Coercion and Community Treatment Orders (CTOs): One Step Forward, Two Steps Back?

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ABSTRACT

The shift from hospital-based care to community-based programs for people with serious and persistent mental illnesses has led to the creation of numerous treatment programs, including the recent implementation of community treatment orders (CTOs). This form of mandated outpatient commitment is controversial because it is widely acknowledged to be a coercive intervention. Yet, there is little discussion about why this intervention is considered coercive and whether coercion is acceptable in the context of emerging commitments to recovery for people with serious and persistent mental illnesses. Moreover, there is a need to evaluate whether CTOs advance or undermine the interests of people who are diagnosed with mental illness. This paper seeks to contribute to a discussion of these issues by exploring coercion and its role in community mental health care, and how it may co-exist with recovery in the implementation of community treatment orders.

There have always been dilemmas surrounding the use of power to mandate someone for psychiatric treatment, but they usually play out away from the eyes of the general public, in institutions that are designated to treat involuntary patients. Now, however, as psychiatric treatment has progressed into the community, tensions about conditions under which clients can be mandated for treatment have followed. Seven of the 12 mental health acts in Canada feature some version of compulsory community treatment, and Ontario is one of the few provinces that has implemented community treatment orders (Gray & O'Reilly, 2005). Similar forms of mandatory outpatient treatment have already been adopted in several other Western nations, including Australia, New Zealand, Israel, the United States (in 42 states and the District of Columbia), Scotland,

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Norway, Switzerland, Portugal, Sweden, Belgium, the Netherlands and Luxembourg, the United Kingdom, and Wales (Bonnie & Monahan, 2005; Churchill, 2007; Gerbasi, Bonnie, & Binder, 2000; Kisely, Smith, Preston, & Xiao, 2005; Lawton-Smith, 2005; Preston, Kisely, & Xiao, 2002; Salize & Dressing, 2004; Swartz, Swanson, Kim, & Petrilla, 2006). The introduction of outpatient commitment via community treatment orders (CTOs) is endorsed as a humane alternative to long-term institutionalization, but this intervention raises questions about how much power we believe the state should have to dictate the treatment of people diagnosed with mental illnesses.

According to the Mental Health Act, a community treatment order is explained as a doctor's order for a person to receive treatment and supervision in the community (Psychiatric Patient Advocate Office, 2003). Torrey and Zdanowicz (2001) describe CTOs as a treatment option that legally mandates a person to follow through with the established treatment plan or "risk sanctions for non-compliance such as potential involuntary hospitalization and treatment" (p. 337).

Unlike other forms of community mental health treatment, however, a CTO is legally enforced. Failure to comply with the community treatment plan[1] that is negotiated with the order can result in legal sanctions. For example, in Ontario a physician can seek police assistance to bring a non-compliant client to the hospital for an assessment. CTOs were introduced with the hope that they would be a resource for treating clients who were hospitalized frequently, but consistently discontinued treatment after discharge and became ill again (Hiday & Scheid-Cook, 1991; Vaughn, McConghy, Wolf, Myhr, & Black, 2000). Descriptions of CTOs maintain that they are a less restrictive alternative than long-term or frequent hospitalizations and have the added benefit of providing consistent support to individuals who are mentally ill and at risk of becoming a danger to themselves and others (Lamb, 1999; Mallan, 2000). In addition, CTO advocates believe that these treatment orders have the potential to establish helping relationships that will ameliorate some of the unfortunate social consequences of inconsistent treatment—criminalization and homelessness (Fielding, 2000).

