Involuntary Treatment, Capacity and Community Treatment Orders: An Introduction for Addictions Providers and Non-Psychiatrists

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Objectives

1. To recognize and understand criteria for involuntary treatment and assessment in Ontario, including the use of the Form 1 and Form 2
2. To describe the process of assessing capacity and incapacity for treatment
3. To discuss the potential role of Community Treatment Orders in addictions treatment

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Involuntary treatment

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Hypothetical Case

"Steve" is a 35 year old man with severe stimulant use disorder, amphetamine type. He is on Ontario Works, and would like to apply for ODSP. When using methamphetamine, he has severe psychosis and fears that law enforcement is conspiring to kill him. When he is in recovery, these symptoms largely subside. He was working until last year, when he lost his job due to frequent absences and one occasion of coming to work intoxicated. He has an apartment, but is at risk of losing it and received an eviction notice. Steve also uses fentanyl, although not regularly, but this has led to accidental overdoses. His father is in town, normally but lives far away. His father brings him to your RAAM clinic. Initially Steve is calm, but when you ask if he wants treatment for the voices he is hearing he starts shouting at you and blocks the door to the exam room, barricading you in, screaming at you and picking up scissors from you desk and brandishing them. You eventually help him calm down, but it takes time and he is shouting, "you're part of it, you're watching me!". You are scared and your heart it pounding. Steve runs out of the clinic, and his father says, "See what he's like! Can't you do something?"

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Pathways to psychiatric assessment

1. Voluntary presentation to an emergency department
   → Assessment and referral to psychiatry

2. Form 1 issued by a physician
   → Assessment and referral to psychiatry

3. Form 2 issued by Justice of the Peace
   → Assessment and referral to psychiatry

4. Apprehension by police under the *Mental Health Act*

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Form 2 Criteria:

Justice of the peace's order for psychiatric examination

16 (1) Where information upon oath is brought before a justice of the peace that a person within the limits of the jurisdiction of the justice,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition based upon the information before him or her the justice of the peace has reasonable cause to believe that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

the justice of the peace may issue an order in the prescribed form for the examination of the person by a physician. R.S.O. 1990, c. M.7, s. 16 (1); 2000, c. 9, s. 4 (1).

- **Similar criteria based on a person's report to Justice of the peace**
- **Any person can apply for a form 2 (family, doctor, case worker, etc.)**

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Action by police, Mental Health Act

17 Where a police officer has reasonable and probable grounds to believe that a person is acting or has acted in a disorderly manner and has reasonable cause to believe that the person,

(a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;

(b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or

(c) has shown or is showing a lack of competence to care for himself or herself,

and in addition the police officer is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

(d) serious bodily harm to the person;

(e) serious bodily harm to another person; or

(f) serious physical impairment of the person,

and that it would be dangerous to proceed under section 16, the police officer may take the person in custody to an appropriate place for examination by a physician. 2000, c. 9, s. 5.

- ➢ may occur after a “Wellness Check”, if staff are concerned about a patient

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Form 1 Criteria:

Apparently suffering from mental disorder

"Box A"

Past or present:

- Threats or attempts to cause bodily harm to him/herself,
- Violent behaviour towards another person or causing another person to fear bodily harm from him/her, or
- Lack of competence to care for self

And future risk of:

- Serious bodily harm to self,
- Serious bodily harm to others, or
- Serious physical impairment

What happened?

What are the symptoms?

OR

"Box B"

- Previously received treatment for same or similar mental disorder of ongoing or recurrent nature
- Has shown clinical improvement
- Apparently incapable and SDM consent
- Likely to cause serious bodily harm to self or others, suffer serious physical impairment, or suffer substantial mental or physical deterioration

Less commonly used

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Ministry of Health

Form 1
Mental Health Act

Application by Physician for Psychiatric Assessment

Clear Form

Name of physician ______ (print name of physician)

Physician address ______ (address of physician)

Telephone number ( ) ______ Fax number ( ) ______

On ______ (date) I personally examined ______ (print full name of person)

whose address is ______ (home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days. In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test

The Past / Present Test *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated to me by others:

Examples of the risk:
-took overdose
-brandishing scissors
-not eating x 3 days

The Future Test *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

6427-41 (00/12) *(Disponible en version française)* *See reverse* 7530-4972

Clear Form

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test *(continued)*

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

Examples of the mental illness:
-tearful, sad
-responding to voices

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: *(please indicate one or more)*
   - ☐ serious bodily harm to himself or herself,
   - ☐ serious bodily harm to another person,
   - ☐ substantial mental or physical deterioration of himself or herself, or
   - ☐ serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

(Disponible en version française)

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Clear Form

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria *(continued)*

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(choose one or more of the following)*
   - ☐ cause serious bodily harm to himself or herself, or
   - ☐ cause serious bodily harm to another person, or
   - ☐ suffer substantial mental or physical deterioration, or
   - ☐ suffer serious physical impairment

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date ______ Today's time ______

Examining physician's signature ______ (signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

