dynamics of dominance (Gil, 1996).

Wartenberg (1990) postulates three levels of dominance:

1. *Life-or-death struggle*. This violent conflict reveals dominance in its most basic form. In this form of dominance, only one protagonist can survive the encounter.

2. *Coercion*. This level of dominance tends to be the most prevalent in modern society. Coercion is the overt threat of violence or other noxious sanctions, often legislated, which serves to maintain the formal structures of dominance. Coercive threats reduce the need for actual violence and are considered socially less costly than are the conflicts manifested in life-or-death dominance models.

3. *Hegemony*. This form of dominance is the control of others through ideas and beliefs which support the dominant agenda. The essence of hegemonic power is that it is covert and largely invisible—those who dominate, as well as those who are dominated, believe that inequity is simply the way things are (Wartenberg, 1990). "We are oppressed from without by a society which does not value us and therefore does not give priority to our needs, and we are oppressed from within because we have internalized those same attitudes towards ourselves" (Wooley as quoted in Prilleltensky & Gonick, 1996, pg. 134).

Both overt and covert forms of coercion exist in the mental health system, and both have the potential for harm. Any form of coercion is harmful when its application is: (a) invisible or denied; (b) falsely justified; (c) in service of robbing clients of their own initiative; (d) severing clients from the consequences of their own actions; (e) unilateral, unfair, incorrect, or without explanation; (f) without an opportunity for clients to have their say; (g) for the convenience of the practitioner and/or his or her agency; or (h) without appeal, second chance, or way out.

Power-as-dominance is only one form of power and it is, by far, the least desirable. In fact, power is not exclusively bad, nor is it a "thing" that can be given, taken away, or shared. Instead, it is relational; it operates in all relationships at all times. Complete equity is a rarity and there is almost always a power imbalance in most relationships. In the client/professional relationship, this imbalance is marked and inherent.

Transformative power (Wartenberg, 1990)—power which nurtures, informs, encourages, inspires, guides, and teaches—is essential to ethical practice. One of the many benefits of transformative power is that it creates power-with relation-

FIGURE 3

	Coercive power creates "power-over" relationships	**Transformative power creates "power-with" relationships**
Focus:	Control	The nature and quality of the client/ professional relationship, itself
Goal:	Compliance	Eventual liberation (independence)
Tactics:	Overt or covert coercion	Encouragement, inspiration, guidance and teaching in an atmosphere of optimism and high expectations
Justification:	You are incompetent and incapable	You are competent and capable of learning new ways to meet your needs
Results:	Clients who are dependent on services and at continued risk of being subjected to coercive measures	Clients who take an active role in their own care and personal growth and are not subjected to coercive measures

ships (Miller & Stiver, 1997) even when power-over situations loom. Power-with relationships offer clients the best opportunity to prevent coercion, or to extricate themselves from coercive measures once they have been applied. These sorts of empowering relationships also allow clients to retain the maximum amount of control possible in the coercive process, even as they move into circumstances where CTOs, for example, are proposed.

Transformative power is the foundation of ethical practice, but ethical practice also must focus on mitigating the harmful effects of the application of both overt and covert coercive measures. Thus, in the context of CTOs, the goals of ethical practice are threefold: (a) to ensure that clients avoid CTOs wherever possible by acquiring the skills and capacities needed to handle competently the exigencies of their lives and their illnesses, (b) to ensure a fair and just process for those who must be placed under CTOs, and (c) to ensure that those who are under orders have access to opportunities and resources to make the necessary internal and external changes that will lead to orders being lifted.

Practice Strategies

In order to achieve these goals, I propose three practice strategies, all of which are underscored by transformative power: (a) liberation tactics, (b) proactive contracting, and (c) procedural justice.

Liberation Tactics. Liberation tactics represent transformative power in action (Everett & Gallop, 2000). They are specifically directed at helping clients grow towards competency and independence. They apply generally, but are especially helpful when clients are trying to avoid CTOs or have already become subject to an order.