Despite these claims, there are many people who contend CTOs are inherently coercive and therefore unacceptable. CTO opponents argue that it is a form of forced treatment that removes clients' autonomy to make their own decisions (Mallan, 2000; Szigeti, 2001; Weitz, 2000). They believe that the power given to physicians to mobilize state control against clients compels their patients to follow through with the treatment whether patients approve of it or not. They assert that although there is a framework for agreement and contractual commitment, clients are entering an arrangement in which their options are severely constrained; either they agree to outpatient commitment or they face prolonged inpatient hospitalization and threat of police apprehension. Examination of Form 45, which defines the community treatment order in Ontario, confirms that although there is an emphasis on consent, clients can be judged incapable of giving consent and ordered under the supervision of a physician by a substitute decision-maker. The legislation defines an expectation that the client will be capable of complying with the community treatment plan, but the assumption of capability does not extend to assuming the client is able to make a sound decision to reject the order. Proponents of mandatory outpatient commitment do not dispute the fact that coercion is an element of the intervention. Instead, they assert that it is necessary to meet the needs of a vulnerable population who might otherwise remain ill and pose potential risks to themselves or other people (Dreezer, Bay, & Hoff, 2005; O'Reilly, 2006).

Simultaneously, the dissemination of research knowledge demonstrating that people with serious and persistent mental illnesses do not inevitably deteriorate has facilitated a focus on the recovery of people with mental illness. In the aftermath of deinstitutionalization, community care has been designed to create opportunities for participation in the life of the community, including work, proximity to families and friends, and living independently (Nelson, Lord, & Ochocka, 2001). The recovery paradigm has advanced that process by working with consumers to create a mental health care system inclusive of many ways of living with mental illness, acknowledging that striving for symptom control is only one of many goals an individual may have (Meehan, King, Beavis, & Robinson, 2008). In this context, the health care system's role is to assist clients in building strengths and resources to pursue purposeful, meaningful lives (Carpenter, 2002). A key principle of recovery-oriented practice is that respect for self-determination replaces the paternalism that previously justified others' determining appropriate ways of living for people diagnosed with mental illnesses (Sowers, 2005).

There is something incongruous about the widespread adoption of interventions that require submission to supervision under threat of loss of freedom when the recovery paradigm is promoting respect for autonomy of people diagnosed with mental illnesses. Yet it is not clear whether CTOs represent an escalation of coercion in community mental health or whether they are consistent with current standards for coercion and also honour principles of recovery. This paper explores these issues by examining coercion in the context of community mental health and the role it plays in CTOs. Exploring such questions is an important step toward evaluating whether this intervention has a place in a recovery-oriented mental health care system.

