**An Exploratory Study of the Use of Community Treatment Orders with Clients of the Guelph ACT Team**

**FINAL REPORT**

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**July 2015**

**Acknowledgements**

We wish to sincerely thank the clients of the Guelph Assertive Community Treatment Team for their willingness to participate in this study. We hope that you feel we have faithfully communicated your experiences. We also want to acknowledge and thank the ACTT clinicians for the very open and collaborative relationship we have enjoyed as we worked together to identify a focus for the research and to conduct the study. We also wish to acknowledge and thank Stephanie Engel, MSW, who assisted with the literature review and the interviews with the ACTT clients. Finally, thank you to the Mitacs Accelerate Program and the Homewood Research Institute for providing the funding for the study.

**Abstract**

In order to better serve the needs of individuals diagnosed with serious mental illness, Ontario implemented Assertive Community Treatment Teams (ACTTs) comprised of mental health clinicians who work both with voluntary and involuntary clients and those subject to mandated treatment through a Community Treatment Order (CTO). This study is the first to focus on the experience of clients and clinicians when CTOs are used in combination with ACT services.

To further understand the experiences of the clinicians on the Guelph ACTT and their clients who are or have been on a CTO, we undertook a qualitative study involving 11 clients and eight clinicians of this team. Analysis of the interview and focus group data, which was organized in accordance with our five research questions, found that although some clients are initially against the decision to issue a CTO, the majority in this study did find some positive outcomes including: more time in the community (fewer hospitalizations); regular access to a psychiatrist; helpful professional support with medication, housing, and transportation; and improvement in overall quality of life. Although the literature raises issues regarding coercion, lack of autonomy, and possible incongruity with a recovery-orientation in the use of CTOs, Guelph ACTT clinicians believe that, for clients with severe mental illness for whom nothing else has worked (to keep them out of hospital or free from repeated psychotic episodes), that CTOs are helpful. Keys to the success of the Guelph ACTT, and their use of CTOs to assist in effective client treatment include: developing a trusting and respectful working relationship; co-creating treatment goals when possible; encouraging client responsibility; and regular communication with clients and between team members. Clinicians identified the mandated six-month review process for CTOs as a time of potential stress.

**Rationale**

The purpose of a community treatment order (CTO) is “to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility” (Ontario Mental Health Act 33.1(3)). While generating considerable controversy (Mfoafo-M’Carthy & Williams, 2010), research has supported the effectiveness of CTOs with respect to reduced hospitalizations, reduced violent behavior and improved client quality of life (O’Brien, Farrell & Faulkner, 2009; O’Reilly, Brooks, Chaimowitz, Neilson, Carr et al., 2009). However, clients tend to have contradictory feelings about being on a CTO (Canvin, Bartlett, & Pinfold, 2002; Gault, 2009; O’Reilly, Keegan, Corring, Shrikhande, & Natarajan, 2006). Coercion is a main critique, and many researchers have expressed concern about stigma and clients not having control of their lives (Brophy & Ring, 2004; O’Reilly et al., 2006).

Assertive Community Treatment Teams (ACTTs) are an evidence-based approach to supporting people with serious mental disorders in the community. While many studies of the implementation and effectiveness of ACTTs have been conducted, we found only one U.S. study using administrative data that focused on individuals receiving ACTT services and simultaneously subject to the equivalent of a CTO, namely an order for Assisted Outpatient Treatment (AOT) (Swartz, Wilder, Swanson, Van Dorn, Robinson et al., 2010). The findings from that study suggested CTOs offer benefits in addition to those of ACTTs, but the perspectives of clients and service providers were lacking.

A recent Ontario study found ACTTs that rated themselves higher on recovery-oriented service provision tended to have better client outcomes (Kidd, George, O’Connell, Sylvestre, Kirkpatrick et al., 2011); this raises the question of how ACTTs reconcile the use of CTOs with the recovery principles of client empowerment, involvement in decisions, and choice, as articulated by the Ontario Program Standards for ACT teams (Government of Ontario, Ministry of Health and Long-term Care, 2005).

While several research projects have studied the perceptions and opinions of individuals who had been placed on CTOs, this is the first Canadian study of the perspectives of clients who are or have been on a CTO at the same time that they are clients of an ACTT. We will also clarify the perspectives and rationales of the ACTT clinicians regarding the use of CTOs with their clients.

*Objectives of the Research Project*

1) To increase knowledge about the experiences and perceptions regarding Community Treatment Orders (CTOs) of clients receiving treatment from the Guelph Assertive Community Treatment Team (ACTT) who are, or have previously been placed on CTOs;

2) To increase knowledge about conditions and circumstances that contribute to decisions to place ACTT clients on CTOs;

3) To increase knowledge about the experiences and perspectives of the ACTT service providers regarding the rationale and effects of these decisions.

Increased knowledge in these areas will contribute to improvement in the community treatment of clients with serious mental illness, and their ability to live productively in the community.

We see this as a first step in a program of collaborative research intended to improve the effectiveness of community treatment of persons diagnosed with serious mental illness such that their quality of life and sense of well-being are enhanced.

**Review of Relevant Literature**

In Canada, Saskatchewan was the first province to implement CTOs in 1995 (O’Reilly, Keegan, & Elias, 2006). New Brunswick is the only province that has considered and decided against using CTOs (Trueman, 2003). Amendments to the Ontario Mental Health Act in 2000 included the introduction of CTOs as a prescribed treatment option for the persistently mentally ill and increased funding to offer case management services for those on CTOs (O’Brien, Farrell, & Faulkner, 2009). In Ontario, the patient or a substitute decision maker (SDM) if the patient is not capable, must consent to the CTO. However, Gray and O’Reilly (2005) state, “[i]n fact the true voluntary nature of the agreement applies to relatively few people who are capable of consenting to a ‘compulsory’ agreement. For the majority who are incapable, the substitute decision maker’s consent makes the order ‘compulsory’ from the patient’s perspective” (p. 19).

Much of the research on CTOs has been done in the United States and Australia. Different jurisdictions have different names and diverse conditions associated with the equivalent of CTOs. For example, in many U.S. States a court rather than a physician issues the order. Increased funding for more resources in the community is not always included in the legislation initiating CTOs (Churchill, Owen, Singh & Hotopf, 2007). A review of the effectiveness of involuntary outpatient treatment in eight U.S. states noted, “The burden of monitoring outpatient commitment orders most often falls to treatment providers, most of whom do not have the resources to provide high levels of supervision” (Ridgely, Borum & Petrila, 2001, p. 64). Because of these differences, generalizing from studies in a different jurisdiction is fraught with difficulty.

Perhaps related to these difficulties, the literature on the effectiveness of CTOs reveals a spirited debate. A group of researchers in Western Australia have been quite vocal in questioning the effectiveness of CTOs. A Cochrane review by this group (Kisely & Campbell, 2014), based on three randomized controlled trials, concluded that CTOs result in “in no significant difference in service use, social functioning or quality of life compared with standard voluntary care” (p. 3). However, people on CTOs were less likely to be victims of violent or non-violent crime. The authors noted it is unclear whether this benefit is due to the intensity of treatment or its compulsory nature. (The evidence from these three trials was rated as low to medium quality). Implementing randomized controlled trials with this population is difficult because of ethical and legal issues (Kisely, Preston, Xiao, Lawrence, Louise et al., 2013). No randomized controlled trials have been conducted in Canada. Most of the studies completed to date have been before and after studies (Kisely et al., 2013)

Some of the debate has been around the most meaningful criteria for measuring effectiveness, as some studies defined it as a reduction in the number of hospitalizations, while others have argued that reduced length of hospitalizations and other quality of life criteria should be employed. The most common outcome measures of CTO research relate to hospitalizations. Several studies found CTOs lengthen the time before readmission into hospital and reduce the frequency of hospital admissions as well as the number of days spent in hospital (Dye, Dannaram, Loynes, & Dickenson, 2012; Frank, Perry, Kean, Signam, & Geagea, 2005; Hunt, da Silva, Lurie, & Goldbloom, 2007; Nakhost, Peery, & Frank, 2012; O’Brien & Farrell, 2005; Swartz et al., 2010; Van Dorn et al., 2010). A study in Western Australia found when number of admissions to hospital was compared to a control group, those on CTOs were more likely to be admitted to hospital but total days in hospital were decreased (Kisely et al., 2013). Other studies have found no significant difference in hospital admissions of persons with a CTO compared to those without a CTO (Burns et al., 2013; Steadman et al., 2001; Swartz et al., 1999).

Some studies have shown CTOs to be useful for clients in multiple facets of life, such as improved contact with mental health services, a reduction in violent behavior, reduced risk of being victimized, reduced mortality rates, and reduced substance abuse (O’Brien & Farrell, 2005; O’Brien, Farrell, and Faulkner, 2009; O’Reilly et al., 2009; Kisely et al., 2013). Offering case management services was associated with increased use of community services by CTO clients (O’Brien et al., 2009). Studies have also shown increased likelihood of employment and increased housing stability when placed on a CTO (O’Reilly et al., 2009).