Sign this part

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

______ (Date and time detention commences) ______ (signature of physician)

______ (Date and time Form 42 delivered) ______ (signature of physician)

Leave this empty for outpatients
Form 42 issued on arrival to psychiatric hospital

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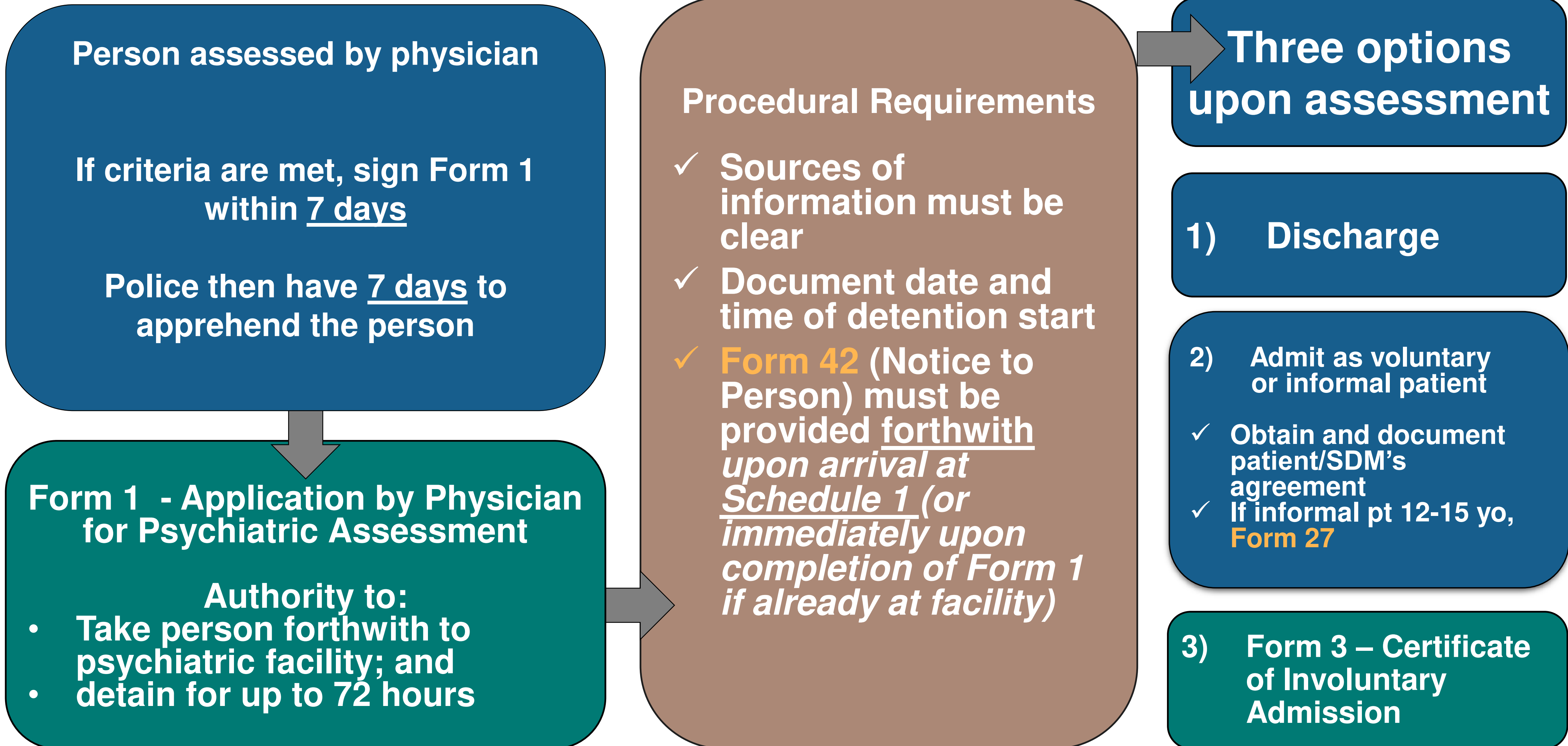
Form 1 Process



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Hypothetical Case

Steve spends three days in hospital under a form 1. He is no longer agitated or threatening anyone or himself. He is caring for himself appropriately. He wants to leave. He has some mild paranoia, but it is vague, and his symptoms of psychosis have clearly improved. Could he be certified under a form 3?