COERCION AND COMMUNITY MENTAL HEALTH

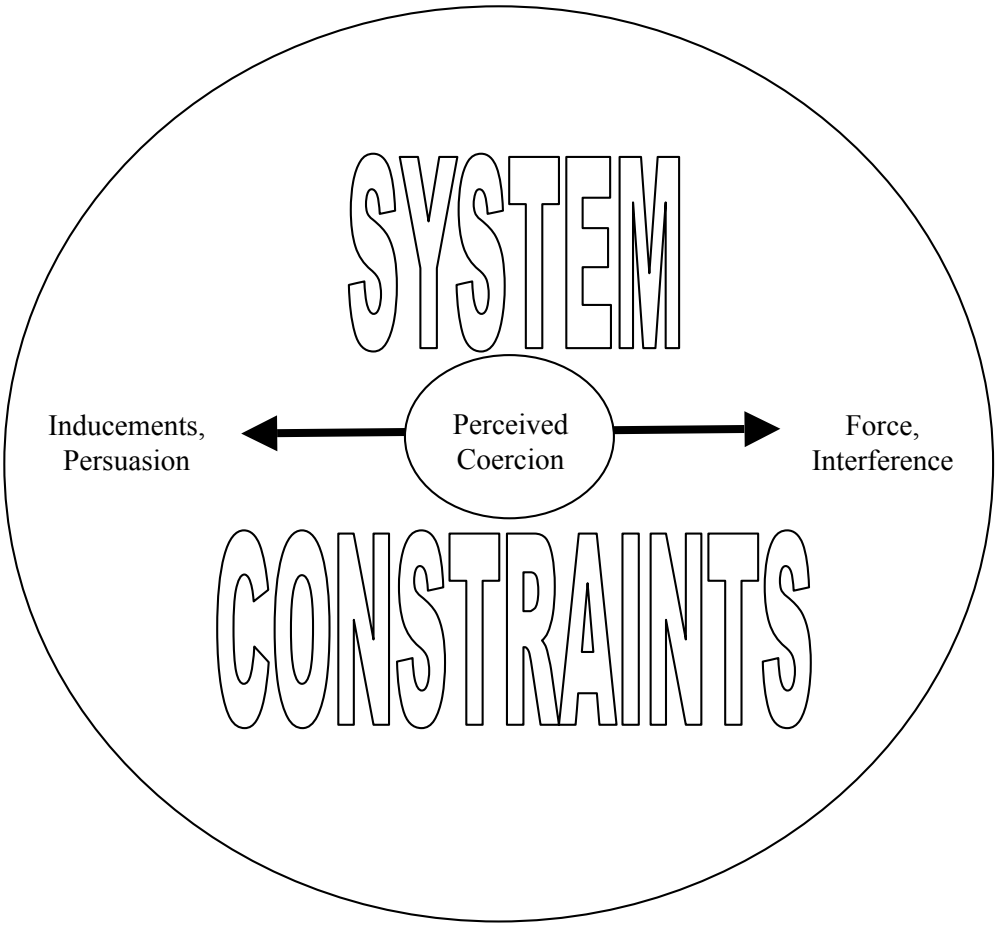
Many writers concerned with the balance of power in mental health practice have attempted to develop definitions of coercion relevant to that context. Some authors have defined coercion as the opposite of autonomy (Hiday, Swartz, Swanson, & Wagner, 1997). Others have defined it as the presence or influence of negative pressures, such as threats or force, and the absence of fair process (Bennett et al., 1993). O'Brien and Golding (2003) have defined it as "any use of authority to override the choices of another" (p. 168). A definition arising from a roundtable sponsored by the National Institute of Mental Health that included consumers, families, and mental health professionals described coercion as any action taken without consent of the individuals involved (Blanch & Parrish, 1993). Davidson and Campbell (2007) added that withholding of services and goods is used to secure compliance and should also be viewed as coercion. Some have suggested that even the provision of incentives like housing, money, food, and goods can be deemed coercive if it is used to secure compliance with treatment (Carpenter, 2006). Although there are many definitions, they have one thing in common: They emphasize that power can be used to eliminate the prerogatives of people who do not have the power to resist.

In a program of research looking at coercion across the community mental health care system, Monahan has suggested that coercion should be seen as occurring along a continuum that begins with positive pressures of persuasion and inducements and ends with negative pressures of threat and force (Monahan et al., 1995; Monahan et al., 1996; Monahan, Swartz, & Bonnie, 2003). As indicated in Figure 1, the continuum of positive to negative pressure contributes to subjective perceptions of coercion that can emerge from

experiences of persuasion, encouragement, intrusion, and leveraging by mental health services. Assertive community treatment teams (Allness & Knoedler, 1998), for example, are often named as a non-coercive alternative to CTOs because they work exclusively with voluntary clients. However, the persistence that teams use to maintain contact with clients has come under scrutiny for potential coerciveness (Gomory, 2002; Neale & Rosenheck, 2000). In addition, clients report being quite aware of the power the treatment team has to transform voluntary treatment into involuntary hospitalization (Gagne, 2005; Watts & Priebe, 2002). Therefore, this intervention may be only superficially collaborative, as clients experience coercion in the form of unwelcomed persistence and ambiguous thresholds for use of force.

Figure 1

A Conceptualization of Coercion in Community Mental Health



Coercion may also be experienced in programs that attempt to aid clients by providing goods and services. The positive pressure of inducements to encourage client compliance with interventions is often used in a context where clients do not have other options for securing those commodities. If clients are constrained in their options, then they might feel compelled to participate due to negative pressure originating outside the program, in an environment that does not provide options to support free, autonomous choices. The constraints are part of a larger coercive experience for clients, as service system resources and opportunities undoubtedly affect their choices. The provision of inducements like housing and food are not perceived to be coercive because the process does not involve direct force or threat, but if the environment penalizes non-compliance with homelessness and hunger, then the only difference between providing these inducements and inflicting punishment is the transparency of the process. Therefore, reduced access to resources for treatment and threats to the survival of people diagnosed with mental illness play a role in facilitating coercion in the mental health care system.