Studies in several countries have reported clients tend to have ambivalent or contradictory feelings about being on a CTO (Canvin, Bartlett, & Pinfold, 2002; Schwartz, O’Brien, Morel, Armstrong, Fleming et al., 2010). Service users in the U.K are often “initially reluctant to comply with mental health treatment, but do eventually accept the need for treatment” (Gault, 2009, p. 504). In a study in Saskatchewan, while “most experienced some degree of coercion . . . many believed that CTOs provided necessary structure in their lives” (O’Reilly et al., 2006, p. 516). In Scotland, Ridley and Hunter (2013) found a common response was that “in practice, community compulsion equated with a ‘medication order’ with the focus on monitoring compliance” (p. 515); however, some service users saw certain advantages of the CTO in that “it keeps me within the system” (p. 516). In terms of satisfaction, some patients in a U.K. study viewed the order positively (41%), some were indifferent (12%) but the largest proportion (47%) had mixed views (Fahy, Javaid, & Best, 2013). A study by Schwartz, O'Brian, Morel, Armstrong, Fleming et al. (2010) is the only published study that has explored service users’ experiences of CTOs in Ontario. They found clients’ experiences were similar to that reported in other countries, but their participants were less concerned about the CTO itself and more concerned “about the labels, control and discrimination associated with severe mental illness” (p. 1).

Coercion is a main critique of CTOs as they may undermine civil liberties. Service providers in Australia were concerned about stigma, clients not having control of their lives, loss of freedom, restrictions, lack of choice in treatment, being disempowered, and having less life opportunities (Brophy & Ring, 2004). Gault (2009) points out that when professionals “see risk rather than people” (p. 511) and fail to work with clients respectfully and collaboratively, clients often resist through noncompliance leading to more coercive measures. Some clients in Gault’s (2009) U.K. study felt a loss of valid identity when coerced as well as a lack of autonomy, but they perceived “playing the game” and being a “good patient” could reduce coercion

Comprehension of CTOs could impact clients’ views of their treatment. Fahy et al. (2013) found that most of their U.K patients understood supervised community treatment was associated with earlier discharge from hospital but many did not feel involved in the planning process. A significant proportion did not understand the verbal or written information pertaining to their legal rights at the time it was given. Some were not aware of their right to appeal or the reasons they could be recalled to hospital. The majority disagreed with extensions of their community treatment. The researchers recommended that a patient’s rights need to be revisited at regular intervals, the case coordinator should be obliged to describe the conditions of the order, and patients should have the right to appeal at frequent intervals. In Ontario, the maximum duration of a CTO is six months; renewal requires both a physician and a Rights Advisor to inform the client that a renewal is being planned and to advise regarding the client’s right to appeal; if the client or SDM requests it, a hearing is held. Hearings are mandatory every second time the CTO is renewed.

*Research Regarding Assertive Community Treatment (ACT) Teams*

ACT has been described as “a model of service delivery that provides continuous services to promote the community adjustments of persons with severe mental illness and high service usage” (Krupa et al, 2004, p. 115). ACT teams provide many services for clients, which often include: counselling; assistance with finances, housing, paperwork, and finding appropriate opportunities for work; medication support; health promotion; getting the clients’ families involved in treatment; and improving daily living skills (Phillips et al., 2001). Individualized services are offered to clients 24 hours a day, 365 days a year in the community by a team with a staff to client ratio of approximately 1:10 (Phillips et al., 2001). ACT programs are also intended to include members providing direct services who have utilized mental health services themselves (Phillips et al., 2001). From 1998 to 2004 the number of ACT programs increased nearly six-times to 59 in Ontario (George, Durbin & Koegl, 2008).

More recently, studies of ACT teams have focused on the recovery model. A recovery approach is grounded in “…hope, personal responsibility, social connections, citizenship, meaningful life activities, a positive identity, full life beyond the illness, and personal growth” (Salyers, Stull, Rollins & Hopper, 2011, p. 169). The recovery model changes the relationship between the service provider and the service recipient in that it assumes the sharing of power, individualized treatment plans, an attitude of hope, goal setting by the service recipient, and increasing autonomy (Felton, Barr, Clark, & Tsemberis, 2006). Kidd et al. (2010) found a moderate to high degree of recovery orientation in service provision within Ontario with no significant relationship between ACT fidelity and consumer and family/key support rating of recovery orientation. Higher ratings of Recovery Self-Assessment by team leaders and service providers were associated with decreased days spent in hospital, less involvement with the legal system, clients more involved in school, and more clients with employment (Kidd et al., 2011). However, it has also been suggested that a number of situations make it difficult for ACT teams to work in a recovery-oriented manner. These include when clients do not “admit to having a mental illness”, when a crisis was occurring, when the client’s treatment goals are not in line with the staff’s goals, and when the client is not interested in forming a collaborative relationship with the team (Felton, Barr, Clark, & Tsemberis, 2006, p.116).

One of the most important precursors of positive outcomes is persuading clients to engage in treatment. In England, Priebe, Watts, Chase, and Matanov (2005) pointed out that assertive outreach was intended to care for “difficult to engage” patients. Themes associated with engagement included workers who spend more time and show more commitment to patients, provide social support and engagement without a focus on medication, and a partnership model of the therapeutic relationship. Themes associated with disengagement included the client’s desire to be an autonomous and able person, a poor therapeutic relationship, and client’s sense of loss of control due to medication and its effects.

Client satisfaction with ACT has been the focus of some studies. In many studies clients were generally satisfied with service, especially with the interpersonal aspects of care, persistence of the staff, and supports for daily living (Chimnan et al., 1996; Gerber & Prince, 1999; Leiphart & Barnes, 2005; Redko, Durbin, Wasylenki, & Krupa, 2004; Watts & Priebe, 2002). Clients also commented positively about assistance with: mental illness in the community and in times of crisis; setting goals, and striving for personal growth; being more involved in their community; and having free activities, as many participants lived in poverty (Krupa et al., 2005). This was somewhat contradictory to results in other studies that reported clients were dissatisfied with the amount of information and influence they had over treatment, side effects of medication, the amount of medication they were taking, staff turnover rate, being visited too often, staff being controlling, dealing with multiple people on the team, ACT being associated with the hospital and the negative experiences there, feeling reliant on ACT to be involved in the community, and not liking when a trustee controlled their money (Gerber & Prince, 1999; Horgan, 2000; Krupa et al., 2005; Redko et al., 2004). Clients’ relationships with their case managers have also been identified as an important component of treatment (Gerber & Prince, 1999; Horgan, 2000).

Being considered coercive has been a well-noted concern of ACT programs (apart from the use of CTOs). Some critics of the ACT model, “contend that ACT is contradictory to the philosophy of empowerment due to the use of interventions that could be considered coercive” (Tschopp, Berben, & Chan, 2011, p. 408). Moser and Bond (2009) found that more control measures were used when more of the clients had some form of schizophrenia and/or when more of the clients used substances.

*Studies of People on CTOs and Registered with an ACT Team*

We have found only one study that compared the progress of individuals on court ordered outpatient treatment who were also receiving ACT services with those who were receiving ACT services but not subject to a court order. Swartz et al. (2010) in their study using administrative data regarding consumers on Medicaid in New York state found that for those who received court orders for Assisted Outpatient Treatment (AOT) “the likelihood of receiving ACT services increased roughly fourfold for both the initial six months (OR= 4.13) and the subsequent six-month renewal of the court order (OR=4.03)” (p. 979). They compared outcomes for clients of ACT who were not subject to AOT with those who received ACT services, or intensive case management as well as the AOT. The addition of the court order to receive ACT reduced the likelihood of hospitalizations by 43% compared with those who were receiving ACT alone, and the combination of ACT with an AOT significantly increased the likelihood of high engagement with services as rated by case managers (OR= 2.13). These authors concluded “these results more directly demonstrate that AOT itself offer benefits in addition to those of ACT – the exemplar of evidence-based community treatment” (Swartz et al, 2010, p. 980).

Few studies have examined the combination of ACT and CTOs with respect to outcome. We found no such studies conducted in a Canadian context. We also did not find any study that has explored service users’ experiences of being both registered with an ACT team and also under a CTO, therefore, this was the focus of the current exploratory study.

CTOs in Ontario are legislated by Section 33 of the Mental Health Act. A person cannot be put on a CTO unless, during the previous three-year period, “the person has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period” (Mental Health Act, Section 33.1). To issue a CTO, a physician must assess the person and consult with other health practitioners or persons involved in the person’s care or supervision to develop a Community Treatment Plan. The assessment must cause the physician to conclude that

if the person does not receive continuing treatment or care and continuing supervision while living in the community he or she is likely because of a mental disorder to cause serious bodily harm to himself or herself or another person or to suffer substantial mental or physical deterioration of the person or serious physical impairment of the person (Mental Health Act, Section 4 (c) iii).

**Method**

*Research Questions*

The following were our specific research questions:

1. What are the experiences of ACTT clients who are or have previously been on a CTO? How do they perceive the decision to put them on a CTO in terms of appropriateness and helpfulness?
2. Are there differences in the experiences and perceptions of CTOs of Guelph ACTT clients who meet criteria for one of the following three groups: 1) those who came to the ACTT already on a CTO; 2) those who were placed on a CTO by the ACTT and 3) those ACTT clients who were previously on a CTO but are no longer under a CTO.
3. What conditions and circumstances contribute to the decision to put ACTT clients on a CTO from the perspectives of the ACTT clinicians[[1]](#footnote-1)?
4. What are the Guelph ACTT clinicians’ experiences and perceptions about the appropriateness and helpfulness of CTOs with ACT team clients?
5. How do the ACTT clinicians reconcile the use of CTOs with the “client-centered, recovery-oriented” approach to service delivery as articulated by the Ontario Program Standards for ACT teams (Government of Ontario, Ministry of Health and Long-term Care, 2005). The ACT Standards state, “Client empowerment, involvement, and choice are fundamental to the principles and operation of individualized, collaborative and effective ACT service delivery” (p. i).