Involuntary Detention – Form 3/4/4A

"Box A" Criteria (*MHA* s. 20(5))

Not suitable to be voluntary or informal patient

Suffering from mental disorder of a nature or quality that likely will result in:

- Serious bodily harm to others
- Serious bodily harm to self
- Serious physical impairment

Unless remains in the custody of a psychiatric facility

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Involuntary Detention – Form 3/4/4A

"Box B" Criteria (*MHA* s. 20(1.1))

1) Not suitable to be voluntary or informal patient

2) Found **incapable of consenting to treatment** and **SDM consent** obtained

3) **Previously received treatment** for mental disorder of ongoing/recurring nature that when not treated will likely result in:

- Serious bodily harm to others
- Serious bodily harm to self
- Serious physical impairment
- **Substantial mental or physical deterioration**

4) Shown **clinical improvement** as a result of the treatment

5) Currently suffering from **same or similar mental disorder**

6) Given history and current condition, like to

- Cause serious bodily harm to self or others
- Suffer serious physical impairment or **substantial mental or physical deterioration**

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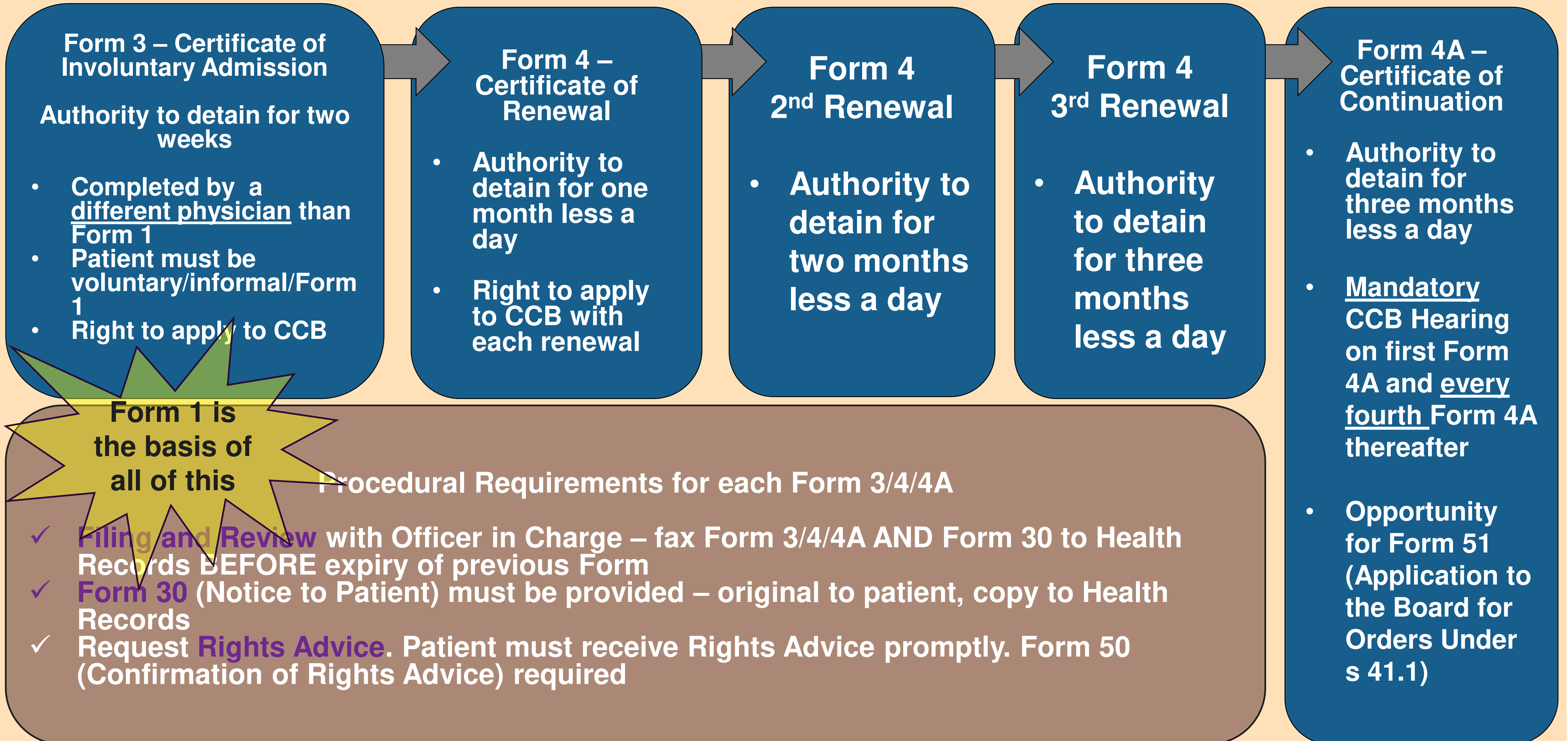
Form 3/4/4A Process



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Cases of Involuntary Treatment in Addiction AJ - 2021

AJ was diagnosed with substance use disorder, which was the basis of her involuntary hospitalization.

AJ's history included a pattern of substance-seeking behaviour and ingestion of large quantities of prescription medications, which had resulted in overdose and hospitalization.

The Board found AJ's mental disorder was likely cause serious bodily harm to herself, either intentionally or unintentionally, unless she were detained in hospital. They cited AJ's overdose history, car accidents in the context of substance use, hospitalization, and ingestion of antifreeze as evidence supporting this ground.

The Board confirmed AJ's involuntary status on the Box A criteria of serious bodily harm to herself.

AJ (Re), 2021 CanLII 61415 (ON CCB).