The first such tactic is the creation of an *atmosphere of continuous learning* in the client/professional relationship. Here, mental health professionals encourage questions from clients and reply with honest, straightforward answers. In addition, information is shared openly, resources are offered, and real discussions are held

regarding clients' views and choices. Through this process, clients are invited to become active participants in the creation of their own care plans and in their personal development.

The second tactic is *skills teaching*. Clients already have a variety of skills which need to be acknowledged. They may advocate well for themselves, may use humour to get others on their side, or they may have developed some supportive relationships. These positive skills require open and frequent reinforcement. Unfortunately, clients also may know how to use aggression to intimidate others, how to numb themselves with alcohol or drugs to avoid overwhelming emotional pain, or how to steal food and clothing. New, more socially desirable skills need to be taught within the past and present contexts of clients' lives. These new skills also must meet the goals of the former, less-acceptable ones. In addition, given that the acquisition of new skills can be a slow process, care must be taken that clients are not denied our optimism. An atmosphere of high expectation and reward for successive approximations is invaluable as clients struggle with new ways of meeting their needs.

Clients must also have *real choices and the dignity of risk*. Even with CTOs and the new parameters of the Mental Health Act, most of the choices clients make are about everyday living. They have the right to be wrong and to experience the consequences of their own decisions. Here, the ethical professional role is to guide the choosing process, not to make choices on behalf of clients.

However, clients can also compulsively engage in dangerous activities and repeatedly make poor decisions. Teaching clients an *internalized sense of self-discipline* while leaving their dignity intact is the final, but nonetheless completely central liberation tactic (Coloroso, 1995). This process has five components: (a) talking openly and clearly with clients about what actions and behaviours are problematic and explaining, in terms they can relate to, why they are troublesome; (b) making it clear that these problems are theirs to own, and that they have full responsibility both for the consequences of their behaviour and for making the necessary changes; (c) offering a variety of resources which will aid clients in finding ways to change; (d) allowing opportunities for clients to access these resources and to practice new ways of doing things (which includes making time to talk with them and to reflect on whether or not the new strategy is working); and (e) allowing clients to experience the consequences of failure (which, initially, is likely to occur) and then invoking the second-chance policy by acknowledging that the sincere effort which has not, as yet, been successful requires further oppor-tunities for practice.

Proactive Contracting. Liberation tactics are, in themselves, proactive interventions. However, for those who are at high risk for being placed under CTOs or who have repeatedly experienced other coercive measures (i.e., involun-tary commitment or restraint), a proactive contract designed to illuminate the step-by-step process that leads to a loss of control is helpful. Figure 4 offers an example of such a contract.

One of the benefits of proactive contracting is that it can occur before matters escalate, when everyone is calmer. It is also mutual, and provides a shareable writ-

FIGURE 4

Proactive Contract

Question 1 is designed to confront the feared possibility head on, but in a way that requires clients to reflect upon and describe in some detail what they are experiencing when they are about to be placed under a CTO (or when involuntary admission, eviction, mechnical restraint, etc. are imminent).

1. What specifically is happening for you when you know you can no longer avoid being placed under a CTO?

What are you doing? What are you saying? What are you feeling?
What are others observing you doing/saying/feeling?
What do you (client) need to do?
What can I (as a professional) do to help at this time? Note: It is important to discuss real legal, ethical limitations to the professional role at this point.

Question 2 takes a step backward in an effort to point out that there is a process involved in the application of coercive measures, and there are points along the way where steps can be taken to avoid what clients often feel is inevitable.

2. What *specifically* is happening for you when you know you are beginning to escalate towards the point where a CTO is likely?

What are you doing? What are you saying? What are you feeling?
What are others observing you doing/saying/feeling?
What do you (client) need to do to prevent things from going further?
How can I (as a professional) support you in preventing the application of a CTO or an admission?

Question 3 asks clients to imagine that the order has been written or an admission has occurred and ways of getting through the experience are being examined.

3. If, despite all our efforts, you agree to be placed under CTO . . .

What do you (client) need to do to support yourself through it?
What would you like my role (as a professional) to be? (Again, it is important to be honest about the limitations of the professional role under these circumstances.)