Because the research questions focused on clients’ and clinicians’ experiences and perceptions, a qualitative research approach was appropriate. We conducted individual interviews with consenting clients of the ACTT, and conducted a focus group and key informant interviews with the ACTT clinicians.

*Recruitment of Client Participants*

The ACTT social work clinicians conducted in-person meetings with all of the current ACTT clients who met the inclusion criteria; they provided them with oral and written information about the study and answered any questions the clients had. The inclusion criteria were: 1) client was placed on a CTO by the Guelph ACTT and continues to be on a CTO; 2) client was placed on a CTO by the Guelph ACTT but is no longer on a CTO; 3) client was placed on a CTO prior to being a client of the Guelph ACTT and either continues to be on a CTO or is no longer on a CTO; 4) the social worker assessed the client as capable of providing informed consent. Twenty of the Guelph ACTT clients were eligible to participate. Clients who met the inclusion criteria and indicated they were willing to participate in the study were assisted by the social workers to schedule an appointment with the research intern at a convenient date and time. Interviews took place at the ACTT office in Guelph, Ontario. All but three participants consented to audio recording of the interviews, which were later transcribed. For the three who declined to have the interview recorded, the intern took notes during the interview and supplemented the notes immediately following the interview. The intern followed an interview guide with open-ended questions and planned prompts to encourage the participants to talk openly and freely about their personal experiences and how they understood and made sense of those experiences. The interview guide was developed based on a review of the literature and previous discussions with the ACTT clinicians. At the end of the interview, client participants were given a $25.00 gift card to express appreciation for their time and contribution to the study. This research protocol received approval from both the Research Ethics Board at Wilfrid Laurier University and the Homewood Health Centre.

*Recruitment of Clinician Participants*

For the focus group with the ACTT clinicians, letters of information were sent inviting them to participate in a focus group to be held at the ACTT office. The researchers sought answers and discussion related to predefined open-ended questions and planned prompts. In addition, two key informant interviews were conducted, one with the ACTT psychiatrist and one with the Program Coordinator. These interviews were guided by the same questions as employed with the focus group, and all were audio recorded and transcribed.

*Data Analysis*

The transcripts of the client interviews, key informant interviews and focus group discussion were reviewed and errors corrected. We began the analysis by creating a coding framework that reflected the questions in the interview guide for the client interviews. The client responses to each question were coded followed by a thematic analysis (Braun & Clarke, 2006) of the client responses to each question. We used an inductive approach (bottom-up) that endeavoured to stay close to the data and avoid imposing a theoretical framework as much as possible. We looked for patterns and themes across the responses to each question. . A similar process was followed for the focus group and key informant interview data. NVivo software was used to facilitate the data analysis. Meetings between the research team members occurred to discuss the evolving themes from the patterns each was identifying in their individual reviews of the client and clinician data sets. Separate summaries of the patterns and themes were created for the client interviews and for the clinician interviews. We then organized the findings according to our original research questions.

Those client participants who requested it were sent a copy of the summary of the patterns and themes, and invited to contact the researchers if they wished to add any thoughts or propose changes. Similarly, the service providers were provided with a summary of the findings from the focus group and key informant interviews and invited to provide feedback.

**Results**

In this section, we first describe the client and clinician participant samples and report the results organized by the Research Questions. The section ends with a description of how the client participants talked about their experiences with this particular ACT team and how the clinician participants described their relationships with clients who are on CTOs.

*Description of the Samples*

*Client participants*

Out of a total of 20 ACTT clients who were currently on a CTO, we interviewed 11 consenting client participants; seven clients declined to participate and two were assessed as not having capacity to consent. Of the 11 clients who were interviewed, 5 were female and 6 male.

Their ages ranged from 27 to 66 years with a mean of 40.5 years. Nine participants identified their ethnicity as “white”, one reported being white and part Native, and one identified his/her[[2]](#footnote-2) ethnicity with the country of birth, which was outside Canada. Two participants reported they graduated high school; eight had attended some high school. One completed grade eight, but had taken some adult education later. Two who had not completed high school as youths reported some post-secondary education.

Seven client participants reported they were single and never married, two were currently single but reported a previous common law relationship, and two were divorced. Five participants told us they had children and the number of children ranged from one to six. Three participants talked about having lost their children. For at least two participants, child welfare had been involved, and in one case, another family member obtained custody of the participant’s child.

One participant was retired, one was working part-time and the remaining participants were unemployed and not currently looking for work. Several said they were receiving the Ontario Disability Support Pension, and one was receiving financial support from the Canada Pension Plan.

Participants had been involved with the mental health system between 4 to 51 years with a mean of 16.3 years. The mode and median were 15 years. In terms of length of time as clients of the Guelph ACTT, the duration ranged from ranged from 3-4 months to nine years. Several reported they had been clients between four and seven years.

The client participants most commonly reported that their diagnosis was bipolar disorder. One participant said s/he had been diagnosed with schizophrenia; two others mentioned the diagnosis of schizophrenia, but indicated they did not agree with it. Two others referred to a diagnosis of schizoaffective disorder, and one referred to a diagnosis of drug-induced psychosis. One participant discussed how he or she was relieved that the diagnosis was schizoaffective disorder as the participant saw this as preferable to the diagnosis of schizophrenia. This participant said,

And I am proud, so it must mean, like if the schizophrenia was like the schizoaffective, I wouldn’t be, oh my God, because you know they say that schizophrenia is for the rest of your life…I just don’t like the schizophrenia…it’s like what I envision schizophrenia and what I had were two totally different things.

Two participants volunteered information about being victims of violence. One reported being the victim of a sexual assault as an adolescent, and another reported being a victim of domestic violence. One participant also believed s/he had been a victim of racism and was mistreated by police because of his/her race.

Three participants reported that they had been placed on a Community Treatment Order (CTO) in the past but were not currently on such an order. The remainder indicated they were currently on a CTO. Some participants were not able to remember how long they had been on a CTO. For those who provided an estimate, the duration ranged from 3 months to 7 years. Several participants were not able to say how many times they had been hospitalized for mental health reasons; for those who did provide an estimate, the number ranged from 2-3 admissions to 16 admissions. One participant stated that the duration of one of his admissions to hospital had been 4 or 5 months, another said one admission had been for 10 months.

*Clinician participants*

In order to answer our research questions regarding the ACTT clinicians’ experiences and perceptions, we conducted a focus group with six ACTT clinicians. Nursing and occupational therapy were the disciplines most represented by the focus group participants. We also interviewed two key informants, namely, the ACTT psychiatrist and the Program Coordinator. The ACTT clinicians have worked on the team for between 2 and 9 years with a mean of 7.4 years. The program psychiatrist has been with the team for four years; the Program Coordinator began working with the team seven years ago and became the Coordinator three years ago.

*Research Question 1:* *What are the experiences of ACTT clients who are or have previously been on a CTO? How do they perceive the decision to put them on a CTO in terms of appropriateness and helpfulness?*

*Client participants’ understanding of reasons for the CTO*

A few participants did not clearly understand or remember why they had been put on a CTO; one participant said, “I thought they thought I was not taking my meds – But I am taking my meds …I don’t know what it was to be honest with you.” However, several participants recognized that at least part of the reason for the CTO had to do with medications. One participant said, “well, I quit taking my pills and they couldn’t trust me.” Another said, “I have more responsibility for what I am doing…just managing my meds, over time and monies.”

Other participants recognized that the service providers believed the CTO would be helpful to them. One said the reason was “to keep me in tow”. When asked to explain, the participant said that the ACTT wanted to see “if there is any improvement”. Several participants indicated that the ACTT wanted them to have a “better life”. One said that she saw the CTO as a way to get help. Another said, “because they think they keep me out of hospital.”

*Feelings about the CTO*

The majority of participants described negative feelings initially, such as anger, being “livid” or “irritated”. One said that s/he hated being on the CTO, felt it was unfair and like s/he was a “criminal” being punished. Another said being on a CTO was like being “on a leash”. Several talked about how having to live with the negative side effects of taking medications significantly contributed to their negative feelings about the CTO. One participant recalled being concerned about privacy and her/his fear that neighbours would find out s/he was under the CTO because the ACTT clinicians were delivering medications to his/her home. Two participants talked about feeling they did not have a choice. One said,

I didn’t feel anything. Like they’re gonna do what they’re gonna do and that. There’s no sense in arguing it because they are going to get their lawyers and that…so it’s just a waste of time getting all these people to come in.

Another reaction was fear because the participant recalled that s/he did not fully understand what a CTO meant:

I got scared that like, my life would go, the other way. It is just like this one time and now I am back in the hospital and this CTO, and oh God, I didn’t know what it was, but it’s actually what I thought it was, this will be really good for me because they’ll – like, I will have somebody, a psychiatrist, I’ll have all that stuff.

However, several participants recalled less negative feelings initially. One participant said s/he had agreed with the decision and had no concerns about it. This participant had a relationship with the ACTT before being put on the CTO and indicated s/he felt better when s/he was expected to attend meetings/appointments regularly and on time. Another participant said s/he saw the benefit of the CTO but said that “it takes away your dignity” and s/he thought people should not be forced . . . “It’s like a knife, can be used two ways, good and bad”. However, this participant said that s/he later “saw the light” meaning s/he recognized s/he needed help, and is now where s/he wants to be in terms of his/her health and lifestyle. Another said, “I am going to be honest with you. I thought maybe it would be good for me. . . Because I am alone, I have no friends, I have no family members, so if I get sick I have nobody to bring me to the hospital.”