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FP - 2021

FP was diagnosed with schizophrenia, however, he was admitted to hospital for the purpose of treating his addiction to fentanyl. At the time of the hearing, FP's schizophrenia was managed by a CTO:

- The Board found that FP "was sufficiently addicted," and suffered consequences as a result, that his use of these drugs constituted a "disease or disability of the mind"
- The Board noted the context of fentanyl use and resulting deaths across Canada, and cited the specific nature of that drug as a particular concern.
- The Board accepted that FP was addicted to fentanyl and had no desire to treat his addiction and "further serious physical impairment was probable, death was possible"

However, FP's involuntary status was overturned on the basis that he agreed to stay in hospital as a voluntary patient.

FP (Re), 2021 CanLII 53197 (ON CCB)

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AH - 2022

AH was diagnosed with schizoaffective disorder bipolar subtype and substance use disorder

The Board's Reasons identify a constellation of risk factors arising from AH's mental conditions, including substance use:

- AH had a long-standing history of stimulant use, but experienced mania and psychosis absent substances
- In finding AH was likely to suffer serious physical impairment due to her mental condition, the Board cited her: poor insight, non-adherence to treatment, refusal of medical investigations, history of sexual exploitation and substance use, along with other factors

While the Board found that any one risk factor in AH's case may not have established a likelihood of serious physical impairment, the risks, when considered in their totality, satisfied this criteria under the *Act*.

Involuntary status confirmed on Box A – risk of serious physical impairment

AH (Re), 2022 CanLII 64985 (ON CCB),

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Case reports: Di Paola et al, The Canadian Journal of Addiction 14(1):p 22-25, March 2023.

- ❑ three reports of patients in their early 20s to late 50s
- ❑ all patients were **capable with respect to treatment**

Case 1: male in his 50s, 30-year history of alcohol use, 26-52 oz a day at admission
- suspected Wernicke's encephalopathy, with ataxia and confusion
- initially admitted for 4 days, then an additional 4 days involuntarily
- started anticraving medications and connected to care, cognition improved

Case 2: female in 20s, severe opioid use disorder, emotional dysregulation
-held on a form 1 after escalating use, not engaging in assessment or safety planning
-3 day admission which allowed stabilization and engagement in care

Case 3: male in early 30s, opioid and methamphetamine use disorders
-long period of recovery followed by severe relapse to opioids and stimulants
-multiple admissions to ED, malnourished, decline in functioning
-involuntarily admitted for 17 days, then an additional 8 days voluntarily
"The patient stated that this decision was beneficial and necessary."

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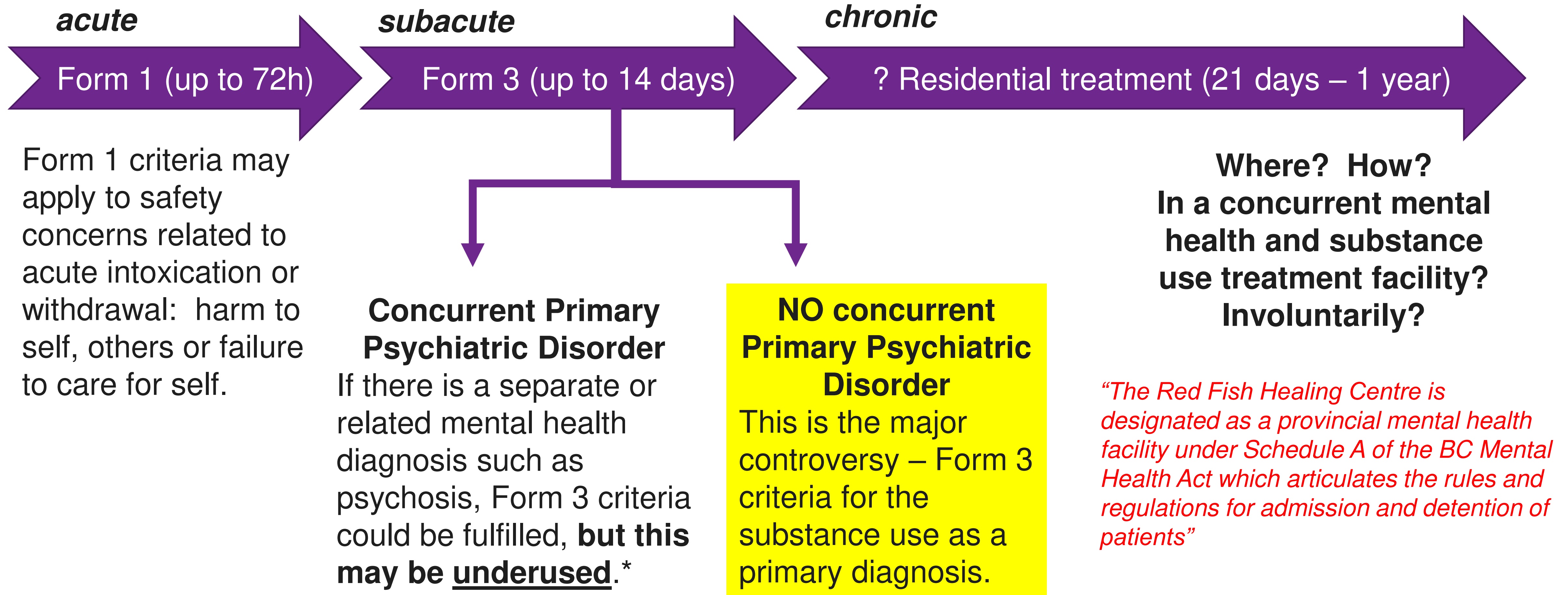
Involuntary Treatment:
When should we (if we can), and to what end?