COERCION, RECOVERY, AND COMMUNITY TREATMENT ORDERS

CTOs use a legal document to compel clients to present for treatment, usually with an emphasis on accepting pharmacological intervention (Chaimowitz, 2004). There is a palpable threat created by the sanctions available to penalize a client who does not comply with the community treatment plan. The structure of the CTO also augments the power difference between clients and their physicians. Physicians are positioned as superior to clients in judging the need for treatment, and they are empowered to designate a client incapable of making treatment decisions so that another person can provide consent. These are elements that are consistent with coercion as it is defined and implemented across the community mental health care system.

Yet, the same legal process that compels compliance includes protections for the client. Clients are provided with rights advice, they maintain the right to appeal the order, and the order cannot be executed without informed consent which the client maintains the right to withdraw. In Ontario, CTOs have a time limit of 6 months and can be renewed. CTOs are regularly reviewed (after every 12 months), and are terminated when clients are deemed to no longer need them. It is also important to note that assignment to a CTO is a transparent process; clients are informed of the order, and the expectations placed on them in the community treatment plan. The client and/or the substitute decision-maker must be included in the development of the community treatment plan and receive a copy when it is completed. Clients and their substitute decision-makers are entitled to legal consultation before, during, and after the plan. In Ontario, the Psychiatric Patient Advocate Office (PPAO) ensures these procedures are in place and can provide consultation to clients and their family members. These rights and protections are consistent with recognizing the client as a self-determined, capable individual who can participate actively in the treatment process. Moreover, transparency in the treatment process is a way to engage clients and has a positive effect on compliance with treatment (Davidson & Campbell, 2007). Therefore, the protection integrated into the structure of CTOs clearly includes elements that are consistent with promoting recovery-oriented practice.

Despite the legal protections in place, clients who have experienced the intervention report feeling coerced in the CTO process and threatened by the legal sanctions (Dawson, Romans, Gibbs, & Ratter, 2003; Kisely, Campbell, & Preston, 2005; Swartz & Swanson, 2004). The perception of coercion may not be a threat

to goals of reducing hospitalization, relapse, and arrests for crime, but there are consequences. Perceived coercion poses a threat to achieving positive goals of building relationships between clients and the service system, and creating opportunities to prevent problems like homelessness, involvement in crime, and poor quality of life. Moreover, the reluctance to be coerced may endanger the primary goals of CTOs if it dissuades people from seeking help (Chamberlain, 1998; Kaltiala-Heino, Laippala, & Salokangas, 1997). The threat of coercion may also endanger goals of recovery, as the disempowering effects of perceived coercion into treatment undermine efforts to foster autonomy, self-determination, and self-confidence (Deegan, 1997; Mullen, Gibbs, & Dawson, 2006).

Potential disengagement from services may be an issue in other interventions that similarly blend elements of autonomy and disempowerment, but CTOs raise unique concerns. The signing of a legal contract implies rights and responsibilities for both parties signing it, yet there is little indication that the physicians or the mental health care system operate with the same threat of sanction as the client. No one will penalize the physician or the health care system if they do not meet implied obligations to keep the client mentally stable, out of the hospital, housed, and free of violence. The contract creates an appearance of mutual commitment that obscures the exertion of power to secure an unreciprocated obligation from the client. The potential for this process to create positive relationships that will facilitate positive health and social outcomes is limited. Threat of apprehension by the police and hospitalization may be sufficient to encourage adherence to the community treatment plan, and may sustain that adherence beyond the CTO because the physician retains the power to renew the CTO after it has expired. However, a relationship built on coercion is not necessarily the gateway to more positive relationships with the mental health care system. In fact, a study by Hunt, da Silva, Lurie, and Goldbloom (2007) of outcomes from CTO intervention revealed that clients who had been placed on the order were less likely to continue with case management services than clients who were receiving the same services without community treatment orders. This suggests that the CTOs provided short-term connection to the mental health care system and little of that was retained beyond the relationship with the person who held the power to reactivate mandated treatment. Such results confirm that the therapeutic alliance with individuals treated under these circumstances is likely to be compromised (Kisely, Campbell, et al., 2005). Similar dilemmas occur in other parts of the system, as clients no doubt participate reluctantly or ambivalently in other interventions. However, the overt legal structure of CTOs may distinguish this form of treatment from other interventions by heightening the salience of the physician's role as an agent of social control, and increasing the perception of coercion to a level that endangers working alliances that could facilitate better outcomes for clients.