Regarding current feelings about the CTO, three participants were quite certain that being on the CTO had helped them. Another participant said s/he was more appreciative regarding the CTO than previously – s/he found the nurses to be dependable, appreciated that the doctors took notes and found the groups s/he attended helpful. S/he also liked the social aspects of being involved with the ACTT. One participant who is now off the CTO, said the ACTT has helped her/him a lot – but also gave credit to friends who taught him/her to meditate and improve self-esteem. The participant who was very concerned about privacy initially is now glad the ACTT is helping her/him to take the medications as prescribed. S/he thinks that without that support s/he would be at risk of relapse.

Two participants acknowledged that they feel a little more positive about being on a CTO than at the beginning. One said that his/her life has changed for the better since being on the CTO, and the other recognized that s/he now avoids people who in the past contributed to him/her being put in jail or hospital. Three participants indicated their negative feelings about the CTO have not changed; one of these continues to hate the CTO but recognizes that it might be helpful to some people.

*What would be different without the CTO?*

When asked this question, four participants clearly indicated their lives would not be as good. One participant said, “I’m way better than I was before”. Two thought they probably would not have followed the recommended treatment and would have had more hospitalizations. One participant acknowledged that being on the CTO helped him/her to realize that s/he did need help, implying that without it s/he might not have “got to a place where I could be healthy”.

However, other participants had different perceptions. One said that without the CTO, “I would have more pride in myself, if I had more freedom”. Two said they would still take the prescribed medication, but would not go to the ACTT office for their medications, as they believed they could manage it themselves. However, one of these clients also said that without the CTO s/he might have ended up back in hospital. Two participants said nothing would be different because they would continue to take the medication, see the psychiatrist, and have similar relationships with family and friends. One said “maybe” s/he would still be involved with the ACTT and “maybe” some of the symptoms might come back again.

*The importance of dignity*

Several participants referred to feeling a loss of respect or dignity when being on a CTO. One participant articulated it well:

Dignity is a big thing for people, some say “it’s (the CTO) just a piece of paper”, but it’s not, it’s shameful – if a cop wanted to he could just pick you up, or if you missed your meds or looked “off” they could just pick you up – I’ve been hurt by a cop before. But it [CTO] also has benefits for people who need it…It’s important once you get well to follow the Doctor’s orders and not screw up, you should get a chance to be off the CTO.

This participant went on to say that rather than involve the police it would be better if trained mental health staff intervened when necessary. If police do need to be involved, s/he thought they should use an unmarked car and plain clothes so the person on the CTO is more likely to stay calm and attention is not drawn to them in their neighbourhood. For this participant, a more private intervention would be a gentler solution that is not as embarrassing for people.

We also heard from several participants about the stigma associated with being labeled mentally ill; one participant said, “I think when they do label you once, you’re labeled for life.” Another participant who has been involved with the mental health system for many years said,

It is very, very hard for a young person to go through this. The shame of it in those days. Forty years ago the shame of it, the prejudice, it is still the same today but not as – it just doesn’t bother me anymore. The mental cruelty that it caused me…because I was too scared. I don’t know why but I was scared to walk downtown, you know, I would think they are all thinking, well there goes the nut, and there goes the crazy person . . .

The participant mentioned earlier who was concerned that his/her neighbours would find out about his/her mental illness when the ACTT came to his/her home with medication was also expressing concern about losing dignity and respect if others knew of their involvement with the mental health system. One of the participants who is no longer on a CTO declined to talk in any detail during the interview about how s/he became involved with the mental health system and why s/he was put on CTO; s/he said that it was painful for him/her “to go back to that part”. S/he stated that while s/he was on the CTO s/he realized that people with mental health issues often see people who want to help them as a bad thing; s/he now believes the ACTT and the CTO “helped me a lot”.

*Research Question 2: Are there differences in the experiences and perceptions of CTOs of Guelph ACTT clients who meet criteria for one of the following three groups: 1) those who came to the ACTT already on a CTO; 2) those who were placed on a CTO by the ACTT and 3) those ACTT clients who were previously on a CTO but are no longer under a CTO.*

Three participants reported that they were no longer on a CTO. For one, who had been on a CTO for five years, the CTO had just recently ended; the other two had been on a CTO for 3 years and 2-3 years respectively; both of these clients had been off the CTO for some time, but continued to be ACTT clients. Although two of the three participants acknowledged that the CTO had been helpful to them, one maintained that s/he still hated the CTO and that her/his life would not be any different now if s/he had not been put on it. This client acknowledged that a CTO might be helpful for people who are not honest about taking their medication or are without family support, but s/he did not believe it was appropriate for him/her. The other two participants acknowledged that the CTO had been helpful. One said that s/he appreciated its value a little more than initially and that it had kept him/her out of hospital. The second participant acknowledged that it had helped her/him obtain employment and without it s/he would be “in bad shape”.

No clear differences were observed between this small group of clients who were currently no longer on the CTO and the group of participants who were currently on a CTO. Among the group that was currently on a CTO, we observed a similar mix of positive perceptions about the helpfulness of a CTO as well as some negative ones as described above.

With respect to differences between participants for whom the Guelph ACTT had issued the CTO and those who came to the ACTT already on a CTO, again we observed no clear differences in the way they described their experiences. Some client participants were not sure who had put them on the CTO. It appeared that for the majority, a physician at the Homewood Health Centre initially issued the CTO when they were in-patients. Two participants said that the Guelph ACTT had issued their CTO, and one said another ACTT had issued the order, and this client came to the Guelph ACTT already on a CTO. It appears that the client participants’ experiences and perceptions of the CTO are more connected to the degree to which they see themselves as having a mental illness that requires treatment than with who issued the CTO initially.

*Research Question Three: What conditions and circumstances contribute to the decision to put ACTT clients on a CTO from the perspectives of the ACTT staff?*

The eight ACTT clinician participants pointed out that according to the Ontario Mental Health Act, clients must meet specific criteria before being considered for a CTO. According to the Act, a client cannot be put on a CTO unless during the previous three-year period, “the person has been a patient in a psychiatric facility on two or more separate occasions or for a cumulative period of 30 days or more during that three-year period” (Mental Health Act, Section 33.1). They also stressed that the use of a CTO is always a last resort. They referred to it as a “protective measure” and a “safety net”.

In addition to lengthy admissions or multiple admissions to hospital, clinician participants noted that both a lack of insight and repeated failure to accept treatment are commonly seen in people considered for a CTO. One clinician said,

It is basically the criteria that are required for the CTO. So, if someone has been hospitalized several times, not compliant with their medications, [we are] not able to address that with them or work with them about that or problem solve about why they are missing their medications. Then that is sort of what leads us to think about a CTO, especially if that is what is impacting either their own safety or the safety to others, or their housing or their financial status.

A second clinician said,

I guess the people who end up on CTOs are the people who might have a more severe course of illness. The ones who lack – who have the least insight into their illness, the ones who maybe have been made incapable but despite that even with their family or their Public Guardian & Trustee’s guidance, still can’t follow the treatment plan.

The clinician participants stated that the decision to put ACTT clients on a CTO always involves “lots of discussion” within the team and with family members as well as with the client.

… the CTO -- it typically is a last resort, right. So, it is usually a result of a number of patient treatment failures so they might already be with us [the ACTT] and it is not working. So in the hospital, this is the prime time to do it because of access to resources and things like that…maybe we can prevent this hospitalization from happening but we might have to go to a CTO as a way to protect you and keep you safe in the community but again, usually a CTO is a last resort, and it is usually the result of a number of out-patient failures.

The clinician participants also pointed out that the team considers whether it is likely that the client will benefit from being put on a CTO – “whatever the CTO could enforce – is that the reason why they are not maintaining their wellness outside of the hospital?”

One factor that guides the process is whether or not the client is assessed as capable of making the decision about treatment. Those clients who are assessed as incapable have a substitute decision maker (SDM) who is empowered to make the decision for the client as to whether the client would benefit from a CTO. Some of the clients who are not capable to make the decision do agree to go on the CTO, and some who are capable of making decisions about their treatment also voluntarily agree to accept a CTO. Every Community Treatment Plan is tailored to the individual’s strengths and needs.

Another circumstance associated with a CTO happens when people are “treatment resistant or fragile”. With these individuals, sometimes only a small change in medication can lead to dramatic changes in behaviour, and so the CTO to enforce medication compliance is seen as very important.

The ACTT clinicians also talked about how the best interests of the clients are the primary consideration. They believed that most of the time they are “on the same page” with each other in terms of making decisions about CTOs. They engage in thorough discussions before putting someone on a CTO. Two clinicians talked about it this way:

…lots of discussion. Lots of discussion happens, we all work as a team. A lot of the information gets shared and we have interactions with - different staff will have interactions with that client and often we are on the same page. Like, we always want the best for the clients but there is discussion and observation that we all have because it is not always one person working with that client. Different staff will have exposure to that person.

With our current team, I don’t think they are – there are any differences of opinion. I think we all agree that only people who require CTOs are on them. We’ve had enough people who have come to point of recovery that they no longer need CTOs that I think, we all understand that we are working towards that. You know it is not meant to be a forever thing. Our hope and desire is that is it not forever. That people reach a point in their recovery that they have insight and um…those are our pipe dreams – and sometimes they happen. Like we do have people where it has been successful that way

One of the issues that can lead to debate among team members is whether someone needs to be on a CTO “when they are going to be voluntary”. This refers to a client who has insight but when s/he is well, sometimes chooses not to take their prescribed medication. The team may question whether there is merit in putting such a client on a CTO when s/he may decide not to follow it. Participants said that if the consensus is that issuing the CTO would benefit the client in some way, then they do so. A second issue that may lead to debate has to do with whether or not a client should come off a CTO. The debate might be around whether the CTO should continue as a “safety thing” or whether it should be removed to show the client how well s/he is doing and perhaps “spur them further in their recovery”.