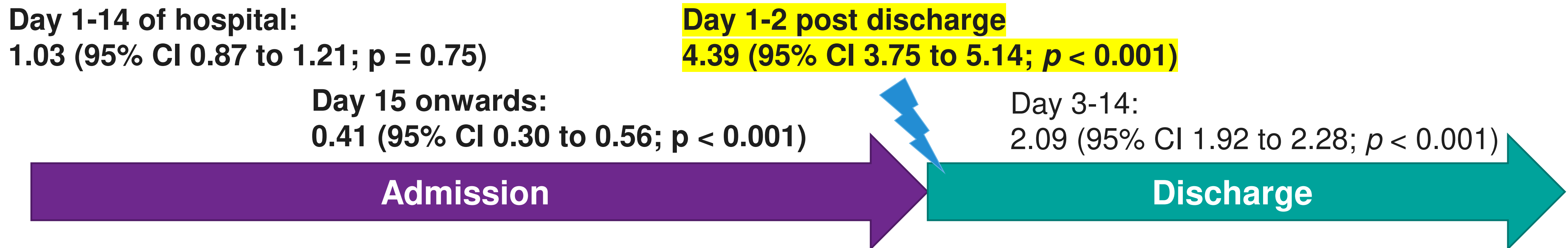


*Being a frequent ED user (5+ visits) for substance use makes it **less likely** (13.8%) that a person receives a psychiatric hospitalization vs. no SUD ED visits (34.4%). (Urbanoski K, et al. Emerg Med J 2018;35:220–225.)

http://www.bcmhsus.ca/Documents/Inpatient_Model_of_Care_120821_online.pdf

Intersections of law and clinical practice: Complexity, nuance and trends

- ❑ Historically, much of the discussion was around **alcohol use**, which is still a leading cause of substance use morbidity and mortality
- ❑ Even within opioid use disorder, secular trends (**fentanyl**) and scientific understanding have changed substantially over the last decade
- ❑ Treatment with opioid agonists (methadone, buprenorphine and newer agents) is by far the most effective and life-saving treatment for opioid use disorder, compared to residential treatment (Wakeman, *JAMA Network Open.* 2020)
- ❑ Discharge from any controlled environment, **including hospital** is a high risk time in terms of relapse and overdose:



Lewer D, Eastwood B, White M, Brothers TD, McCusker M, Copeland C, et al. (2021) Fatal opioid overdoses during and shortly after hospital admissions in England: A case-crossover study. PLoS Med 18(10): e1003759.

Copyright © 2021, JAMA

...to what end?

- There are lengthy wait times for publicly funded residential programs
  - **100 days is the average wait for adult residential treatment (2022) in Ontario -** https://amho.ca/wp-content/uploads/AMHO_BudgetSubmission_2022_FINAL.pdf
- Applications to residential programs require intake assessments (for example, the Global Appraisal of Individual Need Quick3 Motivational Interviewing Ontario (GAIN Q3 MI ONT), which also requires wait times
- Subspecialty services are not available in the majority of the province
- If there no possibility of acute (<14 day) admission voluntarily to residential care, what is the ethical basis of certification for substance use disorder without acute concurrent disorders? Is it reasonable to use certification as a resource for the reason that it may be the *only* available resource?
- **PWUD (people who use drugs) included in a qualitative survey reported, "Participants did not endorse the use of involuntary care, instead emphasizing significant changes were needed to address shortcomings of the wider voluntary care system."**
  - Chau et al (2021). The perspectives of people who use drugs regarding short term involuntary substance use care for severe substance use disorders. *International Journal of Drug Policy, 97*(103208).

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Capacity and Consent

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Hypothetical Case

Steve leaves the hospital and is now receiving treatment at a RAAM clinic. The staff identify that he has been using fentanyl intermittently for the past few months. He does not use daily and has had several accidental overdoses. Due to the risk of overdose, they discuss buprenorphine with him, but he says, "I have to start at 11 mg, that's my Angel number, I can't start at a lower dose". Is he capable with respect to opioid agonist therapy? What if he isn't?