It would be desirable to find a way to implement CTOs without coercion. We could imagine a capable client willingly accepting a CTO, wholeheartedly following through with the expectations of the community treatment plan, and welcoming the structure that will ensure regular contact with a physician and other health professionals engaged in his or her community treatment. This scenario is unlikely, however, because a client actively seeking services in such circumstances could easily be directed to a case management program where he or she would receive services without any legal involvement. This able and willing client would need a CTO only if there was no other treatment option available, and that is a situation in which the client is constrained by the service environment and coerced into a CTO by the lack of options for free choice. In fact, this coercion by constraint has been identified as a particular risk for racial and ethnic minority clients

who have difficulty accessing services because of barriers in the system (Dreezer et al., 2005). Their designation as "hard to treat" clients obscures the system's role in failing to treat them and barring them from all but mandated treatment. Involuntary clients are coerced more directly. They can refuse the intervention if they are considered capable of making treatment decisions. However, once clients are identified as candidates for a CTO, psychiatrists have the power to judge them incapable of making their own decisions and substitute decision-makers are given the power to compel them to accept the intervention, superseding entitlements to autonomy and self-determination.

Therefore, the coercion in CTOs originates in the structure of the intervention in an environment with inadequate community resources that compels clients to accept mandated treatment to receive service. Although coercion may occur in other community mental health interventions, CTOs are unique in the mental health care system because they cannot be executed without coercion. Any individual who is mandated to outpatient treatment has been compelled to either choose the intervention under conditions of system constraint, or accept the intervention because a physician and substitute decision-maker have overruled his or her preferences. Because this intervention cannot be executed without coercion, the CTO represents an escalation of coercion in the mental health care system and a shifting of standards toward increased acceptance of state intrusion in the lives of people diagnosed with mental illnesses.

COMMUNITY TREATMENT ORDERS: ONE STEP FORWARD, TWO STEPS BACK?

Suggesting that CTOs are exceptionally coercive is not the same as suggesting they should not be part of the community mental health care system. The desire to build a system on principles defined by recovery does not remove the need for interventions that can operate in conditions when people are unable to participate in treatment as autonomous, informed clients. Although the recovery movement addresses desires for the most just treatment for people diagnosed with mental illnesses, there is a risk that it can create an environment in which people who could be healthier are left to make autonomous choices that keep them ill (Meehan et al., 2008). Many remind us that CTOs and other mandated outpatient treatments are designed to prevent negative outcomes for people who have illness histories that predispose them to futures marked by prolonged sickness, disability, violence, depression and suicide, endangerment of physical health, and homelessness (Munetz, Galon, & Frese, 2003; O'Reilly, 2006). These negative outcomes are the by-products of a deinstitutionalization process that failed to deliver on its promises of improved quality of life for people diagnosed with mental illnesses. CTOs may provide an opportunity to redress those mistakes by facilitating interventions that prevent the negative sequelae of mental illness. Moreover, the mental health care system's use of coercion is a response to the accountability that it has to the community. Community-based care increases the exposure that community members have to the successes and failures of psychiatric treatment (Meehan et al., 2008). Those community members include family members who are forced to compensate for gaps that emerge when services do not provide adequate support to their relatives (Baronet, 1999; Saunders, 2003). Accountability to these community stakeholders requires the implementation of interventions that provide support in the community and reduce the consequences stakeholders experience when support is not there.