The clinicians provided non-identifying examples of clients for whom they decided a CTO might be beneficial. They referred to a client who had been with the ACTT for many years, but in spite of the team’s assertive interventions had required frequent hospitalizations after s/he became catatonic and very dysfunctional while living in the community. This client did not accept that s/he had a mental illness. Some team members were also concerned about the long-term cognitive deficits that could result from repeated psychotic episodes.

I think the severity of his/her symptoms on repeated presentations that, at least in my mind, I was really worried about the cognitive deficits that were going to start piling up because the symptoms were so severe and so marked each time s/he went into hospital. That without something stopping that we were going to have somebody who was going to have a serious amount of dysfunction.

This long-term ACTT client has not been admitted to hospital since being put on the CTO. The SDM is very supportive of the CTO, but the client continues to deny that it has helped.

*Efforts to avoid enforcing the CTO*

The ACTT clinicians emphasized that they persist in trying to find ways to work with a client when he or she is resisting following the Community Treatment Plan. Sometimes they communicate with the client’s family to seek their help. One clinician talked about how the team works hard to avoid enforcing the CTO

With…a lot of searching I think before [we issue a Form 47[[3]](#footnote-3)]…and it is also educating the patient that you are on the CTO. We give them all the opportunity to come to the office or meet with the worker, wherever they would like to have their injection, within reason. Considering confidentiality, but yeah, giving them the idea you know, we really want to work with you, and we want you to make this appointment or be here when you need to be. However, if you don’t, this is what will happen. So, we definitely give them that and we also work with families to help them understand that if they know where the person is, then to let us know. So we sort of, try everything before we issue a Form 47.

The clinicians stressed that they are as flexible as possible in enforcing the CTO because they know their clients well and they learn that some clients may not follow it exactly, but in the end will normally accept it.

Some people . . . miss a day here or there but their intention is not to continually keep missing, or they change their mind very quickly and decide, that “no I am going to come in and take it”. So, even though they might have told you to get lost one day, the next day they are showing up at the office saying, “I’ll take my medication”.

Steps taken to prevent having to issue a Form 47 include monitoring, communicating frequently with the clients, and offering assistance to the clients to ensure that they follow through with their Treatment Plan. Also, a lot of thought does into the development of the Plan.

…I think a lot of thought goes into the Community Treatment Plan to make sure that it is achievable by the clients as well, so we are not setting them up with expectations that they can’t meet. Especially if it is around like daily contact or things, so we will make sure that we are bringing the meds to them, or we are making it so that it is easy for them to sort of meet some of those obligations and that we don’t need to utilize the form forty-seven. You know hopefully, not at all. So a lot of the – a lot of it is done through the planning and making it achievable for them.

*What is the process when a Form 47 must be issued?*

Although for the majority of clients on CTOs, Form 47s are rarely used, the team recognizes that for some clients, their refusal to follow through with the conditions of the CTO is “the only control left in his/her life.” One clinician said,

Yes, and that is the desire -- is for things to come to a point where that [issuing a Form 47] is not required. With most [clients] it is not required. There are some where it is going to be required, each time. There is no insight level, the level of illness is so severe …there are people who are never going to understand they have an illness that affects them negatively and that’s because of their illness.

Another clinician said,

…[we have a client] who is on an injection every four weeks. That is his/her stance, that s/he will not take his/her injection and myself, not just myself, but the other team members, . . . everybody who goes and sees him/her on the day of his/her injection. S/he is not violent s/he is just very polite and says no, like s/he feels like that is the only kind of -… , it is his/her last piece of control and s/he wants to resist his/her injection. So every four weeks a Form 47is put on him/her and the police know him/her well and they bring him/her to the Guelph General Hospital and s/he gets the injection up there. The team psychiatrist goes, with police, like everybody, the nurse, and s/he gets his injection and s/he just gets up and leaves and that’s it. The same exact conversation will happen, with staff and him/her again in four weeks.

Participants pointed out for many clients the Form 47 is never used, and for others, it may be used once or twice when the CTO is new, but not continuously.

*Research Question 4: What are the Guelph ACTT staff members’ experience and perceptions about the appropriateness and helpfulness of CTOs with ACT team clients?*

It was clear that all of the clinician participants believe that it is in the best interest of certain ACTT clients to employ CTOs at particular times. To better understand their thinking, we asked them if it was possible to predict which clients would have positive outcomes following the use of a CTO. They agreed that it is very difficult to predict which clients will do well on a CTO.

Every client is so different and life is so different, right? Different things come up and – that would be amazing if we could predict, but we can’t, we don’t have that type of power and every client is different, so I don’t think it is a predictable kind of thing.

Several clinicians spoke about how they have often been surprised by clients who have histories of many hospitalizations and seemed to have no or little insight regarding their illness at the time they are put on a CTO; but over time they have progressed very well.

When we either took them on as clients, the ACT team, or when they were put on the CTOs, I probably would not have guessed that they would get to a state that they were going to…have the insight that they have now. If I had just compared them to someone else. I don’t think I would be able to predict which person would do that very well.

Although there was agreement that accurate prediction was not possible, the clinicians identified several types of behaviours that appear to be associated with positive outcomes. These include insight that the client has a mental illness requiring treatment, or at least recognition that following treatment recommendations helps to keep him or her out of hospital.

There are other people, who really don’t have real great insight but they have learned to – they have gotten to a point in their recovery that they – they want to follow treatment because they don’t want to go into hospital and they don’t want to have the negative consequences - and that sometimes has been a changing point.

Another clinician pointed out that when the client’s medication controls his or her symptoms well, this seems to contribute to positive outcomes.

As well as the response when they are on medication; if their symptoms are sort of treated well and well controlled when they are on medication, I think that’s a really positive sign because we do have some folks who are on CTOs who are managed on medication but still have a lot of symptoms even though they are at their highest doses of multiple medications. So, that sometimes it is not so good because they are still quite ill despite having – adhering to their medications. They are on a CTO now but it is just not holding them.

Another positive sign is when a client is able to increase independence with respect to taking medications.

It would be things like they’ve become more independent in their medications. So, we are not watching them every day now. They are taking a week supply at a time. So, once they are doing that, taking a week’s supply at a time, we are really watching closely, are they having symptoms, you know, is there blood work that is going to look at levels?

Other factors that appear to have a positive impact include changes in lifestyle – particularly stopping the use of substances.

…and I’m talking about clients that use substances. If they change that lifestyle they might be able to gain more insight or be well enough to be more compliant. Those are the clients I think maybe I would say predict a level of insight if the lifestyle was different but it is very hard.

Some clinicians noted that peer or family support for the CTO seems to be helpful.

I think for folks who have family or peer support who can sort of reinforce those positives that they see occurring because of the CTO would be helpful. Especially if people are saying they are on a CTO and they don’t really think it is doing anything, if they have reinforcements from family who says, yeah, but you came out to three events and you don’t usually come out to events. Or you know, we could have a conversation or we – they could interact - that feedback is really, really powerful when it comes from families or peers so I think that is helpful. I don’t know how…yeah…how often that happens though.

The clinicians also emphasized the importance of the client’s own efforts as well as the support from family.

I think his/her goals changed quite a bit too. I think s/he became more health oriented, so s/he was looking at life differently. . . s/he got more focused on taking care of him/herself than in substances, so there was a little bit of insight, a shift . .

I think a lot of it came from her/him. One of the things I noted is that s/he had a very contentious relationship with family members but the parents were steadfast in supporting that CTO. They came to every meeting, and they tried to enforce that we kept the CTO and that s/he took the medications. So, s/he got a lot of support from there.

*The importance of the combination of the CTO and Assertive Community Treatment*

Clinicians noted the *combination* of the CTO and the intensive support from the ACTT seemed to be important to positive outcomes. One clinician pointed out that the ability to extend the duration of a CTO for an adequate period of time along with the continuing support from the ACTT is important.

They [a client] began with us fairly intensively in that we were daily going and seeing them for medication, they knew that that was mandatory and that…there were consequences if they weren’t there or they refused to take their medications. That, I think, led to more stability where this person hasn’t gone back into hospital since joining the ACT team but [it] allowed them to look at different medications and different regimens for us meeting with them that work better for the client. So the client has…I wouldn’t say just managed their illness better but things in their life and they’ve been able to successfully gain employment and develop some social groups. Start to investigate interests and life goals and that too. I think that a lot of that has come from the stability they’ve gained and with that stability the ACT team has then been able to move away a bit to less intensive services with the knowledge that we could implement while they are still on the CTO, we could go back to seeing them daily again if needed or up the…contacts or interventions that we are doing with them. So, I think that is probably a big part of it. That whole time there was that ability to increase services again, it wasn’t like as soon as they did slightly well the CTO was gone. Then they could have a real big change or big fall in how well they are doing.

We heard that one of the clients who is no longer on a CTO attributes the CTO to making a difference in his/her recovery:

I believe . . . . s/he did a lot on his/her own, the whole independence piece but I think the thing that changed the cycle was the CTO. It really – and s/he’ll even say it. S/he tells us all the time – sometimes we have altercations in the waiting room upstairs with other clients and s/he is just, like, “I know what that feels like. I was there one day and I know what that feels like. I wish I could just talk to them but I know I am not supposed to”. Yeah, so definitely, yeah, the CTO played a big part in his/her recovery.