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Decision-making capacity – legal overview

Is **presumed** (*HCCA* s. 4)

Is **time specific** (*HCCA* s. 15)

Is **task specific**

- Treatment vs Finances vs. Admission to long-term care facility

Is **treatment specific** (*HCCA s. 15*)

- Antipsychotics vs. mood stabilizers
- Diabetes management vs. cancer
- Heart surgery vs. Tylenol for headache

Is **functional**

- Diagnosis does not indicate incapacity

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Consent and Capacity to make *treatment* decisions

- Capacity to consent to treatment is defined in the *Health Care Consent Act* (HCCA): https://www.ontario.ca/laws/statute/96h02
- Who assesses it: "A health practitioner who proposes a treatment" must determine if the person is capable
- The capable person **or** the incapable person's substitute decision maker (if the patient is incapable) has the legal right to make decisions about treatment
  - Exception for emergencies
- Substitute decision makers are determined by the hierarchy in the act

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Legal test of capacity for treatment

Ontario's *Health Care Consent Act* defines capacity with respect to treatment as follows:

"A person is capable with respect to a treatment…if the person is able to understand the information that is relevant to making a decision about the treatment…,

…and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

- ❑ capacity is specific to the treatment
- ❑ ***"Best Interest" or consideration of outcomes is not part of this definition***
- ❑ consent must be obtained **prior** to starting a treatment (except in emergencies) from the capable person, or incapable person's substitute decision maker
- ❑ any inpatient or outpatient can contest a finding of incapacity, with respect to any treatment by requesting a hearing of the Consent and Capacity Board

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Aid to Capacity Evaluation tool: Dr. E. Etchells

https://www.cmpa-acpm.ca/static-assets/pdf/education-and-events/resident-symposium/aid_to_capacity_evaluation-e.pdf

EXAMPLES OF SCORING

1. Able to Understand Medical Problem		
Sample Questions	**Sample Responses**	**Suggested Scoring**
What problem are you having right now?	*My foot hurts. I can't walk.*	YES
What problem are you having right now? Do you have a foot problem?	*I don't know.* *Yes, I can't walk.*	UNSURE
What is your most serious medical problem right now?	*I don't know.*	NO

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Findings of Incapacity (Treatment) - Process

Finding of incapacity is made for:	Finding of incapacity is made for:
- an **inpatient in Schedule 1 facility** - **≥14 y.o.**, **AND** - the treatment is **for a mental disorder:** √ **Form 33** √ **Rights advice** √ Right to apply to the **CCB**	- **<14 y.o.,** - **outpatient,** - **inpatient in non-Schedule 1**, **OR** - the treatment for **anything other than a mental disorder** √ No Form 33 √ **Physician/Health practitioner provides rights advice** and documents same √ Right to apply to the **CCB**

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Finding of Incapacity – Medical/Community

STEP 1: Documenting the Assessment

1) The *specific treatments* for which the client has been found incapable (recall that capacity is treatment specific);

2) A consideration of each branch of the capacity test and whether s/he passes or fails:

Does the client have *the ability* to understand the information provided to him/her; and

Does the client have *the ability* to appreciate the reasonably foreseeable consequences of a decision or lack of decision regarding the treatment?

3) What information has been given to the client, including:

Nature of the treatment

Risks and benefits of same

Possible side effects/negative outcomes

Alternatives

4) The responses s/he gives to that information;

5) Whether the inability to understand/appreciate is due to a mental disorder (broadly defined as any disease or disability of the mind);

6) That the healthcare practitioner has provided Rights Advice (see next slide).

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Finding of Incapacity – Medical/Community

STEP 2: Providing Rights Advice to the Client

According to the CPSO, delivering **Rights Advice** involves;

1) Informing the incapable patient of the finding and that a SDM will assist them in understanding the proposed treatment and will be responsible for making the final decision;

2) If the patient disagrees with the finding, advising that patient that s/he can apply to the CCB for a review of the finding;

3) If the patient disagrees with the involvement of the current SDM, advising the patient s/he can apply to the CCB to appoint a different SDM; and

4) If the patient wishes to exercise either of the option in (2) or (3), taking reasonable steps to assist the patient in making an application to the CCB.

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Who Is the SDM?
HCCA s. 20

Guardian of the Person

Attorney for Personal Care

Representative appointed by Consent and Capacity Board

Spouse or Partner

Custodial parent (or CAS) or child

Parent with right of access only

Brother or sister

Any other relative

Public Guardian and Trustee

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Capacity and Consent to Treatment: An intertwined issue

- Today's discussion is focused on involuntary treatment, but inevitably this relates to capacity to consent to treatment in a number of ways:
  - "Box B" criteria for incapable patients
  - Capacity with respect to treatment for primary mental disorder versus substance use disorders
  - The potential use of Community Treatment Orders for people with substance use disorders as a less restrictive or coercive measure than hospitalization or coercive residential treatment

- Tension about how the legal test of capacity (*Starson v. Swayze*) applies in populations such as youth that have impaired capacity due to substance use, intoxication, overdose, and possibly developmental considerations
  - Goodyear, T. *et al*. (2023). Autonomy and (In)Capacity to Consent in Adolescent Substance Use Treatment and Care. *Journal of Adolescent Health, 72*(2) 179-181.