Question 4 is more of an empathetic statement in preparation for looking back on the imagined event in order to find ways to prevent further CTOs even before the symptoms or behaviours listed in Question 1 begin to appear.

4. These events are paintul for everyone. It hurts me to see this happen to you and I know it hurts you to go through it.

What do you need to do so that it won't happen again?
How can I help (as a professional) so that it won't happen again?

ten record of how help is best offered when coercive measures are in the offing. Finally, it clearly demonstrates that coercive measures don't just happen out of the blue, that there is a step-by-step process, and that, at each juncture, there are actions which could be taken to prevent escalation.

Procedural Justice. When all preventative measures have failed and clients become subject to CTOs, ethical practice demands that we maintain our commitment to the integrity of the therapeutic frame (Pearlman & Saakvitne, 1995). To do so, we must stick to our helping role and not impose our personal or political views on clients. While it may be entirely appropriate to advocate vociferously for better

evaluative measures for CTOs, or for modifications in their implementation, or for their complete abolition, these activities and views are to remain outside the helping encounter. Aside from the fact that our clients may not agree with our perspective, our focus is to ensure that clients get the help they need, and in the specific case of CTOs, that the tenets of procedural justice are followed.

Procedural justice involves treating clients with respect, concern, and fairness in the process of invoking coercive measures (Lidz et al., 1995). Research has shown that clients who are subjected to coercive measures report significantly fewer negative experiences if they feel that every effort was made to use a less-restrictive alternative (Ray, Myers, & Rappaport, 1996). I propose that community mental health practitioners ask themselves the following questions when determining if the CTO process their clients are about to enter conforms to the ethic of procedural justice: (a) Do clients have full information about CTOs? (b) Do they understand which of their behaviours, actions, or symptoms can lead to the application of a CTO? (c) Have all less-restrictive alternatives been exhausted? (d) Do clients fully understand their rights? For example, do they understand the con-sent process under CTO legislation? (e) Do they understand under what conditions a CTO can be lifted? And, (f) have they had an opportunity to talk through their feelings and have their views heard?

Coercion threatens trust—a central but fragile component of the client/professional relationship. Procedural justice focuses on preserving trust, insofar as it is possible in power- over circumstances, in order that the client/professional relationship survives, and continues to sustain clients before, during, and after a coercive episode.

CONCLUSIONS

CTOs have been introduced in Ontario into an inadequately funded mental health system, without strong evidence of their effectiveness. While proponents believe that positive outcomes will be demonstrated over time, those opposed to them fear that, at best, CTOs will be useless and, at worst, they will be harmful. With the passage of legislation in June 2000, overt legalized coercion has come to the community mental health service sector. Community mental health practitioners are obliged to develop empowering and ethical practice strategies to assist clients in dealing with CTOs, as well as with other forms of coercion. This paper introduces three practice approaches all underscored by transformative power—liberation tactics, proactive contracting, and procedural justice. They represent the first steps in what will become an important ongoing discussion.

RÉSUMÉ

Par suite de la loi adoptée en juin 2000, certaines mesures coercitives font désormais partie du paysage de la santé mentale communautaire en Ontario, sous forme d'ordonnances de traitement en milieu communautaire. Étant donné que les praticiens et praticiennes communautaires accordent beaucoup d'importance à la création de partenariats volontaires et égalitaires avec les membres de leur clientèle, il est justifié de se demander si une pratique éthique est pos-sible dans un contexte de coercition législative. À la lumière des arguments soulevés lors de l'adoption de la loi et des recherches sur l'efficacité, cet exposé pose le

constat qu'une certaine forme de pensée magique semble pré-valoir chez les deux parties au débat entourant les ordonnances de traitement en milieu communautaire. L'auteure suggère une définition plus large de la notion de coercition, englobant à la fois ses manifestations explicites et im-plicites. Finalement, on propose une approche de la pratique éthique fondée sur le pouvoir transformateur plutôt que le pouvoir coercitif, articulée autour d'une stratégie en 3 temps faisant usage de tactiques de libération, de contrats proactifs et de procédures justes.

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