The close working relationship between clients and clinicians, alongside the frequent contact they typically have, appears instrumental in the ability of the ACT team clinicians to act quickly to support their clients. The team members meet daily to discuss the clients with whom they work (not all are on CTO’s), which provides the opportunity to discuss medication issues with the psychiatrist, as well as to discuss any problematic issues that require immediate attention.

One clinician compared the support clients on CTOs receive from this ACTT with what appears to happen in other settings:

What I see in other community resources is that they are on a CTO, they miss the appointment or they miss the injection but I don’t know if it is a communication issue but despite being on a CTO, nothing is done about it. They are allowed to decompensate to the point to where they require issuing a Form 1, and then it, it doesn’t really change their course of treatment. Whereas here we are very diligent, mostly because of the team are very aware of who needs medications when, and how many times they have missed it in the last week if it is oral medications and really staying on top of it…

This clinician shared the belief that the ability of this particular ACT team to communicate well and to intervene quickly leads to a reduction in the degree of decompensation in client functioning, resulting in fewer hospitalizations or shorter hospital stays.

…they have relatively shorter hospitalizations and get out quicker so it doesn’t have a big impact on their life as it had in the past. I think it really has to do with the team’s ability to be mobile to reach out to people. To stay on top on them.

Overall, the clinicians stated that their clients have had a decrease in hospitalizations since being placed on a CTO. “Most of our patients, probably all of them had, if not no hospitalizations, a decrease in hospitalizations since they have been on a CTO.”

*How should effectiveness of a CTO be defined?*

We asked the clinicians about clients for whom the outcome of the CTO was not what the team had hoped. This question evoked further questions about how the effectiveness of a CTO should be defined.

When I was thinking of this question somebody popped into my mind and then I had to kind of re-think because like what is success and what is failure on a CTO? And while this person really is adamant – that s/he doesn’t like it, s/he doesn’t want to be on it and if you asked him/her any day of the week s/he would rather not be on a CTO. So, in the long run we were hoping that s/he would maybe see the benefit of it but s/he hasn’t gained any insight. You know, I look back and I think, like s/he is not in hospital and s/he was in hospital chronically, s/he was homeless for a very long period of time. S/he is no longer homeless and has had stable housing for a year. So his/her medication is – s/he is more compliant with his/her medication, which is great, s/he uses substances so his/her symptom management is not ideal. So, there are some things where you think despite this, s/he is not well managed on his/her medication and s/he is still very, very resistant to the idea of a CTO; but those are huge successes to have – have stability in terms of shelter and not be in hospital and have some of those deficits kind of build up for him/her.

Another clinician made a similar point:

I’ve had experiences with people who never gain insight. We have a few on the team now who absolutely have no insight but objectively are doing better so they are not hospitalized as much. So, from their perspective – they would say it is terrible and it never works and how dare they . . . but objectively they don’t end up in hospital as often or at all since the CTO.

Another example of a client for whom the question of effectiveness is complex was described

like this:

There is one person . . . . we – I think as a team we feel torn about that CTO. S/he came to us from hospital and on the CTO and it has been enforced ever since. S/he has a long history of illness, no insight, still no insight, despite that. Every six months when the CTO comes up for renewal and the papers have to be signed. It is a very transparent process. You have to go explain why they [clients] remain incapable and these are their SDMs and this is the reason we are renewing the CTO. Every six months there is an increase in symptoms for this, this person where s/he is increasingly paranoid, and increasingly avoidant, sometimes s/he will hop on a bus to [another city]. So it is – a very stressful, stressful situation for him/her. That being said, s/he has a long history of homelessness and things like that, so right now the CTO has been a very – has been used as a protective factor, right. So, s/he has remained housed, s/he has remained as far as we know compliant with his/her medications. Those types of things so – and we’ve – we as well as the family have seen a vast improvement in his/her quality of life right? So, s/he is able to do things during the day, s/he is able to find enjoyment in activities, those types of things.

Clients with personality disorders are not seen as good candidates for a CTO.

People with personality disorders, it is just a conflict because you are trying to promote independence but the CTO sort of takes away that independence, sort of puts the onus of care on the team. So, it just – especially the cluster B type personality disorders. It just becomes a conflict and they use it against [us] - Like,” I need your help now, I am not going to take my meds, you’ll have to do a form forty-seven.” It is not good.

Apparently when clients get caught up in control issues with the treatment team it undermines the goals of treatment.

We asked whether involvement with the law was commonly a reason for putting a client on CTO. The clinicians agreed that the decision to put an individual on a CTO is not dependent on an individual’s involvement with the police per se, but rather more individualized and based on a number of factors.

It is other issues that are causing them to get involved with the law…finances, housing, …that can all play a factor since it is dependent on sort of the mental health status. If it is just dependent on anger issues or just drug issues, then this is not as much [of an influence on the decision] – but if they are psychotic and they are out there committing crimes – assaulting people because of that, then definitely it would play a factor in thinking about putting them on a CTO.

It is very individualized. Our clients often have interactions with the police but it might not be related to…you know, it is unrelated but it doesn’t mean that they are going to go on a CTO just because they had an interaction with the police. It is very individualized. Yeah we look at the history, either hospitalizations or level of insight.

*Research Question 5: How do the ACT team members reconcile the use of CTOs with the “client-centered, recovery-oriented” approach to service delivery as articulated by the Ontario Program Standards for ACT teams (Government of Ontario, Ministry of Health and Long-Term Care, 2004[[4]](#footnote-4).*

The ACTT clinicians, all of whom have completed recovery training, agreed that the answer to this question depends on one’s view of the word “recovery” and what client-centred recovery care looks like. One clinician said,

I strongly believe that a person who is not capable to make treatment decisions in that they don’t understand sort of, the signs and symptoms of their illness, can’t really appreciate the risk and benefits of treatment and how it applies to them, and therefore, can’t really make decisions about how to best proceed with their recovery. It is a more long term solution versus when they come into hospital, they are made incapable, they are started on treatments and we are supposed to think that after two weeks of an inpatient stay they have all of a sudden gained insight to their illness and go out and function well and move on to do what they want in their life.

It appears that as a group, the ACTT clinicians see the recovery model as being compatible with their work in that, even when a client is subject to the conditions of a CTO, the client’s personal goals remain a priority and are respected and supported as much as possible by the team. The clinicians work to incorporate the client’s goals with the treatment goals of the CTO, so that what are first involuntary, mandatory goals (of the CTO) become mutual goals between the clinicians and client aimed at enhancing their lives in the community.

In my mind, recovery is letting the client sort of steer the ship. Where do they see themselves, what are they wanting to engage in and what are their goals? So, I think that when people are on a CTO, it is about blending what their goals are with also staying focused on what are some of the goals of the CTO, and hopefully making the CTO a part of their goals. So, they might not agree to why they may be on the CTO, but we might be able to come to a common ground that we both don’t think that you should be in hospital and that in fact, your goals of returning to school or starting relationships would be really impaired if you were in hospital. And so, you know, really allowing them the opportunity to voice what their goals are and to support parts of it as much as we can.

Regarding clients of the ACT team who are not subject to a CTO, the clinicians believe the ACT model is compatible with a recovery model. The ACT clients who are voluntary “guide the level of interactions” they have with the team and if being involved with the ACT team is not helping them reach their goals, the team will refer them to other community resources that better meet their needs.

I think, depending on how you define recovery, it can’t be one hundred percent because there are a bunch of people on the ACT team that are not voluntarily doing it…but the hope is to help them to get to a state in their life where they can engage fully in a kind of recovery-oriented way.

One clinician spoke about the impact of severe mental illness on some clients’ ability to develop their own goals toward recovery, and how a CTO and the ACT team can have a positive influence in the recovery process:

Without the CTO, with some clients you would never be able to start to help them reach their goals. So they wouldn’t be at a point where they could define their goals. Where they could understand that they had goals, that they were at a point where they could even evaluate where they want to go and what they want to do, and what is important to them and how they might get there. They wouldn’t be at that point without a CTO. And that is directly based on the level of mental illness. You know, especially with schizophrenia, which is, the majority of our clients suffer from schizophrenia and it strikes at a time in life when you start to develop life goals, where you start to develop independent living skills. All of those things are stolen from young people who are diagnosed with schizophrenia and – severe schizophrenia. So, there are varying levels - we deal with the most severe. That is what our mandate is and so it is really tragic, what these people lose. Not all of them, some of them get to – it is amazing, where they can be and what they can do. [For] some of them that is directly related to the CTO. It is what got them well, kept them well and got them to a place where they could develop insight.

Clearly, a common view on this ACT team is that CTO’s do assist in recovery with some clients who are living with severe mental illness. They see the CTOs as preventing lengthy periods of psychosis and frequent re-hospitalizations, thus allowing clients to experience longer and longer times of stability during which they can develop and achieve life goals in a way they have not been able to previously.

*The Context from Clinician and Client Perspectives*

This section includes what we learned from the clinician and client participants about the relationships between the clinicians and clients on CTOs and how the clients feel about being clients of this ACT Team. We think it provides important context for the results reported above.