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CCB Reasons and Addictions Treatment: A Review

- Review of all CCB Reasons for Decision publicly reported on CanLII in Ontario (**10,463**) *
- Not all hearings are reported, e.g. in the 2020/2021 fiscal year only 12.4% of CCB hearings were reported
- Only **71** reported CCB Reasons included the key words “methadone”, “buprenorphine”, “Suboxone”, “opioid agonist”, “opioid replacement” or “naltrexone” (the hearing was not necessarily regarding capacity whatsoever)
- In comparison, **5016** included “schizophrenia”, **7148** included “antipsychotic” or "anti-psychotic" and **525** included “surgery”
- Only **6** CCB Reasons specifically reference a determination of capacity with respect to addictions treatment, and only **1** found a patient being incapable with respect to opioid replacement therapy

AM (*Re*), 2019 CanLII 46829 (ON CCB)

43 year old man detained under the Ontario Review Board, with a history of aggression related to requesting escalating doses of methadone.

“For the foregoing reasons, it was determined that AM was not capable respecting treatment with antipsychotic medications (oral and injectable); anti-anxiety medications; and opioid replacement therapy. It was not necessary to specify blood work and EKG testing as they were ancillary to said treatments; and as such included.”

***The Consent and Capacity Board (CCB) publishes all Reasons for Decision issued by the CCB since June 1, 2003 on the Canadian Legal Information Institute (CanLII) website: https://www.canlii.org/en/on/onccb/index.html. Some Reasons issued before June 1, 2003 are also available on CanLII. Note that Reasons for Decision are only issued if one of the parties to a CCB hearings makes a request for reasons for a decision, within 30 days after the hearing ends.*

See also: Hauck TS, Goud R, Warner M, et al. Capacity to Consent to Treatment of Substance Use Disorders at Ontario’s Consent and Capacity Board: A Review of Past Reported Decisions. *The Canadian Journal of Psychiatry*. 2024;69(10):781-783.

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CCB Reasons for Decisions for Incapacity to Substance Use Treatment

Decision	Patient	Site	Incapacity Finding	
AK (Re) #26051 2016	57 M	St. Joseph's Healthcare Hamilton - Charlton Campus	Yes (including naltrexone)	Patient with history of schizophrenia, SUD and brain injury, and previously on methadone. Involuntary status upheld and incapacity towards bloodwork, APs, mood stabilizers, BZs, cogentin for side effects and naltrexone.
AM (Re) #52835 2015	40 M	CAMH	Yes (APs, anxiolytics, anti-cholinergics)	Patient with history of SCZ and OUD, previously found capable to consent to methadone and gabapentin. CCB upheld incapacity towards treatment with APs, anxiolytics and anticholinergic medications.
AM (Re) #28874 2020	53 M	Owen Sound, Ontario	Yes (capable to naltrexone and CTO)	Patient with SCZ and on a CTO, previously found capable to consent towards naltrexone treatment for AUD. CCB confirmed CTO renewal and incapacity towards APs and the CTP.
JG (Re) #138886 2021	62 W	Mount Sinai Hospital	No	Patient with history of major neurocognitive disorder, taking anti-craving medication for AUD. Previously found incapable to consent to ADs only. Involuntary status was revoked. There was discussion that the finding of incapacity around anti-craving medication was unclear: **“The panel also had some difficulty finding whether there was a finding of incapacity related to the anti-craving medication.”**
RB (Re) #120998 2018	37 M	Waypoint Centre for Mental Health	Yes (APs and MS)	Patient with history of SCZ and previously found treatment capable with regards to methadone. Incapacity towards APs and mood stabilizers was upheld.

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Consent and Capacity: Implications and Future Considerations

- ❑ Methamphetamine use has been escalating in North America as part of a "twindemic"
- ❑ Methamphetamine use increased from 0.3% of population (USA) in 2015 to 0.9% in 2021
- ❑ Between 2015 and 2017, methamphetamine use tripled among people using heroin (9.0% to 30.2%)
- ❑ Stimulant use can lead to persistent psychosis in individuals concurrently using opioids, particularly fentanyl
- ❑ A recent study from British Colombia found that, "Among people with a mental illness, the highest overdose mortality rates were among those with schizophrenia and other psychotic disorders (2.7, 95% CI = 2.3–3.3)" (Keen et al, *Addiction* 2022)
- ❑ There are many reasons why a patient may be incapable with respect to addictions treatment such as OAT, including psychotic disorders, traumatic or anoxic brain injury, neurocognitive disorder, or neurodevelopmental disorders

→How does this impact care in an ACT setting, as opioid overdose becomes a major source of mortality?