CTOs may represent a step forward in the attempt to balance the interests of clients, family members, and community members. The CTO process goes to great lengths to involve clients in constructing a plan

for recovery while retaining the power to act in circumstances when clients do not have the capacity to make sound decisions that are in their best interests. One could argue that the end justifies the means. Yet, CTOs may put us in the position of accepting an unacceptable level of coercion, given the actual influence on the outcomes for diagnosed individuals. In fact, the widespread adoption of mandated outpatient treatment might represent two giant steps back for the advancement of people with mental illnesses.

First, CTOs reverse gains that have been made to improve the lives of people diagnosed with mental illnesses. A major reform in mental health legislation particularly in Ontario was the shifting of commitment law from the standard of "need for treatment" to the standard of "imminent dangerousness" (Munetz et al., 2003). CTOs reverse this shift by basing commitment on a physician's judgment that the individual needs to be treated to prevent future harm. The treatment dictated almost invariably includes medications and, therefore, the CTO removes the right to refuse treatment that is preserved during inpatient commitment (Chaimowitz, 2004). Moreover, CTOs are promoted as less restrictive alternatives to hospitalization, but are executed for much longer than inpatient commitments. The 6-month duration of an Ontario CTO far exceeds the length of time required to stabilize someone on medication, potentially forcing the individual to remain committed for an extended period of time without the required recertifications that accompany inpatient commitment. Finally, CTOs do damage to the work that has been done to reduce stigma against mental illness. Legislation to introduce mandated outpatient commitment is commonly initiated under titles that associate people diagnosed with mental illnesses with murder victims (for example, Brian's Law in Ontario and Kendra's Law in New York). These tactics exploit negative images of diagnosed individuals, stoking fears in the community that subvert efforts to decrease stigma (Kisely, Campbell, et al., 2005). The CTO may function well as a tool to reduce the anxieties of mental health professionals who fear repercussions from negative outcomes of untreated patients (Mullen, Dawson, & Gibbs, 2006), but its significant disempowerment of individuals diagnosed with mental illnesses is a high price to pay.

The second step backwards signalled by this legislation is the sanctioned use of invalidated interventions on a vulnerable population. Bioethics has a clear standard that patient care should be based on the best evidence available (Kerridge, Lowe, & Henry, 1998). There is surprisingly little evidence supporting the effectiveness of CTOs. Although studies of CTOs have demonstrated benefits with regard to relapse reduction, reduced hospitalizations, and shorter stays in hospital, current analyses suggest these results may have reflected regressions to the mean for clients who were extreme consumers of service (Hunt et al., 2007). When reviews of the entire body of research have been conducted, mandated outpatient commitment has not been demonstrated to be superior to standard care (Kisely, Campbell, Scott, Preston, & Xiao, 2007). A Cochrane systematic review showed that there was some evidence that clients under CTOs were less likely to be victims of violent and non-violent crimes, but there were no significant differences between them and clients receiving standard care in terms of service use, social functioning, or quality of life (Kisely, Campbell, et al., 2005). Moreover, when these reviewers used the data to calculate a "number needed to treat/harm" statistic for the intervention, they discovered that it would take 27 CTOS to prevent an episode of homelessness, 85 CTOs to prevent a rehospitalization, and 238 CTOs to prevent one arrest. Those numbers represent high costs to the freedoms of people diagnosed with mental illness in exchange for relatively low benefit.

CONCLUSIONS

Preventing homelessness, relapses, violence, and victimization are important goals for the mental health care system. CTOs were designed to help to achieve those goals. However, in the current system they function as a highly coercive tool of social control that has significant potential to undermine the interests of people diagnosed with mental illness. Some may see CTOs as an opportunity to engage physicians in providing care to underserved groups (Dreezer et al., 2005), but CTOs cannot compensate for an underresourced system or a system that is not accessible and equitable. Clearly, commitments need to be made at the system level to ensure that there are non-coercive options available to clients and that coercion in existing interventions is reduced to a minimum.