*How the clinicians described their relationships with clients on CTOs*

All of the ACT team clinicians agreed the *quality* of the relationships that team members develop with clients plays an important role in client outcomes. They spoke of the challenges clients have faced in the past with multiple hospitalizations and numerous mental health professionals in and out of their lives, and how this influences their initial ability to develop trust in the ACT team professionals. However, although the existence of a CTO often impairs the relationship with the client initially, in the long run it can lead to a stronger rapport:

But I don’t think over time that that [the CTO] remains as a barrier to having a strong therapeutic rapport with someone. If anything I think it probably has allowed us to have better rapport with some people in that they have maintained some stability for a longer period so you can get to know them better, you can meet their needs in many different ways so that you know, if they do have a period of increased symptoms or end up going to hospital again, you do have that to build on still.

The clinicians stressed the importance of developing trust in the working relationship and being aware of the power held by the clinician (when a CTO is in place).

I think it is very important that there is a trusting relationship…because there is a very big power differential between what you could enforce and what [the client] is able to do to avoid that.

The clinicians agreed that a balance must be struck between the power and control inherent in the CTO while also encouraging clients to exercise autonomy in their personal goals related to living in the community.

So the CTO is very specific and it may be they aren’t able to exert their autonomy when it comes to their medication decisions, but where else in their life can they utilize their autonomy?

We asked the clinicians about the differences between the relationships they have with ACTT clients on CTOs and those they have had in other workplaces. Several clinicians noted that a major difference is the long-term nature of the client-worker relationship through an ACTT. They highlighted that they work with clients over a much longer time period than most community treatment organizations, and, because of this, they can develop relationships more slowly, allowing for patience and persistence for clients who are initially against complying with the CTO conditions.

… you have time for that patient or client that it may take two years before they agree that they are not going to slam the door every time you show up or walk out of your appointments every time. The importance of ACT is that it meets people on a much different level in their life and can be supportive in different ways then…short-term programs.

Others talked about how well they come to know their ACTT clients, and how with developing trust, the clients share aspects of their lives apart from their illness.

It is pretty amazing working with someone for over such a long period of time, we have the opportunity to, you know, be involved with the patient, but they share a lot about what is going on, you know outside of them. So, we get to learn about, what is happening with their children and you know, someone’s kids is getting straight A’s and they tell us that and that is really important for them that they are able to share that information.

The clinicians acknowledged that developing trusting working relationships is also important because “…for some folks we are their only support”. This echoes comments from some of the client participants who shared that they have strained or non-existent relationships with their family members, and may have no supportive friends, which makes their connections with the ACT team clinicians so significant.

*Professional boundaries*

The issue of professional boundaries was discussed in light of these close working relationships; the clinicians very frequently work with their clients in their own homes as well as in the community, and due to the long-term nature of the work, the clients often know when a clinician is on parental leave, for example, and will ask about their family as well. The “relational” nature of the clinician/client relationship was stressed as the work is not solely focused on “treatment”. The clinicians purposefully dress in casual clothing, so that when they are spending time in the community with their clients they do not “stick out like a sore thumb” as the person’s worker. With respect to attention to boundaries, one clinician put it this way:

Just based on the intensity of our service we are more apt to develop a closeness and a protective nature of our patients and it is something we have to monitor closely because we have to maintain that professional mental health worker/client relationship. Our clients, based on the fact that they see us sometimes twice a day every day seven days a week, they sometimes start to view us as friends and you know, some of them don’t have family. They have ACT, so it is – can be difficult to maintain that boundary and it is not always easy to see yourself slipping into it.

The ACTT clinicians discussed the importance of supporting clients in their personal life goals and remaining client focused, even when a CTO is in place and may require enforcement. They shared the following case example:

[The client] has very poor insight, is quite contentious – but s/he is off a CTO now. Had many very long hospitalizations and throughout those often…disagreeing with their care compared to other people and you are always at odds with them. I think through some change in our approach with them, in giving them a little more leeway and also just being upfront, saying, “this is what we are going to do, but we don’t ever want you to be in hospital again. So we are going to do everything to help you avoid that”. S/he has – since the last time s/he has been in hospital, which I think is coming on two years now or more, …has mellowed quite a bit more, still has periods of being quite symptomatic and not necessarily agreeing with us on everything by all means but is at a point where the SDM has decided that this CTO isn’t being used, it is not having to be enforced; and this client is actually following through with taking their medication in a much more compliant way, to how it is ordered. They still make some different choices in that too, but I think that has come from the client beginning to trust the team that we are not out to get them or not going to be unfairly treating them when they are unwell or do have symptoms arise.

It is apparent that working towards giving the client as much control as possible has been helpful in engaging clients and developing trust.

*Challenging times in the relationship*

We asked the clinicians about differences in the relationships they have with clients on CTOs compared to those they have with ACTT clients who are not on a CTO. Several clinicians saw their relationships with these two categories of clients as very similar. Two differences were mentioned. One difference is associated with the difficulty in developing a trusting relationship in the early stages of the CTO when the client is often very upset about having been put on a CTO. The second difference relates to the need to discuss the CTO with the client every six months. This discussion is mandated by the legislation, which requires that a CTO cannot last longer than six months; a renewal involves a number of steps that make the client aware that the CTO is to be renewed. At the time of renewal the physician is required to work with all who are involved in providing care and supervision in the community, including the client, to develop a renewed Community Treatment Plan (CTP). The physician must also assess the client’s capacity to consent to treatment for the CTO. The client (and the SDM if applicable) must receive a copy of the “Notice of Intention to Issue or Renew at CTO” and a copy of the Community Treatment Plan (CTP). The Rights Advisor is also informed of the intention to renew the CTO and this Advisor informs the client about his or her rights and then informs the treatment team whether or not the client wishes to have a hearing regarding the renewal of the CTO. A hearing is mandatory every second renewal or every 12 months.

Several clinicians talked about how upsetting this process is for many clients on CTOs. The reasons for issuing the CTO must be described and clients often find this review of past behaviours upsetting and embarrassing. It was clear that the clinician participants wished that it did not have to happen so often.

I can think of two patients that every time the CTO renewal process comes up, it doesn’t – it doesn’t go over too well. They are upset, they…during one particular patient’s meetings s/he, like, always gets up and leaves and is angry. . . . With this particular person we remind her that s/he came to us on a CTO. We didn’t – they think that it is our fault, so we try to let them know, that we are only trying to help you – but sometimes they do have that perception that we are the bad guys and we have this control over them. So it does happen, but, that is during the renewal time. These two individuals that I can think of have become really upset. But otherwise, they are pleasant on the most part to work with and they interact with us.

Another participant said,

The clients, they don’t really talk about the CTOs unless, like I said, we are thinking about issuing a Form 47 and they have to know. Other than that, we don’t try to bring it up as an area of [discussion]. So, … we are talking about other things and really having them as much as possible to be involved in their treatment planning and care. Never sort of using the CTO punitively, although they see it that way sometimes, but trying to work with them and giving them options to take responsibility. “We don't want to do this [issue a Form 47], so when would you be able to come in? When would be the best time? Can we meet you somewhere? Can you come here?” … like, really working with them.

Several other participants also emphasized that the CTO is never used as a “punishment” and that the team members work very hard to find ways to engage with the clients and avoid having to issue a Form 47.

Apart from the difficulty establishing trust initially and the disruption associated with renewals of the CTO, clinician participants noted that they work hard to engage the clients, to be client-centered, to enable the client to have as much choice as possible, to focus on supporting the client to meet his or her own goals, and to increase the client’s independence.

We want to maintain health, we want to maintain independence and we want to do that long-term out of hospital and that is what we are trying to prevent, to keep you [the client] well in the community.

*Client participants’ perceptions of the Guelph ACT Team*

Recognizing that the client participants were experiencing CTOs within the context of a particular ACT team, we asked them to share their thoughts and feelings about their experiences with the team. Most comments were very positive. Two participants talked about feeling more trust in the members of the ACTT as the years have gone by. Another said “the longer I come here, the better I feel”. Yet another participant explained what may be one of the reasons many clients were so positive about the team.

I don’t think you can make them mad…No, they won’t say, “listen here”…if you get off the medication then you will be locked up’. …They won’t say that. They say, “my highs are too high and my lows are too low”…Maybe. I agree with them there.

Several client participants talked about how much they liked individual ACTT clinicians – and knew they were genuinely trying to help them. One participant said the staff members seem to really care, and s/he described them as responsible, friendly and knowledgeable. This same participant indicated that in some ways the ACTT were like family. Another said “there was a lot that they did for me, that I appreciate, you know, we became like friends, you know, they are really nice”.

Another client participant said the ACTT gets him/her out of his/her home “they’ve helped me with programs, and the community and where I can go. . . They’ve done quite a bit”. A second participant also acknowledged that the ACTT helps him/her to get “out and about” by encouraging attendance at various activities. Another participant indicated the ACTT want him/her to get out more with them, and that sometimes s/he plays pool or goes bowling with a team member– but this client also noted that sometimes the staff member is too busy to do these activities.

The researchers received the impression that most of the client participants experience the ACTT staff as very responsive to their individual needs. For example, one participant who had been the client of another ACTT indicated that the Guelph ACT team seemed to be able to provide support without leaving the client feeling intruded upon.

This one is better….The other ACT team was frustrating. They were sort of like cheerleaders….They had like this…– they were hyper active. That is what I mean….They were too involved….I like living on my own, um, but they [Guelph ACTT] give me my space.

*Helpful ACTT services*

Client participants talked about the following as helpful services that the Guelph ACTT provides: medication delivery; convenient office location; help with finding housing and obtaining subsidies; frequent home visits; help with grocery shopping or getting telephone service/repairs; help to get a health card, to get a driver’s license and to get eyeglasses; transportation; help to better understand the mental illness they are dealing with; opportunities to participate in sporting events and groups such as cooking groups.