→ What are the implications for a CTO if a patient is incapable with respect to OAT such as buprenorphine extended-release?

https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf
https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf

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3

Community Treatment Orders: Preventing the Revolving Door

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Community Treatment Orders

Designed to assist “revolving door” client/patient

Facilitate supervision of treatment in the community

Less restrictive than staying detained in hospital

Criteria for issuing CTO

- during prior 3-year period
  - > experienced two or more admissions to a psychiatric facility OR
  - > admitted to a psych facility for a cumulative period of 30 days OR
  - > been the subject of a previous CTO
- Community Treatment Plan
- Examined patient within 72 hours
- Form 1: Box A or B criteria met
- Consulted with others
- Rights advice for client and the SDM

Allows you to bring client back to hospital (Form 47)

Expires in 6 months (but may be renewed)

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Community Treatment Orders: The Forms

- Form 49 — Notice to Patient of Intention to Issue/Renew Community Treatment Order
- Community Treatment Plan
- Form 50 — Confirmation of Rights Advice (Client)
- Form 50 — Confirmation of Rights Advice (SDM)
- Form 45 — Community Treatment Order
- Form 46 — Notice to Patient of Issuance/Renewal of Community Treatment Order

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CTO Checklist – The Steps

***Only a physician may issue (or renew) a CTO. Onus is on the physician to make sure all steps have been completed.**

Step 1: The physician must **determine the person's eligibility for a CTO.**

-client has been a patient in a psychiatric facility on 2 or more separate occasion in the last three years **or**
-client has been a patient in a psychiatric facility for a cumulative period of 30 days or more in the last three years **or**
- client has been the subject of a previous Community Treatment Order

Step 2: The issuing physician consults and collaborates with outpatient team, the client, SDM (if applicable) and anyone else involved to **develop a Community Treatment Plan (CTP).**

- A CTP is a comprehensive plan of community based treatment, care or supervision that is less restrictive than being detained in a psychiatric facility.

Step 3: The issuing psychiatrist will **assess the client's capacity to consent to the CTP**.

- The CTP is considered a distinct treatment under the *Health Care Consent Act* and thus, the person must be assessed specifically for capacity to consent by to the CTP. This assessment must be documented in the chart.
- If the person is incapable, the SDM must be involved and informed about the rights and responsibilities in assuming the role of SDM.

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CTO Checklist – The Steps (cont'd)

Step 4: **If the client is incapable of consenting to the CTP**, the issuing physician must obtain informed consent to the CTP from the SDM (and document same).

Step 5: The issuing psychiatrist must **assess whether the client meets the criteria under s.33.1(4)(c) of the *MHA*** and document same.

- Is the client suffering from a mental disorder such that he or she needs continuing care, treatment or supervision in the community?
- Does the client meet the criteria for an Application for Psychiatric Assessment (Form 1), either Box A or Box B?
- If the client does not receive care, treatment or supervision in the community, is he or she likely to cause serious bodily harm to him/herself or another person, suffer serious physical impairment, or suffer substantial mental or physical deterioration?

Step 6: The **CTP must be signed within 72 hours of conducting the assessment in Step 5**. The Notice of Intention to Issue or Renew a CTO **(Form 49)** should also be issued at this time.

- The original Form 49 and the CTP signed by all parties must be placed on the chart.
- A copy of the Form 49 and the CTP must be given to the person and the SDM (if applicable).

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CTO Checklist – The Steps (cont'd)

Step 7: **Request and Obtain Confirmation of Rights Advice (Form 50).**

A CTO cannot be issued until both the client and SDM, if applicable, have obtained rights advice (or best efforts to provide rights advice have been unsuccessful).

Step 8 Complete the **Community Treatment Order (Form 45)**

-Both the issuing physician and the person (or SDM) must sign the Form 45 in order to complete the CTO.
-NOTE – The person/SDM must sign *before* the physician.
-The Form 45 is to be given to the : the person, their SDM (if applicable), others named in CTP (eg, the monitoring physician, case manager, etc)

Step 9: Complete the **Notice of Issuance or Renewal of Community Treatment Order (Form 46)** and provide a copy to the client.

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CTOs: Consent and Capacity Board Hearings and Renewals

- ❑ CTOs are generally overseen by Assertive Community Treatment teams or other community based service with intensive case management support; sometimes a family physician has role of monitoring physician

- ❑ Psychiatric hospitals generally have a CTO Coordinator, who supports physicians in managing the CTO process and ensuring completion of the relevant paperwork

- ❑CTO's expire at 6 months, but may be renewed for up to 6 months at a time thereafter

- ❑Person subject to CTO may apply to CCB for review of CTO criteria each time CTO is issued or renewed

- ❑At point of every second renewal (ie, every 12 months) there is a deemed application to the CCB which cannot be waived by patient (ie, mandatory CCB hearing)

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For more information about CTO's:

EENet | Community Treatment Orders (CTO): A course for CTO Coordinators, Physicians and others involved in CTOs

This free, online, self-directed course is designed for community treatment order (CTO) coordinators, physicians and other in Ontario who are involved with CTOs.

The goal of the course is to increase knowledge and awareness of CTOs for CTO coordinators, physicians and others in Ontario. The course consists of five interactive modules that include learning activities, videos, and case studies on the following topic areas:

1. Legislation related to CTOs
2. The CTO process
3. Community Treatment Plan content
4. Past Consent and Capacity Board and court decisions
5. Tracking CTOs across the province

The course takes approximately three hours to complete, and you can choose to complete the whole course or only certain modules. If you complete the entire course, you will receive a letter of completion or a letter of accreditation.

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Questions?

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