Although we have argued that CTOs may not have earned their place in a recovery-oriented mental health care system, they seem to be a fixed element in the current policy environment. This does not mean, however, that the way in which they are executed is fixed as well. Canada has inherited an intervention that is preoccupied with exerting biomedical social control over people diagnosed with mental illnesses, but we have the opportunity to transform that intervention into something more consistent with a system based on empowerment, social inclusion, and self-determination. A first step toward increasing the capacity for empowerment and self-determination in CTO interventions would be to consult with clients about the potential for utilizing mandated outpatient treatment as part of a client's pre-approved plan for intervention during times of incapacity. As the literature suggests that CTO candidates are people who recover when hospitalized, clients could be introduced to the intervention and engaged during periods of improved capacity in creating advance directives requesting CTOs. They could also have discussions with family members who may have future roles as substitute decision-makers about how they want to be treated if they lose the capacity for informed decision-making (La Fond & Srebnik, 2002; Munetz et al., 2003). Such approaches can enhance the capacity for CTOs to be part of a self-directed recovery plan and may also have positive effects on reducing coercion in other types of interventions.

In addition, it is within our reach to redefine the community treatment order as an intervention that a client might choose to ensure adequate interdisciplinary support from the mental health care system. This would require building measures into the CTO framework to hold mental health professionals accountable for failure to meet the expectations of an agreement designed to serve the interests of our most needy clients. Further, the community treatment plan that is currently so focused on ensuring medication compliance could be broadened to include contractual agreements between clients and health professionals that define activities in place to achieve client-determined goals in areas like social networking, education or work, and other types of community integration. At present these elements are not included in CTO agreements, but the only barrier to their inclusion is creativity and willingness of health professionals to accept a more collaborative and accountable relationship with their clients. Medication compliance could still be important in such plans, as symptom reduction could be very important to achieving goals that clients have for other areas in their lives. Moreover, it may be too much to expect that medication could be an optional part of such plans in an environment where the public has become so invested in the belief that medication is the key to keeping diagnosed individuals, their families, and their communities safe. Educating the public about the fallacy of those beliefs is a long-term project. In the meantime, however, modifying CTO intervention to be

more client-led, to oblige equal commitment from clients and their treatment teams, and to ensure execution of more holistic community treatment plans would be major steps toward making this intervention a more appropriate addition to a recovery-oriented system of care.

RÉSUMÉ

La transition du milieu hospitalier vers le milieu communautaire, en ce qui concerne les soins livrés aux personnes qui souffrent des maladies mentales sévères et persistantes, a entrainé de nombreux programmes de traitement, dont l'implantation récente des ordonnances de traitement en milieu communautaire. Ce type de traitement externe obligatoire soulève la contreverse parce qu'il est largement perçu comme une intervention coercitive. Or, il y a des questions qu'on n'a guère discutées: Pourquoi cette intervention est-elle jugée coercitive? La coercition est-elle acceptable dans le contexte de l'émergence d'un engagement envers le rétablissement des personnes souffrant des maladies mentales sévères et persistantes? En plus, il est nécessaire d'évaluer si les ordonnances de traitement en milieu communautaire avancent les intérêts des personnes identifiées comme souffrant d'une maladie mentale ou si, par contre, elles minent les intérêts de ces personnes. Cet article a pour but de contribuer à une discussion de ces questions en explorant la coercition et son rôle dans les soins communautaires de santé mentale. On examine aussi comment la coercition pourrait coexister avec le rétablissement dans l'implantation des ordonnances de traitement en milieu communautaire.

NOTE

1. A community treatment plan is a written document developed with input from all parties involved with the client's treatment, including the client, the substitute decision-maker if applicable, the physician, and other community-based mental health or case management providers involved. Details to be included in the plan are as follows: physician follow-up, community follow-up, medication compliance, lab work (if necessary), role of the substitute decision-maker (if applicable), and information sharing among the treatment team. Failure to comply with this agreement could be grounds for the client's apprehension or hospitalization, or evaluation of the treatment agreement.

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