One service that some participants noted is very helpful and not as available through other mental health programs is frequent contact with a psychiatrist. One participant said s/he was very grateful that s/he could see the psychiatrist every two weeks. S/he said, “that is what I was dying to have…was someone like…to tell me what is going on.” Another participant talked about how repeated efforts to adjust his/her medication had been very helpful.

Only two participants had anything negative to say about the ACTT. One participant said s/he did not like one particular clinician as well as a previous one, and the second said s/he has noticed some recent reductions of services. S/he said, “They used to take us to twice a week activities…. They have something like two or three events a month now. We used to go play volleyball, soccer, we used to go hiking, walking and the new owner [of the Homewood Health Centre] cut everything.” According to this participant, previously ACTT staff would take clients to the clients’ homes after activities, but now they have to take the bus. This participant clearly appreciated the activities that are provided and was missing those that are no longer available.

It is apparent that the Guelph ACTT clinicians very much enjoy working with the clients and genuinely care about their wellbeing. When they talked about the clinicians as being “like friends,” the client participants also seemed to be saying they are aware that the clinicians care about them and some were able to say how much they appreciate this kind of relationship and support.

**Discussion**

Analysis of the data collected from the client participants revealed themes similar to those reported in previous studies of service users’ perspectives on CTOs (Brophy & Ring, 2004; Fahy et al., 2013; Gibbs et al., 2005; O’Reilly et al, 2006). Clients’ attitudes toward CTOs in this study were contradictory or mixed. The majority of the clients described negative feelings initially, but a few recognized from the beginning that it might be helpful to them. After a period of time on the CTO, three clients were very sure it had been helpful and had improved their lives while several others acknowledged they felt less negative about the CTO than initially. However, some of those who recognized its benefit expressed a wish that when enforcement is necessary it could be done in a less public and embarrassing way.

Similar to the results of a study by Fahy et al., (2013), a few participants in this study did not seem to remember or understand why they had been put on the CTO; this may be related to the fact that for most, the CTO was issued just prior to discharge from hospital. Some seemed to be aware that they could legally challenge the CTO, but two participants seemed resigned to accepting the order, believing that a challenge would be futile. Most of the client participants recognized that the ACTT clinicians believed the CTO would benefit them. While some believed that without the CTO their quality of life might be worse, others stated the CTO was unnecessary and that they would follow the treatment plan without it.

Similar to the previous study of clients on a CTO in Ontario (Schwartz et al., 2010), several participants in this study were concerned about the stigma associated with mental illness and the loss of dignity that accompanied the experience of being on a CTO. They stressed the importance of dignity and respect, and feared further stigma if the existence of the CTO became known. This concern led to the suggestion from one client participant that instead of police officers, trained mental health staff should be designated to bring a client to the physician when a client has reneged on the treatment plan. This mirrors a concern expressed by family members in a previous Canadian study – “When the police come I wish they would come up in a plain car, but when they come up in the black and whites and coming rushing up… it’ll take you a month to live it down” (O’Reilly et al., 2006, p. 520). Family members as well as clients are concerned about public perception and the stigma associated with police involvement. Police officers in plain clothes and unmarked cars would clearly be a welcome alternative. We recognize, however, that some situations may require uniformed police officers.

The data collected from the ACTT clinicians indicated that this team is clearly following the requirements and intentions of the Mental Health Act with regard to Community Treatment Orders. They are working closely with in-patient hospital teams, family members, community resources and the client to develop comprehensive treatment plans that are “less restrictive than being detained in a psychiatric facility” (Ontario Mental Health Act, Section 33.1 (3)), and which they believe will benefit the client. They are also following the Act’s conditions for issuing an order for examination (Form 47). These conditions include making reasonable efforts to locate and inform the client and/or the SDM of the failure to comply and that an order for examination may be issued. The clinicians must also provide the client with assistance to follow the order.

We repeatedly heard from the clinicians that issuing a CTO is always the “last resort” and happens only after less coercive measures have failed. Furthermore, when a client fails to follow the treatment plan, the ACTT clinicians put much effort into locating the client, offering alternative ways of following the plan and ensuring he or she is aware of the consequences of continued failure to meet his or her obligations under the order. It was also clear that the decision to put a client on a CTO is carefully considered with all team members involved in the discussions. They told us that in most cases the team reaches consensus about the decision.

All of the clinicians with whom we spoke believe that for clients with severe mental illness for whom nothing else has worked (to keep them out of hospital or from being incarcerated or free from repeated psychotic episodes) that CTOs are helpful. They were able to describe several clients who have developed insight into their illness and/or recognized their need for treatment after a period of time on a CTO. They acknowledged that with respect to some clients, they were truly surprised at the outcome and would not have predicted it.

Although accurate prediction is not possible, from their experience, the clinicians identified several conditions that seem to be associated with positive outcomes. These include: insight that the client has a mental illness requiring treatment, or at least recognition that following treatment recommendations helps to keep the client out of hospital; the client’s medication controls his or her symptoms well; increased independence in managing medications; peer or family support for the CTO; and the client’s own efforts. The ability of these conditions to predict outcome could be tested in future research.

This study is the first to focus on the experience of clients and clinicians when CTOs are used in combination with Assertive Community Treatment. One of the themes in the CTO literature is the need to ensure that the resources in the community are sufficient to support the use of CTOs. Several studies of clients’ perspectives have reported clients recognize that one advantage to being on a CTO is that it ensures they get the services they need (Gibbs et al., 2005; Brophy & Ring, 2004). Some reviews of the research have pointed out that the positive effects of CTOs may be more related to the intensity of services clients receive than the compulsory nature of the CTO (Churchill et al., 2007; O’Brien, McKenna & Kydd, 2009).

As reported in this study, this team meets daily and communicates well. They become very familiar with their clients and work with them on a long-term basis. Turnover among the clinicians is very low. All of these factors are very likely contributing to the positive outcomes reported by both the client participants and the clinicians in this study. The findings from this study certainly support those of the U.S. study reporting that the combination of a CTO with ACT services significantly decreased the likelihood of hospitalization and increased the likelihood of high engagement in services (Swartz et al., 2010). This points to the need for future studies to explore the relationship between intensity of services and outcomes for clients on CTOs. Should all clients put on a CTO receive Assertive Community Treatment, or should Assertive Community Treatment be tried in all cases before the use of a CTO? Do CTOs benefit clients who are being monitored by a less intensive service?

This ACT Team makes a strong argument that the coercion inherent in a CTO is justified in view of the increased quality of life they have witnessed for many severely mentally ill clients. They argue that while the CTO does decrease client autonomy, skilled and dedicated clinicians, through patience and persistence, can develop a positive rapport with these difficult to engage clients; they can also successfully encourage them to identify personal goals toward which they and the client can work together. As has been shown in previous studies, this ACT Team can identify a number of individuals who in spite of long histories of severe illness and initial resistance to the CTO have come to a point where they perceive the CTO as helpful and facilitating a better life. They can describe still more who may not themselves acknowledge positive changes related to the CTO but whose living situation and functioning in the community are objectively much improved.

One change that the clinicians would welcome is a longer period between renewals of the CTO. They referred to how several clients repeatedly become upset and angry at the time of CTO renewal, yet are cooperative at other times. A previous study also reported that a relative complained that the three-month duration of the CTO in Saskatchewan was too short because “the time of renewal of a CTO could reignite conflict” (O’Reilly et al., 2006, p. 522). A few of the client participants in this study declined to talk about the events and behavior that led to their involvement in the mental health system and being the subject of a CTO. One acknowledged that it was very painful to talk about this history; another stressed concerns about privacy. Although this requires further study, we wonder if some clients might also prefer to have longer periods between renewals. Such a change in the legislation may be unrealistic in view of the continuing controversy about CTOs and the need to balance individuals’ rights to autonomy and self-determination with the need to reduce risk. However, it is an observation that should be explored further and considered when policy regarding CTOs is reviewed.

This study is limited by its reliance on clients and clinicians from only one ACTT. The findings are therefore not generalizable. It is also limited in that it did not include the perspectives of family members or substitute decision makers. However, the findings support those of previous studies, and suggest the need for more research into questions about the optimal amount and type of community services required by clients on CTOs and the characteristics of clients who are most likely to respond well to a CTO. We also need to know more about how to create and support teams of mental health professionals who are able to do this important work effectively. In particular, it will be important to study the most optimal composition for an interdisciplinary team to ensure team members have the appropriate education, training and resources; ongoing attention to caseloads will be important to ensure clients with higher levels of acuity receive the more intensive support they require.

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1. The Guelph ACT prefers to use the term “clinician” rather than “service provider”, to denote that all of the team members are members of a regulated health care profession. [↑](#footnote-ref-1)
2. We are using numbers and “his/her” and “s/he” in this document in order to protect the identity of client participants. With such a small sample, identifying gender might make the participants more identifiable by those who know them well. [↑](#footnote-ref-2)
3. This refers to the form that the physician completes when a client has failed to follow his or her obligations under the CTO; it authorizes the police to bring the client to the physician for an examination as to whether or not the client needs to be placed on a Form 1. If the psychiatrist does not deem that the client meets the criteria for a Form 1, the client will be offered ACTT services including medication support as well as other services if needed at the time of the assessment. [↑](#footnote-ref-3)
4. The ACT Standards state, “Client empowerment, involvement, and choice are fundamental to the principles and operation of individualized, collaborative and effective ACT service delivery” (p. i). [↑](#footnote-ref-4)